United States Department of Labor
Employees' Compensation Appeals Board

R.T, Appellant	)	
and	)	**Docket No. 16-0374**
	)	**Issued: November 2, 2016**
DEPARTMENT OF THE INTERIOR, NATIONAL PARK SERVICE, Deer Lodge, MT, 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:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On December 28, 2015 appellant, through counsel, filed a timely appeal from an August 11, 2015 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.

[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 established chemical encephalopathy causally related to exposure to chemicals on July 8 and 10, 2009 in the performance of duty.

FACTUAL HISTORY

On July 15, 2009 appellant, then a 36-year-old seasonal maintenance worker, filed an occupational disease claim (Form CA-2) alleging that on July 11 and 12, 2009 he experienced tingling, nerve spasms, loss of muscle control, numbness, rapid and heavy breathing, tightness in chest, sweating, panic, and fear after he cleaned out hazmat sheds on July 8 and 10, 2009. He continued to work full duty and stopped work on July 31, 2009.

An incident investigation report prepared by Robert Glover, an accident investigator, indicated that on July 8 and 10, 2009 appellant and three other Youth Conservation Crew (YCC) members cleaned out a building spill in a hazardous materials (hazmat) storage shed. He noted that the shed contained a 55-gallon barrel of boiled linseed oil, which was 80 percent of the contents of the spill reservoir, and the other 20 percent of the spill were unknown organic and nonorganic solvents. Mr. Glover reported that the workers used rubber gloves, latex gloves, wide putty knives, paint stripper, Grez-Off, and N95 respirators.

The employing establishment provided various statements from appellant's supervisors. In a July 13, 2009 statement, James W. Perkins, a project manager, related that on July 8, 2009 he directed YCC members to clean out excess material that had collected in the bottom of a hazmat storage shed. Appellant assisted the other YCC members on July 8 and 10, 2009. On July 13, 2009 he informed Mr. Perkins that on July 11 and 12, 2009 he experienced episodes where he felt like he could barely breathe or feel his extremities. Appellant believed that it could be related to the chemicals he cleaned. In an August 14, 2009 statement, Laura Rotegard, the superintendent, related that appellant informed his supervisor of symptoms that he suffered over the weekend, which he attributed to exposure at work. Appellant was instructed to file an occupational disease claim. Ms. Rotegard noted that she requested that her zone-safety manager, Mr. Glover, conduct an investigation. The employing establishment also submitted notes from a July 27, 2009 conference call regarding actions to take following the July 8 and 10, 2009 employment exposure incidents.

On July 22, 2009 appellant was initially examined by Dr. Patrick J. McGree, a Board-certified surgeon, for toxic exposure to multiple chemicals at his workplace. Dr. McGree recounted that on July 8 and 10, 2009 appellant cleaned out a building where multiple chemicals were stored and that on July 11 and 12, 2009 appellant experienced episodes of cramps and numbness. He reviewed appellant's history and reported an essentially normal physical examination. Dr. McGree opined that appellant had chemical exposure, multiple spasms and contractures, and a history of Hepatitis C. He continued to treat appellant and provided progress notes dated July 23 to August 21, 2009 regarding his treatment of and communication with appellant for complaints of tremors, chest pain, and difficulty breathing. In an August 7, 2009 progress note, Dr. McGree informed appellant that his drug screen was positive for marijuana and opiates. Appellant explained that he had been treated for chronic pain and had a medical card to smoke marijuana.

Appellant also underwent diagnostic examinations. A July 24, 2009 chest examination by Dr. Dennis Palmer, a Board-certified diagnostic radiologist with a subspecialty in vascular and interventional radiology, revealed clear lungs and no evidence of acute cardiopulmonary disease. A July 30, 2009 pulmonary function examination by Dr. K.J. Popovich, a Board-certified internist with subspecialties in pulmonary disease and sleep medicine, demonstrated no significant changes in measured airflow parameters.

Dr. Carlos P. Sullivan, a neurologist, also treated appellant. In an August 12, 2009 neurology consult report, he described the July 8 and 10, 2009 exposure incidents at work and the symptoms appellant experienced after the exposure, including the July 11 and 12, 2009 panic episodes. Dr. Sullivan identified linseed oil and acetone as two of the chemical agents to which appellant was exposed in the storage shed. He reviewed appellant's history and reported essentially normal physical and neurological examination findings. Dr. Sullivan diagnosed probable carpal pedal spasm related to stresses. He opined that toxic chemical effects could not be ruled out completely as it was unknown to which chemicals appellant had been exposed.

