United States Department of Labor
Employees' Compensation Appeals Board

R.A., Appellant	)	
and	)	**Docket No. 20-1612**
	)	**Issued: June 21, 2021**
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
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On September 10, 2020 appellant, through counsel, filed a timely appeal from a March 31, 2020 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 met his burden of proof to establish a pulmonary condition causally related to the accepted factors of his federal employment.

FACTUAL HISTORY

On November 27, 2018 appellant, then a 55-year-old scrubber board operator, filed an occupational disease claim (Form CA-2) alleging that he developed occupational pneumoconiosis due to factors of his federal employment. He noted that he first became aware of his condition and its relation to his federal employment on September 4, 2018. Appellant did not stop work.

In support of his claim, appellant submitted a statement dated September 4, 2018, asserting that he had 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 on July 18, 2018.

In answers referencing FECA Bulletin No. 85-33, "Evidence Required in Supporting a Claim for Asbestos-Related Illness," accompanying his claim, appellant asserted that he began working at the employing establishment on July 20, 1987 as a public safety officer in the employing establishment. Initially, he was exposed to coal dust eight hours a day, five days a week. Appellant noted his federal positions included that of a conveyor car dump operator in the coal yard, operator's maintenance training program, scrubber assistant unit operator, and scrubber board operation. In his subsequent positions, he indicated that he was exposed to coal dust, limestone dust, and asbestos from boilers and steam lines on a daily basis. Appellant advised that he wore paper masks occasionally. He asserted that he did not smoke.

In an October 10, 2018 report, Dr. Glen Baker, a Board-certified pulmonologist and National Institute for Occupational Safety and Health (NIOSH) certified B-reader, noted that he examined appellant for possible dust-induced lung disease secondary to his employment. Dr. Baker indicated that appellant worked at the employing establishment for 31 years with exposure to asbestos, coal dust, odors, and fumes. He further noted that appellant had never smoked. Dr. Baker listed appellant's symptoms of dyspnea on exertion for the past one to two years, occasional cough, and obstructive sleep apnea. On physical examination he found that appellant had 16 respirations per minute and that his lungs were clear to auscultation and percussion. Dr. Baker reviewed an August 16, 2018 chest x-ray which indicated occupational pneumoconiosis category 1/2. He also provided findings of October 5, 2018 pulmonary function studies and interpreted these findings as mild restrictive ventilatory defect. Dr. Baker diagnosed occupational pneumoconiosis category 1/2, mild restrictive ventilatory defect based on pulmonary function testing, and obstructive sleep apnea. He opined that appellant's occupational pneumoconiosis and mild restrictive defect was caused by asbestos and coal dust exposure at the employing establishment. Dr. Baker attributed appellant's sleep apnea to obesity. He found that appellant had a permanent impairment rating of six percent.

In a December 3, 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 January 16, 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 a January 18, 2019 response to OWCP's development questionnaire, the employing establishment noted that appellant was employed for approximately 31 years. It further indicated that data of exposure to asbestos and coal dust for appellant was not available, but that assessments for car dump operators at the employing establishment consistently demonstrated that personal exposures experienced by all workers were below occupational exposure limits. The employing establishment contended that appellant did not perform insulating/abatement duties of asbestos and that his positions did not routinely require the use of respirators because dust levels were well below Occupational Safety & Health Administration (OSHA) established limits. It disputed appellant's allegations of dust or asbestos exposure.

In a February 26, 2019 report, Dr. Haller noted appellant's employment exposure and symptoms. He reviewed the spirometry from Dr. Baker dated October 5, 2018 and found no evidence of significant lung disease. Dr. Haller 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. He also disagreed with Dr. Baker's finding of occupational pneumoconiosis category on x-rays. Dr. Haller recommended a high resolution chest computerized tomography (CT) scan to identify pneumoconiosis. Dr. Haller performed lung volume testing, and found that appellant's lung volumes were well within normal limits and noted that appellant's restrictions could be due to his obesity. He also noted that appellant's diffusing capacity was normal, while even mild restrictive disease would result in a decreased diffusion capacity. On physical examination Dr. Haller noted that appellant had no bloody sputum, chest discomfort, coughing, or shortness of breath. He found that appellant's examination was generally normal, but that appellant did experience nasal congestion, sleep apnea, and had a history of dyspnea. Dr. Haller opined that it was very unlikely that appellant currently had any significant pulmonary disease.

By decision dated March 28, 2019, OWCP denied appellant's occupational disease claim, finding that Dr. Haller's report was entitled to the weight of the medical evidence.

On April 2, 2019 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

On May 7, 2019 appellant sought treatment due to shortness of breath. He underwent an electrocardiogram (EKG) and Allen's test for arterial blood gas (ABG) results.

Following a preliminary review, by decision dated June 18, 2019, OWCP's hearing representative found that the case was not in posture for a decision and remanded the claim for a supplemental report from Dr. Haller, including review of the May 7, 2019 test results.

On June 19, 2019 OWCP requested that Dr. Haller provide a detailed narrative report reviewing the May 7, 2019 ABG and EKG results and opining whether there was significant lung disease based on these studies.

In notes dated May 28 and August 23, 2019, Dr. Haller noted reviewing the ABG and EKG results from May 7, 2019 and found that these results did not change his diagnosis or impression of appellant's conditions. He further noted that the EKG was in normal sinus rhythm.

By decision dated August 28, 2019, OWCP denied appellant's occupational disease claim finding that Dr. Haller's reports were entitled to the weight of the medical evidence and did not establish a medical condition as the result of his accepted employment exposures. On September 5, 2019 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

On January 15, 2020 appellant testified before an OWCP hearing representative and described his employment exposures to coal dust, limestone dust, and asbestos. He noted that he had never smoked or experienced difficulty breathing prior to his employment. Counsel contended that there was a conflict of medical opinion evidence between the reports from Drs. Baker and Haller.

By decision dated March 31, 2020, 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 medical opinion 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, 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 condition for which compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the identified employment factors.[6]

[3] *Id*.

[4] *K.V.*, Docket No. 18-0947 (issued March 4, 2019); *M.E.*, Docket No. 18-1135 (issued January 4, 2019); *Kathryn Haggerty*, 45 ECAB 383, 388 (1994).

[5] *K.V.*, *id.*, and *M.E.*, *id.*; *Elaine Pendleton*, 40 ECAB 1143 (1989).

[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).

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 states 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 exists 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.

Dr. Baker, in his October 10, 2018 report, reviewed appellant's August 16, 2018 chest x-ray and found occupational pneumoconiosis category 1/2. Dr. Haller disagreed with the finding of occupational pneumoconiosis 1/2 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 physician, Dr. Baker, who found occupational pneumoconiosis 1/2 on x-rays and Dr. Haller, the second opinion physician, who disagreed. Drs. Baker and Haller both offered assessments of appellant's chest x-rays and their reports are of equal probative value. Consequentially, the case must be referred to an impartial medical specialist to resolve the existing conflict in the medical opinion evidence regarding whether appellant's chest x-rays demonstrated occupational pneumoconiosis 1/2.

[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] *See J.R.*, Docket No. 20-0903 (issued April 22, 2021); *Victor J. Woodhams*, *supra* note 6.

[10] 5 U.S.C. § 8123(a); *see C.G., Sr.*, Docket No. 20-0808 (issued April 23, 2021); *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; *C.G., Sr., id.; 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).

On remand OWCP shall refer appellant, along with the case file and a SOAF, to a specialist in the appropriate field of medicine 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 March 31, 2020 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: June 21, 2021
Washington, DC

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

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

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