

U.S. Department of Labor

Office of Administrative Law Judges  
St. Tammany Courthouse Annex  
428 E. Boston Street, 1<sup>st</sup> Floor  
Covington, LA 70433

(985) 809-5173  
(985) 893-7351 (FAX)



Issue Date: 29 December 2009

CASE NO.: 2009-LDA-174

OWCP NO.: 02-149349

IN THE MATTER OF:

EDWARD M. LARKIN

Claimant

v.

SERVICE EMPLOYEES INTERNATIONAL, INC.

Employer

and

INSURANCE COMPANY OF THE  
STATE OF PENNSYLVANIA  
c/o American International Underwriters

Carrier

APPEARANCES:

GARY B. PITTS, ESQ.  
For The Claimant

LIMOR BEN-MAIER, ESQ.  
For The Employer/Carrier

Before: LEE J. ROMERO, JR.  
Administrative Law Judge

#### DECISION AND ORDER

This is a claim for benefits under the Defense Base Act, 42 U.S.C. § 1651, et seq., an extension of the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. § 901, et seq.,

(herein the Act), brought by Claimant against Service Employees International, Inc. (Employer) and Insurance Company of the State of Pennsylvania (Carrier).

The issues raised by the parties could not be resolved administratively and the matter was referred to the Office of Administrative Law Judges for hearing. Pursuant thereto, Notice of Hearing was issued scheduling a formal hearing for August 3, 2009, in Houston, Texas. All parties were afforded a full opportunity to adduce testimony, offer documentary evidence and submit post-hearing briefs. Claimant offered ten exhibits, two of which were rejected, while ten were admitted. Employer/Carrier proffered 30 exhibits which were also admitted. The record was held open until August 11, 2009, for the admission of EX-28, which was timely proffered and admitted. No joint exhibits were proffered either at the formal hearing or otherwise prior to the closing of the record. This decision is based upon a full consideration of the entire record.<sup>1</sup>

Post-hearing briefs were received from the Claimant and the Employer/Carrier. Based upon the stipulations of Counsel, the evidence introduced, my observations of the demeanor of the witnesses, and having considered the arguments presented, I make the following Findings of Fact, Conclusions of Law and Order.

## I. STIPULATIONS

At the commencement of the hearing, the parties stipulated, and I find:

1. Claimant's average weekly wage is \$1,574.39. (Tr. 77).
2. That all of the facts of the case are identical to the facts set forth in Case No. 2007-LDA-49. (Tr. 11-12).<sup>2</sup>
3. That if the undersigned finds an employee-employer relationship existed at the time of the injury, and Claimant is found to have sustained the injuries in the course and scope of his employment, jurisdiction exists under the Act. (Tr. 11).

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<sup>1</sup> References to the transcript and exhibits are as follows: Transcript: Tr.\_\_\_\_; Claimant's Exhibits: CX-\_\_\_\_; Employer/Carrier's Exhibits: EX-\_\_\_\_. Employer/Carrier submitted EX-28 post-hearing, which is hereby received into evidence.

<sup>2</sup> See Case No. 2007-LDA-49 (Feb. 26, 2008).

## II. ISSUES

The unresolved issues presented by the parties are:

1. Causation; fact of injury.
2. The nature and extent of Claimant's disability.
3. Whether Claimant has reached maximum medical improvement.
4. Entitlement to and authorization for medical care and services.
5. Attorney's fees, penalties and interest.

## III. STATEMENT OF THE CASE

### The Testimonial Evidence

#### Claimant

Claimant testified at the formal hearing. He was forty-three years old at the time of the hearing. (Tr. 22).

Claimant was a truck driver "outside the wire" for approximately sixteen months in Iraq. During that time, he was threatened with explosions. In October or November 2005, Claimant was subjected to one explosion that "felt like if [he] had not been in an armor vehicle, [h]e would have probably been killed." (Tr. 22-23).

Claimant testified he lived in a hooch with another person, but also lived in a tent for approximately ten months while in Al Asad. (Tr. 23-24). He stated the tent contained mold "growing up the walls." Claimant attempted to prevent the mold by putting a tarp over the top of the tent, but it did not work. After multiple complaints, Claimant was to receive a new tent, but was moved to the hooch before it arrived. (Tr. 25).

Claimant testified he had difficulty breathing after he came home from Iraq, and that he was hospitalized approximately four months after returning to the United States. (Tr. 25-26). He was admitted to the hospital for three days, and was discharged because the hospital's physicians did not "find anything really wrong with [him]." (Tr. 26).

Two days after he was discharged, Claimant was readmitted to the hospital. According to Claimant, the hospital staff knew something was wrong, but could not "pinpoint" what it was. Thinking it may be cancer, Claimant underwent surgery. He testified the doctors at the hospital told him, "[i]t's not cancer. It's the histoplasmosis that you got in Iraq." (Tr. 26). Claimant stated he was hospitalized several times because of lung problems, and was put into an induced coma for a "couple of weeks" because his breathing and blood oxygen levels were thirty percent. (Tr. 27).

