United States Department of Labor
Employees' Compensation Appeals Board

T.R., Appellant	)	
	)	
and	)	**Docket No. 14-1919**
	)	**Issued: May 7, 2015**
TENNESSEE VALLEY AUTHORITY, NUCLEAR POWER, Chattanooga, TN, Employer	)	

Appearances:
Ronald K. Bruce, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On September 4, 2014 appellant, through counsel, filed a timely appeal from the July 23, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant met his burden of proof to establish a pulmonary condition in the performance of duty.

FACTUAL HISTORY

On January 31, 2013 appellant, then a 66-year-old boilermaker/welder, filed an occupational disease claim alleging that his work duties in his federal employment caused

[1] 5 U.S.C. §§ 8101-8193.

occupational pneumoconiosis. He indicated that he first became aware of the condition and its relationship to his federal employment on November 1, 2012, the date that he learned of his diagnosis from a report of Dr. Glen Baker, an attending physician who is Board-certified in internal medicine and pulmonary disease and a certified B-reader.[2]

In a letter dated March 7, 2013, OWCP informed appellant of the type of evidence needed to support his claim and requested that the employing establishment submit exposure data and his employment history.

Between October 18, 1978 and December 16, 1991, appellant worked as a boilermaker/welder for the employing establishment.[3] During this period he claimed to have been exposed to asbestos on a daily basis at the Widows Creek fossil fuel plant and the New Johnsonville fossil fuel plant. Appellant was exposed to asbestos when he tore casing from boiler walls, when he chipped asbestos off burners with a pneumatic chipping hammer, and when it fell off the steam lines. At times he draped an asbestos cloth over his shoulder or would lay on it. Appellant was also exposed to coal dust and fly ash on a daily basis. He acknowledge that he smoked a pack and a half of cigarettes daily for approximately 18 years, but he quit smoking in 1977.

Appellant submitted a December 31, 2012 report in which Dr. Baker noted appellant's federal employment history, including his years of exposure to asbestos, coal dust, fly ash, and other harmful substances. Dr. Baker acknowledged appellant's history of smoking cigarettes until 1977. He reported that a November 1, 2012 chest x-ray showed occupational pneumoconiosis, category 1/0, consistent with pulmonary asbestosis. Dr. Baker indicated that December 28, 2012 pulmonary function studies were normal, including both pre and post-bronchodilator pulmonary function studies. He diagnosed occupational pneumoconiosis, category 1/0, with pulmonary asbestosis based on long history of asbestos exposure. Dr. Baker indicated that appellant had no impairment under Table 5-4 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (6th ed. 2009). He attached copies of the x-ray interpretation, which indicated a 1/0 profusion of small opacities and parenchymal abnormalities consistent with pneumoconiosis, and the pulmonary function studies, interpreted as normal.

The employing establishment submitted a February 2013 environmental assessment report indicating that appellant was exposed to dust and asbestos at work between 1978 and 1991, but that the exposures would have been below the applicable safety limits.

In May 2013, OWCP referred appellant, along with a statement of accepted facts, a set of questions, and the medical record, to Dr. Mohammed K. Shubair, Board-certified in internal medicine and pulmonary disease, for a second opinion evaluation.

[2] B-readers are physicians who have passed a proficiency test administered by the National Institute for Occupational Safety and Health. *See* 42 C.F.R. § 37.52. On the same claim form, appellant's immediate supervisor indicated that he was last exposed to the conditions alleged to have caused illness on December 16, 1991.

[3] Appellant indicated that he worked 40 to 60 hours per week between 1978 and 1991.

In a June 10, 2013 report, Dr. Shubair noted appellant's employment history and his reported symptoms. He determined that, based on appellant's pulmonary function tests conducted on June 10, 2013, "it did not seem that he had significant damage in his lungs, whether it is from asbestos or his long history of smoking." Dr. Shubair requested additional testing, including chest x-rays.

In a September 11, 2013 supplemental report, Dr. Shubair stated that the chest x-ray on June 19, 2013 which was interpreted by the radiologist as ruling out active pulmonary disease.[4] The additional pulmonary testing he conducted showed normal diffusion capacity with no evidence of impairment in the functional unit of the lung. Dr. Shubair stated, "Overall, as in my previous note, the chest x-ray and lung functions [have] ruled out that there has been any significant damage, whether functional or pathological on the pulmonary function test and chest x-ray respectively."

On October 1, 2013 Dr. Shubair noted his June 10 and September 11, 2013 reports and stated:

> "After reviewing the whole test including the chest x-ray and the pulmonary function tests, I do not believe that [appellant] has sustained any significant damage to his lungs whether structural as evident by the normal chest x-ray as well as functional as evidenced by a normal pulmonary function test including a normal diffusion capacity. As far as the pulmonary status, it seems that it has not been affected by the … exposure that he was exposed to. All the findings as above exclude any significant impairment whether it is secondary to pulmonary [sic]. [H]owever, if there is any exertional limitation, I believe [that] this will be something to do with deconditioning rather than a significant pulmonary disease."

In an October 8, 2013 decision, OWCP denied appellant's claim for a work-related pulmonary condition, finding that the weight of the medical evidence regarding this matter rested with the opinion of Dr. Shubair, an OWCP referral physician. It accepted that appellant had been exposed to hazardous materials at work, including asbestos, but found that he had not submitted sufficient medical evidence to show that he suffered a medical condition due to this exposure.

Appellant submitted a February 10, 2014 report in which Dr. Matthew A. Vuskovich, an attending physician Board-certified in occupational medicine and a B-reader, read the November 1, 2012 x-ray. Dr. Vuskovich indicated that appellant had 1/1 small opacities and pleural abnormalities and that the study was consistent with pneumoconiosis.