In progress notes dated August 13 to September 15, 2009, Vincent P. Matule, a licensed social worker, noted that appellant sought therapy after assisting in a clean-up at work. He explained that appellant still experienced body twitches, seizure-type activity, drooling, slow and heavy breathing, and anxiety. Mr. Matule reported that it was obvious that appellant had a great deal of fear, anxiety, depression, and anger as a result of his participation in clean-up activity in 2009.

By letter dated August 17, 2009, OWCP advised appellant that the evidence submitted was insufficient to establish his occupational disease claim. It requested that appellant submit additional factual information regarding the July 8 and 10, 2009 employment exposure incidents and medical evidence to establish that he sustained a diagnosed medical condition as a result of the alleged exposure at work. A similar letter was sent to the employing establishment.

In a letter dated September 17, 2009, Judy Schnittker, an employee relations specialist for the employing establishment, recounted that during an interview after the clean-up on July 8 and 10, 2009, appellant complained of feeling "light-headed" and having to "spit junk out of his throat." She indicated that he did not take any time-off work until July 22, 2009 and that the other staff members did not notice anything unusual with appellant at work.

The employing establishment provided an inventory list dated May 15, 2009 of the 62 materials stored in the hazmat shed, which included ortho, indoor insect fogger (pyrethrum, permethrin). It also submitted a position description for a maintenance worker, the results of the analysis screening of the spilled material, and an August 25, 2009 investigative activity report.

Several material safety data sheets (MSDS) were also provided by the employing establishment for the materials o-xylene, m-xylene, p-xylene, toluene, ethylaminoethanol, black toner type L1, stripping gel, weatherseal, multipurpose grease, petroleum oil, prestone anti-freeze coolant, motor oil, butatone, dioctylphthalate, tetrachloroethylene, ethyl benzene, isopropyl, nonchlorinated brake parts cleaner, super heavy duty radiator cleaner, insect fogger, klean-strip kerosene, neatsfoot oil, Pyroil regular starting fluid, weitron-134a, super concentrated lead substitute, multi-surface waterproofer, premium starting fluid, and methyl ethyl ketone. The

MSDS indicated that aspiration and inhalation of these hazards could cause severe eye and skin irritation and that inhalation may cause central nervous system effects such as nausea, headache, dizziness, unconsciousness, drowsiness, and depression. The employing establishment also included MSDS for the chemicals linseed oil, motor oil, aquatic weed and brush herbicide, Hi-Light blue liquid, windshield deicer, Valvoline crimson #2 grease, safety solvent 5115, petroleum-based lubricating oil, tractor fluid, supreme engine oil, Valvoline oil, antifreeze-coolant, brake fluid, steering fluid, rust dissolver, mineral oil, transmission fluid, benzo perylene, thread cutting oil, WD-40, engine oil, hy-gard low viscosity, nondetergent motor oil, transmission fluid, and hydraulic jack oil. The MSDS indicated that these chemicals were slightly toxic and harmful and mildly irritant.

On December 31, 2009 appellant responded to OWCP's development letter. In an undated statement, he reported that when he arrived at work on July 8, 2009 he was assigned to assist the YCC members to clean the hazmat shed. Appellant noted that they used Citrus Clean, a paint remover, and Grez-off, a heavy duty degreaser, to clean up the floor and had to scrape up the sludge with a metal scraper. He indicated that he worked for eight hours on Wednesday and for five hours on Friday. On Saturday and Sunday afternoon, appellant experienced episodes of tingling and numbness in his fingers, arms, and face, heavy breathing, confusion, and panic. He also submitted an EPA fact sheet about the chemical methyl ethyl kerone (MEK), a print-out about the type of injuries that exposure to MEK could cause, and various medical reports with his personal, handwritten notes in the margins.

In a September 23, 2009 consultation report, Dr. Dana Headapoh, Board-certified in occupational medicine, noted that appellant was a short-term employee at the employing establishment in 2009. She described the July 8 and 10, 2009 clean-up incident at work and the symptoms that appellant developed in the two days after the incidents. Dr. Headapoh related appellant's current complaints of memory lapses of approximately 10 minutes, increased anger, hand cramps, and pins-and-needles sensation on the top of his head. She reviewed his medical records and reported an essentially normal physical examination. Dr. Headapoh opined that appellant had occupational exposures to various solvents in semi-solid state and aerosolized state. She indicated that his symptoms were consistent with inhaled solvent exposure at levels causing temporary symptoms, but she could not then conclude today whether his symptoms could be causally linked to his occupational exposures of July 8 and 10, 2009. Dr. Headapoh recommended a chest x-ray, pulmonary function tests, heavy metal screen, complete blood count (CBC), and chemistry panel.