Claimant testified that within the thirty days prior to the hearing, Dr. Saraiya performed a breathing test, and Claimant's lung capacity was only sixty-two percent. (Tr. 27). He stated he cannot do much, and that he even has to rest after doing a load of laundry. (Tr. 28).

Claimant denied ever working in his garden within the first four months after returning to the United States. (Tr. 26). He stated he sat in his back yard and listened to the radio with a friend. (Tr. 27).

Claimant testified he suffers from chronic headaches beginning in the morning, fading during the day, and coming back thereafter later in the day. He stated he also experiences dizziness; when he stands up, he has to wait at least thirty seconds before he can walk. Claimant testified Dr. Tan told him he suffered from BPPV, but he did not know what that meant. (Tr. 28).

Claimant testified Employer paid him approximately \$81,868 during the fifty-two weeks he was employed overseas in Iraq. He stated his doctors have not released him to return to work, and that he has not been employed since his return to the United States. (Tr. 28-29).

Claimant has been prescribed an inhaler with a steroid, along with Zolof, Wellbutrin, Ablify, Buspar, and something for his histoplasmosis, which name he could not recall. He further testified his doctor recommended he stop taking the histoplasmosis medication because it causes liver damage, and, in fact, began to damage Claimant's liver. (Tr. 29).

Claimant testified he submitted to a pre-employment physical before deployment to Iraq; the physical included a hearing examination. (Tr. 29-30). He stated within the last month, he cannot hear well in his right ear. He testified, "I

can't hear in my right ear. I can hear, but not great. I can't put the phone to my right ear. My wife is always yelling at me, 'Put the phone to your left ear.'" (Tr. 30).

On cross-examination, Claimant testified he lived in a hooch at Anaconda for the first six months, then lived in the tent when he was transferred to Al Asad in early September 2005. (Tr. 30-31). He stated he lived in the tent for nine months. He also testified he stayed in the tent for six or seven months. (Tr. 31). Claimant testified he did not know whether he was having breathing problems while in Iraq, but stated it was sandy and dusty, and that other people had trouble breathing. (Tr. 32).

Claimant further testified on cross-examination that he sought medical treatment from the medics in "Q-West" "when [he] got blown up" in April 2005. (Tr. 32). He stated "[e]verybody made me go, because. . .they said I was blabbering, and I wasn't walking right." (Tr. 32). Claimant clarified that "not walking right" meant he was walking unbalanced. Claimant testified the medic wanted to keep him, but he refused to stay because he "wanted to go back with [his] guys." Claimant stated he was not diagnosed with anything in April 2005. He additionally stated he was told he signed something, but does not remember signing anything. (Tr. 33).

Claimant returned to Anaconda after the incident, but did not return to work. He wished to see the medic there, but stated he was told he "need[ed] a break," and was instructed to stay and rest in his hooch. He repeated his request to see a medic, and was told he would be brought to the military site the following day. The medic told Claimant he was fine and instructed him to go back to his hooch." (Tr. 34).

Claimant was still experiencing dizziness and headaches at the time of the hearing, and he felt like he had a concussion in April 2005 when he was "blown up" because he was "[t]hrowing up and everything like that." (Tr. 34).

Claimant testified he was making a claim for traumatic brain injury based on the April 2005 explosion and a separate and distinct September 2005 IED explosion. When asked to elaborate on the April 2005 explosion, Claimant stated he dropped a load off at the Turkish Border and left around

midnight in a sandstorm. (Tr. 35). Claimant stated "[t]hey were discussing if we should go or not because they were thinking there might be an ambush waiting for us." Claimant further testified there were reports of the explosion from the military and his convoy commander, but he did not have copies. (Tr. 36).

When discussing the IED explosion (September 2005), Claimant testified he was coming back from Rawah when he "hit an IED." He testified his entire truck exploded, but he was in a Level III armored truck. He explained the structure of the truck in the following manner: "Well, say, you go inside a container, and you take a sledge hammer, and somebody on the outside smashes the container. And that's what it feels like. Like, a concussion. Like, a (sic) implosion, almost." Claimant elaborated that the truck was a palletized-loading system that looked like a "duck bill bullet" with "tires throughout the whole thing, and. . .[the trailer is] the same size as [the] truck." Claimant stated the "end of the truck" and the "beginning of the trailer" were damaged, but the cab was not. (Tr. 38). Claimant pulled the truck out of the "kill zone" by dragging it ten miles per hour; meanwhile, Claimant and others were under fire. He further stated that after they got out of the "kill zone," the military arrived, made a perimeter, worked on the truck to salvage it, and "brought it back." (Tr. 39).

Claimant stated he did not receive medical treatment from the medic, even though the medics "were all there waiting for [them]." (Tr. 39-40). He testified an incident report was filed by the convoy commander and by the military, but he did not have copies. Claimant further stated he never sought medical treatment in Iraq after the September 2005 IED explosion. (Tr. 40).