Appellant requested a hearing with an OWCP hearing representative. During the hearing held on May 8, 2014, he provided further testimony regarding his exposure to asbestos, coal dust, fly ash, and other harmful substances in the workplace. Counsel argued that appellant's attending physicians were more qualified than Dr. Shubair to interpret the x-ray testing of record because they were certified B-readers while Dr. Shubair was not certified in this regard.

[4] The record contains the report of this x-ray testing.

In correspondence dated June 17, 2014, Mike Patty of the employing establishment provided comments regarding the hearing transcript and maintained that an x-ray diagnosis by a B-reader alone was not sufficient for a diagnosis of occupational pneumoconiosis. He attached a publication from the Centers for Disease Control and Prevention regarding chest radiography.

In a July 23, 2014 decision, the hearing representative affirmed OWCP's October 8, 2013 decision denying appellant's claim for a work-related pulmonary condition. She found that the weight of the medical evidence regarding this matter continued to rest with the opinion of Dr. Shubair, the referral physician.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of establishing 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 and/or specific condition for which compensation is claimed are causally related to the employment injury. These are the essential elements of each and every compensation claim, regardless of whether the asserted claim involves traumatic injury or occupational disease, an employee must satisfy this burden of proof.[5]

OWCP regulations define the term occupational disease or illness as a condition produced by the work environment over a period longer than a single workday or shift.[6] To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit the following: (1) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; (2) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant. The medical opinion 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.[7]

Causal relationship is a medical issue, and the medical evidence required to establish a causal relationship is rationalized medical evidence.[8] 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 employee.[9] Neither the mere fact that a disease or condition manifests itself during a period

[5] *Roy L. Humphrey*, 57 ECAB 238 (2005).

[6] 20 C.F.R. § 10.5(ee).

[7] *Roy L. Humphrey*, *supra* note 5.

[8] *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

[9] *Leslie C. Moore*, 52 ECAB 132 (2000); *Gary L. Fowler*, 45 ECAB 365 (1994).

of employment nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.[10]

ANALYSIS

On January 31, 2013 appellant filed an occupational disease claim alleging that work duties in his federal employment caused occupational pneumoconiosis. OWCP denied his claim finding that the weight of the medical evidence regarding this matter rested with the opinion of Dr. Shubair, an OWCP referral physician who is Board-certified in internal medicine and pulmonary disease. Dr. Shubair did not diagnose pneumoconiosis and did not find a work-related condition.

Before OWCP and on appeal, appellant's counsel has argued that Dr. Shubair's opinion is of reduced probative value because he is not a B-reader. While neither FECA, nor OWCP's regulations impose such a restriction, OWCP examination requirements in asbestos disease cases state that chest x-rays shall be read by either a Board-certified radiologist or a pulmonary specialist.[11]

The Board finds that this case is not in posture for decision regarding whether appellant has an employment-related pulmonary condition due to a conflict in the medical opinion evidence.

Section 8123(a) of FECA provides in pertinent part: "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 who shall make an examination."[12] When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of FECA, to resolve the conflict in the medical evidence.[13]

Dr. Baker, an attending pulmonologist and certified B-reader, diagnosed occupational pneumoconiosis, based in part on a November 1, 2012 chest x-ray which the physician indicated showed had a 1/0 profusion of small opacities and parenchymal abnormalities consistent with occupational pneumoconiosis. Pulmonary function studies were interpreted as normal. The chest x-ray was also read by Dr. Vuskovich, also an attending pulmonologist and certified

[10] *Dennis M. Mascarenas*, 49 ECAB 215 (1997).

[11] *J.B.*, Docket No. 06-905 (issued September 1, 2006). Federal (FECA) Procedure Manual, Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600.8(b) (September 1995) (Exhibit 7) (December 1994). *See also M.D.*, Docket No. 14-2037 (issued February 24, 2015).

[12] 5 U.S.C. § 8123(a).

[13] *William C. Bush*, 40 ECAB 1064, 1975 (1989).

B-reader, who advised that appellant had 1/1 small opacities and pleural abnormalities, which he indicated that was consistent with occupational pneumoconiosis.[14]

In contrast to these opinions, Dr. Shubair, an OWCP referral pulmonologist, provided an opinion, in reports dated June 10, September 11 and October 1, 2013, that appellant did not have a work-related pulmonary condition. He interpreted a June 19, 2013 chest x-ray and pulmonary function studies and posited that they did not show any specific pulmonary abnormality, whether related to federal employment or not.

Consequently, the case must be referred to an impartial medical specialist to resolve the conflict in the medical opinion evidence regarding whether appellant has a work-related pulmonary condition. On remand, OWCP should refer him, along with the case file and statement of accepted facts, to an appropriate specialist for an impartial medical evaluation and report including a rationalized opinion on this matter.[15] After carrying out this development, OWCP should issue an appropriate decision regarding appellant's claim.

CONCLUSION

The Board finds that the case is not in posture for decision regarding whether appellant met his burden of proof to establish that he sustained a pulmonary condition in the performance of duty. There is a conflict in the medical opinion evidence on this matter which necessitates further development of the evidence.

[14] Pneumoconiosis is defined as the deposition of large amounts of dust or other particulate matter in the lungs and the subsequent tissue reaction. Types range from harmless to destructive conditions and are often named for the implicated substances including anthracosis, asbestosis, and silicosis. DORLAND'S *ILLUSTRATED MEDICAL DICTIONARY*, 29th edition (2000).

[15] *See R.A.*, Docket No. 14-1918 (issued March 3, 2015); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

ORDER

IT IS HEREBY ORDERED THAT the July 23, 2014 decision of the Office of Workers' Compensation Programs is set aside and the case remanded to OWCP for further proceedings consistent with this decision of the Board.

Issued: May 7, 2015
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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