On December 3, 2009 appellant was examined in the emergency room by Dr. Richard Thorne, a Board-certified family practitioner, for complaints of anxiety, behavioral changes, depression, and anxiety. He indicated that appellant was exposed to toxins at work five months ago and his symptoms had worsened since the exposure. Dr. Thorne reported essentially normal findings on examination and opined that appellant suffered from changed mental status, anxiety, and depression.

In a December 3, 2009 magnetic resonance imaging (MRI) scan report of the brain, Dr. Keith Edwards, a Board-certified diagnostic radiologist with a subspecialty in vascular and interventional radiology, noted an unremarkable, noncontrast MRI scan of the brain.

Appellant was also examined by Dr. Shawn M. Smith, a Board-certified family practitioner, who provided December 3 and 4, 2009 records that described the July 8 and 10, 2009 incidents at work and the symptoms appellant experienced on July 11 and 12, 2009. Dr. Smith related that appellant continued to experience twitching movements involving his face and upper extremities and mood swings. He reviewed appellant's history and conducted an examination. Dr. Smith observed chronic lower back pain with no swelling, pain, or heat. He indicated that he had reviewed the MRI scans and agreed that the scans were normal. Dr. Smith reported that appellant had atypical episodic twitching and jerking movements that were distractible, without stereotypy, and nonphysiologic, and a normal MRI scan. He related that appellant attributed his symptoms to chemical exposure at work.

Dr. McGree examined appellant again on December 10 and 28, 2009. In a December 10, 2009 note, he indicated that he spoke with appellant's mother because she was concerned about appellant's behavior. Dr. McGree reported a history of injury of exposure to chemicals on July 8, 2009 and provided essentially normal examination findings. He diagnosed no specific neurologic changes.

In a decision dated February 4, 2010, OWCP denied appellant's occupational disease claim. It accepted that on July 8 and 10, 2009 he was exposed to various chemicals at work, but denied his claim finding insufficient medical evidence to establish that he sustained a diagnosed condition causally related to the accepted employment factors.

Appellant filed multiple requests for further review by OWCP. On March 9, 2010,[3] February 17, 2011,[4] and May 15, 2012[5] OWCP received his requests for a telephone hearing before a Branch of Hearings and Review hearing representative. By decisions dated July 29, 2010, September 1, 2011, and June 29, 2012 OWCP's hearing representative vacated the denial decisions and remanded the case for further medical development.

Appellant submitted various articles regarding exposure to pyrethroid and pyrethroid intoxication. He also resubmitted the MSDS, the inventory list of the chemicals stored in the hazmat shed dated May 15, 2009, and the laboratory analytical reports of the chemicals.

Appellant also submitted various medical reports with personal, handwritten notes in the margin in support of his requests for further review. In a March 1, 2010 report, Dr. McGree noted that he had examined appellant on multiple occasions relative to exposure at work. He could not find a specific cause-effect correlation between the chemical exposures of July 8

[3] A telephone hearing was held on June 8, 2010. Appellant stated that he was not able to provide a well-rationalized medical report because the physicians in his town were not familiar with chemical exposure cases. He explained that he was currently seeing a physician in California who believed that he suffered from dystonia.

[4] Appellant was appealing a January 21, 2011 decision, which denied appellant's occupational disease claim based on a December 17, 2010 second-opinion report. A telephone hearing was held on June 9, 2011. Counsel represented appellant and Dr. Kaye H. Kilburn, appellant's treating physician, was a witness. Dr. Kilburn testified that appellant had chemical encephalopathy as a result of exposure to chemicals, specifically pyrethroids, on July 8 and 10, 2009 at work. He also noted the differences between specialties in neurotoxicology and toxicology.

[5] Appellant was appealing a May 7, 2012 OWCP denial decision. On May 15, 2012 OWCP received his request for a telephone hearing.

and 10, 2009 and appellant's symptoms, but he opined that it was certainly possible that they were connected. In reports dated April 19 and May 17, 2010, Dr. Smith related that appellant continued to experience symptoms. He discussed his concern with appellant that these abnormal movements were not related to his occupational exposure in a physiologic sense. Dr. Smith indicated that there was some somatization secondary to increased psychosocial stressors about the event.

On April 29, 2010 appellant was also examined in the emergency room by Eric Leber, a certified physician assistant, for complaints of right wrist pain and upper extremity spasms. He reported that x-rays and CBC testing were normal. Mr. Leber diagnosed upper extremity pain involving the right wrist and left wrist tenosynovitis.

Dr. Kilburn, Board-certified in internal and occupational medicine, began to treat appellant in June 2010. In a February 17, 2010 letter, he noted that appellant had an appointment at his clinic for evaluation of effects of June 8 and 9, 2009 chemical exposure. Dr. Kilburn also provided his credentials and the experience he had evaluating and providing therapy for neurotoxicological conditions. Appellant provided Dr. Kilburn's curriculum vitae and résumé.

In a June 9, 2010 report, Dr. Kilburn noted appellant's description of his exposure to hazardous materials and fumes on July 8 and 10, 2009 and his complaints of nausea, confusion, seizures, convulsions, headache, repeated body electric muscle contractions, numbness, hands locking up, freezing contractures, muscle contractions, and twitching in the face after the incident. He reviewed appellant's history and noted that appellant used to be a marijuana user, but had not used marijuana since May 20, 2010. Dr. Kilburn indicated essentially normal findings on physical and neurological examination. He reported that cerebellar signs demonstrated unsteady gait, ataxic normal dysmetria, and slowed rapid alternating movements. Neurophysiological tests demonstrated abnormal balance measured by sway speed with eyes open and closed. Blink reflex latency was abnormal on the right and normal on the left. Vibration was also abnormal in the lower extremities. Dr. Kilburn further indicated that appellant's affective status was elevated, particularly in anger, and depression. He diagnosed chemical encephalopathy, peripheral neuropathy, and chemical intolerance due to exposure to pyrethroids and similar chemicals. Dr. Kilburn explained that testing showed 12.5 total abnormalities, which exceeded the 0 to 2 abnormalities in people unexposed to chemicals. He opined that appellant suffered multiple chemical exposure at his workplace in July 2009, resulting in lack of concentration, recent and long term memory loss, instability of mood, loss of balance, extreme fatigue, shortness of breath, headache, nausea, and insomnia. Dr. Kilburn indicated that there was probably a single causal factor for these manifestations, which was pyrethroid exposure. He noted that pyrethroids were included in the inventory list of 64 chemicals in the hazmat shed.

On August 2, 2010 Dr. Kilburn provided an addendum disability statement to his June 9, 2010 report and reported that appellant was disabled from employment because of a chemical brain injury, also called chemical encephalopathy. He explained that the "hours of exposure to cleaning, sorting, and disposing of stored chemicals and waste in the storage shed on July 8 and 10, 2009, were the major exposure to pyrethroids (pesticides) that caused the impairment and symptoms." Dr. Kilburn also noted that appellant used hydrocarbon solvents to clean the

hazmat shed, which caused lightheadedness, dizziness, loss of concentration and memory, and muscle twitching.

In reports dated January 24, 2011 to June 25, 2012, Dr. Kilburn indicated that the 30 objective tests that he performed on appellant revealed brain impairment. He related that appellant had been under his care since June 8, 2010 for pyrethroid exposure. Dr. Kilburn indicated that exposure to pyrethroid, which was found in indoor insect foggers, adequately explained all of appellant's movement disorders, disturbance balance, deficient memory, slowed blink reflex, diminished grip strength, and blind spots. He noted that he published a paper about the effects of insecticide on airline flight attendants and explained that appellant's impairment was similar to the flight attendant exposure in crew quarters. In a July 15, 2011 report, Dr. Kilburn explained that appellant was physically and neurologically normal prior to the hazmat clean-up job on July 8 and 10, 2009, but experienced nausea, confusion, seizures, headaches, strong unexpected muscle contractions, numbness, hands locking up and freezing, and twitching of the face, neck, lips, eyelids, and eyes. In a June 25, 2012 letter, he explained that neurotoxicology was a specialty in neurology and toxicology, which used many quantitative measurements of brain function, but toxicology was a poison control function of physicians in emergency medicine without special training in neurology.

Following the hearing representative's July 29, 2010 decision, which vacated OWCP's February 4, 2010 denial decision and remanded the case to the district office, OWCP referred appellant's claim, along with a statement of accepted facts (SOAF) and the medical record, to Dr. Edward Cetaruk, Board-certified in emergency medicine with a subspecialty in medical toxicology, for a second-opinion examination to determine whether appellant sustained a condition causally related to alleged chemical exposure on July 8 and 10, 2009 while at work.

In a December 17, 2010 report, Dr. Cetaruk accurately described the July 8 and 10, 2009 employment incidents and the symptoms that he experienced following the incident. Dr. Cetaruk reviewed the medical treatment that he received and his social and family history. He indicated that appellant had preexisting disability, hepatitis C, and polysubstance abuse. Dr. Cetaruk reported essentially normal physical and neurological examination. He reported that he had no current diagnoses to be made from a toxicological perspective, but appellant could be considered to have had exposure to fumes on the dates of July 8 and 10, 2009. Dr. Cetaruk opined that he did not believe that appellant's exposure while cleaning out the hazardous materials shed were related to his current complaints. He explained that he reviewed the inventory list of materials in the hazmat shed and asked about the condition of the containers in which the pyrethrin insecticides had been found and was told that they were on a shelf in a container with no evidence of spillage. Dr. Cetaruk found that none of the compounds would be expected to cause the episodes appellant experienced on July 11 and 12, 2009 or his continued symptoms.

Following the September 1, 2011 OWCP hearing representative decision, OWCP requested that Dr. Cetaruk provide clarification of his December 17, 2010 second-opinion report. It advised him to review the lab results of the testing performed on the materials contained in the hazmat shed and the MSDS sheets of the substances and provide an opinion on whether the nature and extent of appellant's exposure in the hazmat shed contributed to chemical encephalopathy condition as suggested by Dr. Kilburn. OWCP also requested that Dr. Cetaruk discuss the medical literature cited by Dr. Kilburn.

In an April 19, 2012 supplemental report, Dr. Cetaruk indicated that he reviewed the medical record and the new, additional documentation forwarded to him since his December 17, 2010 report. He opined that based on the toxicology of all compounds in the matter and the history obtained by appellant, he found no demonstration of an exposure pathway or documentation of toxicological chemical exposure to pyrethroid compounds. Dr. Cetaruk also reported that none of the pesticides listed on the May 15, 2009 inventory list was known to cause the history of appellant's complaints. He disagreed with Dr. Kilburn's medical opinion and asserted that nothing on the record supported that appellant was exposed to over 60 compounds. Dr. Cetaruk further noted that the case study that Dr. Kilburn cited lacked adequate controls and included significant selection bias. He opined that there was no epidemiological data to support a valid causal relationship between appellant's current complaints and his potential exposure to pyrethroids and/or the other compounds in the hazmat shed.

Following OWCP's June 29, 2012 hearing representative decision remanding the case, OWCP referred appellant's case, along with an updated SOAF, to Dr. Scott D. Phillips, Board-certified in internal and emergency medicine with a subspecialty in medical toxicology, for an impartial medical examination to resolve the conflict of medical opinion between Dr. Kilburn, appellant's treating physician, and Dr. Cetaruk, an OWCP referral physician, regarding whether appellant's exposure to chemicals or substances on July 8 and 10, 2009 caused or contributed to a medical condition.

In a September 26, 2012 report, Dr. Phillips related that on July 8 and 10, 2009 appellant cleaned up spilled linseed oil in a hazmat shed that contained several containers of various substances. He noted the immediate symptoms appellant experienced and described the two episodes appellant experienced on July 11 and 12, 2009. Dr. Phillips reported that since the employment incident appellant complained of muscle spasms in his face, difficulty talking, and spasms of his arms, primarily on the right side. He reviewed appellant's history and noted that appellant used methamphetamine intravenously and by smoking in the 1990s. Appellant denied any significant drug use since that time other than medical marijuana. Dr. Phillips reviewed appellant's medical records, including Dr. Cetaruk's December 17, 2010 and April 19, 2012 reports and Dr. Kilburn's various reports. He noted that Dr. Kilburn opined that appellant suffered from pyrethroid poisoning, but he noted that pyrethroids did not cause this cluster of symptoms as described by appellant.

Upon examination, Dr. Phillips observed some intermittent twitching movements primarily involving the right side of appellant's face and his right upper extremity. He noted that these were transient symptoms that lasted only a few seconds. Dr. Phillips listed normal findings on physical and neurological examination of the head, ears, nose, throat, chest, abdomen, extremities, and skin. Mental status was described as grossly normal with some pressured speech at times. Dr. Phillips indicated that appellant did not have signs or symptoms after leaving the office. He diagnosed other and unspecified factitious illness, episodic mood disorder, and hepatitis C without coma. Dr. Phillips reported that, based on his evaluation of the exposure history and consideration of the chemicals being provided, he did not believe that there was "a causal nexus between the work in the hazardous materials shed and the complaints proffered by [appellant] and supported by Dr. Kilburn." He explained that this opinion was supported by the focality of the symptoms, signs displayed by appellant, his training and experience in medical toxicology, and peer-reviewed scientific literature. Dr. Phillips recounted that the chemicals

listed were not known to cause the types of symptoms claimed by appellant and supported by Dr. Kilburn and that there was no evidence of pesticide poisoning, particularly pyrethroid poisoning. He did not believe that the alleged exposures on July 8 and 10, 2009 caused or contributed to any medical condition in this claimant. Dr. Phillips opined that appellant was not totally disabled and was able to perform full duty.

By decision dated October 10, 2012, OWCP denied appellant's claim. It found that the special weight of medical evidence rested with the impartial medical opinion of Dr. Phillips, who determined that appellant's exposure to chemicals on July 8 and 10, 2009 did not cause or contribute to any medical conditions.

On October 17, 2012 OWCP received appellant's request for a telephone hearing before a Branch of Hearings and Review hearing representative. He indicated that he was including a report from Dr. Michael Gray, Board-certified in occupational medicine, who also diagnosed encephalopathy. In an August 23, 2012 report, Dr. Gray related appellant's complaints of experiencing almost-daily confusion, spaciness, inability to concentrate, memory problems, tremor or shakiness, low energy, unusual fatigue, poor appetite, muscle and joint discomfort and pain, and frequent jerking. He reviewed appellant's history and reported an essentially unremarkable physical and neurological examination. Dr. Gray opined that appellant had mixed solvent and aromatic hydrocarbon, which induced toxic encephalopathy, toxic effect of nonmedicinal substance NEC, balance disorder, color blindness, memory loss, decreased perceptual motor speed, and decreased long term memory. He recommended that appellant undergo neuro-test battery and pulmonary function testing.

Appellant submitted November 15, 2012 and February 25, 2013 letters from Bradley Fimrite, an employee of Mountain States Environmental Services, Inc., which confirmed that their company was contacted by the employing establishment to sample a cleanup of spilled waste material and noted that they did not test the samples for pesticides.

In a December 6, 2012 report, Dr. Kilburn indicated that he reviewed Dr. Phillip's September 26, 2012 report. He pointed out that Dr. Phillips was a poison control clinic director and associate professor, but he did not demonstrate an understanding of the neurotoxic effects of pesticides, particularly pyrethrins, and the solvents used to remove residue from the floor of a storage building. Dr. Kilburn reported that there were "many brain damaging chemicals on the exposure list" and opined that appellant's problems "suggest pyrethrins" but it was a multi-chemical exposure.

On February 11, 2013 a hearing was held. Appellant pointed out that prior to July 11, 2009 he never had any episodes or symptoms prior to July 8 and 10, 2009. He described the employment exposure incidents and the symptoms he experienced shortly after he cleaned out the hazmat shed. Appellant noted that both physicians to whom he was referred by OWCP were toxicologists instead of neurotoxicologists. He indicated that he sought treatment from two neurotoxicologists, Dr. Gray in Arizona and Dr. Raymond Singer, a Board-certified neuropsychologist, in New Mexico.

In a February 27, 2013 report, Dr. Singer, a clinical neuropsychologist, described the July 8 and 10, 2009 exposure incidents at work and the onset of appellant's symptoms. He noted

that he had reviewed OWCP's October 10, 2012 denial decision, Dr. Kilburn's June 25 and December 6, 2012 reports, and Dr. Phillips' September 26, 2012 report. Dr. Singer asserted that Dr. Phillips' qualifications in poison control, internal medicine, and medical toxicology were not the type of credentials needed to diagnose mental health disorders such as "factitious illness" and "episodic mood disorder." He also pointed out that Dr. Phillips had not described the methodology that he used to diagnose these conditions nor did he explain possible causes for these illnesses. Dr. Singer asserted that Dr. Kilburn's opinion carried more weight since he had used objective testing to identify neurobehavior deficits and has experience in detailing neurotoxicity cases. He noted that the hazmat shed included ortho indoor insect fogger, which contained permethrin, and explained that common symptoms of permethrin exposure included paresthesias, headaches, and dizziness and excessive exposure could cause hyperexcitability, panic, and fear, such as what happened to appellant. Dr. Singer opined that based on his review of the hazardous materials and his experience in neurotoxicology, Dr. Kilburn's explanation of appellant's illness was more probative than that of Dr. Phillips.

By decision dated April 26, 2013, OWCP affirmed OWCP's October 10, 2012 denial decision. It determined that the additional medical evidence was insufficient to overcome the special weight of evidence attributed to Dr. Phillips' September 26, 2012 referee medical report.

On July 18, 2013 OWCP received appellant's request, through counsel, for reconsideration. Counsel submitted a July 10, 2013 report by Dr. Kilburn who reiterated that appellant's symptoms were caused by pyrethroid exposure at his workplace in July 2009 and opined that he was totally disabled.

In a decision dated August 20, 2013, OWCP denied appellant's reconsideration request finding that the evidence submitted was insufficient to warrant further merit review.

On October 30, 2013 OWCP received appellant's request, through counsel, for reconsideration.

In an October 3, 2013 report, Dr. Kilburn related that appellant was exposed to at least 64 hazmat chemicals on July 8 and 10, 2009 while at work. He noted that he picked pyrethroids as the best fit to appellant's impaired brain function, as evidenced by measurements for balance, color, vision, peg placement, memory verbal recall, and long term memory. Dr. Kilburn reviewed Dr. Cetaruk and Dr. Phillips' reports and noted his disagreements with their opinions. He related that he had practiced in neurotoxicology for over 30 years and published 70 peer reviewed papers on the subject. Dr. Kilburn alleged that his credentials and examination of appellant, based on objective testing, treatments, and follow up, should be accepted as the definitive medical opinion.

By decision dated November 14, 2013, OWCP denied modification of the April 26, 2013 decision.

Appellant filed an appeal before the Board, but later withdrew the appeal.[6]

[6] Docket No. 14-0517 (issued October 23, 2014).

On September 16, 2014 OWCP received appellant's request, through counsel, for reconsideration of the November 14, 2013 denial decision. Counsel submitted an April 3, 2014 report by Dr. Singer who recounted his disagreements with OWCP's denial decisions, which granted the special weight of medical opinion to Dr. Phillips. Dr. Singer alleged that appellant should be evaluated by a neuropsychologist experienced in neurotoxicology in order to determine whether he suffered from a mental health disorder due to a mental health issue or a neurotoxic cause.

By decision dated August 11, 2015, OWCP denied modification of the November 14, 2013 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA 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[7] including that he or she sustained an injury in the performance of duty and that any specific condition or disability for work for which he or she claims compensation is causally related to that employment injury.[8] In an occupational disease claim, appellant's burden 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.[9]

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.[10] 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 the specific employment factors identified by the employee.[11]

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 make an examination.[12] This is called a referee examination and OWCP will select a

[7] *J.P.*, 59 ECAB 178 (2007); *Joseph M. Whelan,* 20 ECAB 55, 58 (1968).

[8] *M.M.,* Docket No. 08-1510 (issued November 25, 2010); *G.T.,* 59 ECAB 447 (2008); *Elaine Pendleton,* 40 ECAB 1143, 1145 (1989).

[9] *R.H.,* 59 ECAB 382 (2008); *Ernest St. Pierre,* 51 ECAB 623 (2000).

[10] *I.R.,* Docket No. 09-1229 (issued February 24, 2010); *D.I.,* 59 ECAB 158 (2007).

[11] *I.J.,* 59 ECAB 408 (2008); *Victor J. Woodhams,* 41 ECAB 465 (2005).

[12] 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).

physician who is qualified in the appropriate specialty and who has no prior connection with the case.[13] When there exists opposing medical 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.[14]

When OWCP obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, OWCP must secure a supplemental report from the specialist to correct the defect in his original report.[15]

ANALYSIS

Due to a conflict in medical opinion evidence between Dr. Kilburn, appellant's treating physician, and Dr. Cetaruk, an OWCP referral physician, OWCP referred appellant to Dr. Phillips for an impartial medical examination to determine whether he sustained any medical conditions as a result of exposure to chemicals at work on July 8 and 10, 2009. In a September 26, 2012 report, he concluded that appellant's exposures on July 8 and 10, 2009 did not cause or contribute to any medical condition. The Board finds that Dr. Phillips' report is insufficient to resolve the conflict in medical opinion evidence.

Dr. Phillips provided an accurate history of the July 8 and 10, 2009 exposure at work and noted appellant's immediate and current symptoms. He reviewed appellant's records and reported normal findings on physical and neurological examination of the head, ears, nose, throat, chest, abdomen, extremities, and skin. Dr. Phillips observed some intermittent twitching movements primarily involving the right side of appellant's face and right upper extremity. He reported that appellant's mental status was grossly normal with some pressured speech at times. Dr. Phillips diagnosed other and unspecified factitious illness, episodic mood disorder, and hepatitis C without coma. He opined that there was not a "causal nexus" between appellant's exposure while working in the hazardous materials shed and his current complaints. Dr. Phillips explained that this opinion was supported by the exposure history, consideration of the chemicals being provided, focality of the symptoms, signs displayed by appellant, his training and experience in medical toxicology, and peer-reviewed scientific literature. He further reported that the chemicals listed were not known to cause the types of symptoms claimed by appellant and supported by Dr. Kilburn and that there was no evidence of pesticide poisoning, particularly pyrethroid poisoning. Dr. Phillips concluded that the alleged exposures on July 8 and 10, 2009 could not have caused or contributed to any medical condition in appellant.

Dr. Phillips report is deficient because it is not sufficiently well rationalized. His opinion is simply a composite of conclusory statements and there is no rationale provided for any of

[13] 20 C.F.R. § 10.321.

[14] *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

[15] *Raymond A. Fondots*, 53 ECAB 637 (2002); *Nancy Lackner* (*Jack D. Lackner*), 40 ECAB 232 (1988); *Ramon K. Ferrin, Jr.*, 39 ECAB 736 (1988).

these statements. Dr. Phillips does not cite to clinical findings to substantiate his assertion, he provided no comparative analysis of appellant's condition prior to or after the exposure, and made no references to the case record to demonstrate that he was drawing his conclusion from medical facts.[16] While he noted that his opinion was based on "the focality of symptoms and signs displayed by appellant" he did not further elaborate on how these symptoms and signs formed his opinion on causal relationship. Nor did Dr. Phillips point to the scientific literature that supported his conclusory opinion. An opinion based on conclusory statements without further rationale cannot serve the basis for resolution of the conflict in medical evidence.[17]

The task of an impartial medical specialist is to review the reports that were the source of the conflict and provide a sound rationale for the resolution of the conflict. While he does note having read the previous medical reports which set up the conflict, he fails to address them in any way. The impartial medical specialist's only reference to Dr. Kilburn's report was his concern that the protocol being used by Dr. Kilburn in treating appellant for alleged pyrethroid poisoning was experimental with no FDA approval and no institutional review board approval and expressed great concern for appellant about the validity of such treatment. While those certainly should be a cause of concern for appellant, it does not provide the rationale expected from an impartial medical specialist to resolve the conflict of medical opinion on whether appellant is suffering from any condition due to a possible exposure to chemical substances at the employing establishment.

Under section 8123(a), the report of an impartial medical specialist will be accorded the special weight of the evidence when it is sufficiently well rationalized, based on an accurate factual basis, thoroughness of examination performed, accuracy and completeness of the physician's knowledge of the facts and medical history, the care of analysis manifested, and the medical rationale expressed by the physician.[18] In this particular case, Dr. Phillips' report does meet the criteria to be accorded the special weight and should be provided an opportunity to clarify his report. As a conflict in medical opinion still exists, the case will be returned to OWCP for further medical development.

On remand, OWCP should obtain a supplemental report from Dr. Phillips that provides a well-rationalized medical opinion regarding whether appellant sustained a medical condition causally related to the accepted work exposure. The Board notes that, following Dr. Phillips' September 26, 2012 report, additional medical evidence was received. On remand, Dr. Phillips should be provided an opportunity to review any new medical evidence. Following any necessary further development, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for a decision as the conflict in medical opinion evidence remains unresolved.

[16] *See Willa M. Frazier*, 55 ECAB 379 (2004).

[17] *Jack. R. Smith,* 41 ECAB 691 (1990).

[18] *James T. Johnson*, 39 ECAB 1252 (1988).

ORDER

IT IS HEREBY ORDERED THAT the August 11, 2015 decision of the Office of Workers' Compensation Programs is set aside and the case remanded to OWCP for further action consistent with this decision of the Board.

Issued: November 2, 2016
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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