Claimant testified he missed approximately three weeks of work after the first explosion in April 2005. He stated he was given a "mini vacation" and was sent to Dubai "[j]ust to chill out, because they said [he] was sporadic." Claimant re-stated that the only medical treatment he sought was immediately after the April 2005 explosion and when he requested an additional medic in Anaconda. (Tr. 41). He stated he did not seek any further or additional medical treatment until June 8, 2006. (Tr. 42).

Claimant further testified on cross-examination that he was terminated for drinking on the job and gambling. He stated he was gambling but not drinking, and he was never asked to take a breathalyzer test. When reminded by Employer's counsel that he

previously testified that he refused the breathalyzer, Claimant stated, "I guess you can call me a liar, but, see, to tell you the truth, I don't remember. So you can say what you want." (Tr. 42).

Claimant testified that no one was in the truck with him during the April 2005 explosion, but his convoy commander was in the truck during the IED explosion in September 2005. (Tr. 42-43). Claimant further testified no one died in either the April 2005 or the September 2005 explosion. (Tr. 43).

Claimant further stated that "April 24<sup>th</sup> is a fog." He stated, "I think I lost [consciousness]. . . I don't know. I was blown up." (Tr. 43). Claimant clarified his testimony that he believed he lost consciousness in the April 2005 explosion. He further testified he had no burns on his body after the incident, but had a "tiny cut [that] bled like crazy." (Tr. 44). Claimant testified that a medic in Q-West examined the cut and wanted him to stay because he "wasn't normal," but he "wanted to go back with the guys." (Tr. 45).

Claimant testified that prior to going overseas, he had no respiratory problems, and that he never sought treatment for fluid on his lungs. He also denied ever being told he had a respiratory disease. (Tr. 47). He additionally denied reporting to Employer he had any respiratory problems prior to deployment. (Tr. 48-49).

Claimant further testified he began smoking at the age of sixteen. He smoked one to two packs of cigarettes per day before going to Iraq, which increased to four packs per day while in Iraq. (Tr. 48-49). After his return to the United States, Claimant continued to smoke two to two and a half packs of cigarettes per day. Claimant testified he no longer smokes, but "once in a blue moon," he smokes a tobacco pipe. (Tr. 49). Claimant stated he stopped smoking cigarettes in January 2007, but had "a few slips here and there." (Tr. 50).

Claimant further testified Dr. Simms's records will indicate he smokes five packs per day, and that Claimant had shortness of breath and difficulty breathing two years prior to going to Iraq. (Tr. 51). Claimant stated that ". . . [h]e kept complaining of chest pains, and [Dr. Simms] thought it was [his] lungs. . . it turned out to be an ulcer." (Tr. 51).

Claimant stated he did not know Dr. Genovese, and denied any recollection of Dr. Genovese telling him he had fluid on his lungs in August 2004. Additionally, Claimant admitted that if his medical records do so state, he was told "something was not right with [his] breathing during [his] DOT physical." (Tr. 51). Claimant stated if the medical records showed he had respiratory problems prior to going overseas, he did not know if he would dispute them. (Tr. 52).

Claimant stated he lives in a suburban home in Corinth, Texas, but does not mow the lawn or do any gardening. (Tr. 52). He testified he did not recall whether he dug holes in the dirt at his home after returning to the United States, but that he did not perform any yard work. (Tr. 52-53). He stated his neighbor dug and replaced the common fence. (Tr. 52).

Claimant testified he cannot return to work because he cannot breathe, and the traumatic brain injury causes him to "mess everything up" and "lose everything." Claimant additionally stated he suffers from "headaches and dizziness," cannot pronounce or remember some words, and turns in the wrong direction. (Tr. 53). Claimant testified he was driving at the time of the hearing, but for the limited purpose of dropping his wife off at the movie theater to catch the bus because they cannot afford parking. (Tr. 53-54). The drive from his home to the movie theater is approximately one mile, and he drives a Ford F-150. He testified he also drives to Wal-Mart, which is approximately one to one and a half miles from his home. Claimant denied driving on a regular basis, but renewed his Class A commercial driver's license (CDL) on or before June 8, 2008. (Tr. 54). Claimant testified he did not have to undergo a DOT physical to renew his CDL because he was not driving. He further testified he is not allowed to drive a tractor-trailer; he knows he will not pass the DOT physical. Claimant denied ever failing a DOT physical. (Tr. 55).

Claimant additionally testified he suffers from hearing loss, but stated he was able to hear Employer's counsel at the hearing. (Tr. 55-56). He stated he always experiences ringing in his ears. He further stated he was told he suffers a substantial percentage of hearing loss in his ear. When questioned as to whether he had mild hearing loss in his right hear before going overseas, Claimant stated, "I haven't seen that before, and they didn't tell me anything." (Tr. 56).

Claimant testified he has not worked since returning to the United States. (Tr. 56-57). He stated he did not know whether he could work as a security guard because he not know whether he would be hired because of his "mental state." Claimant further stated he does not "have the stamina to do anything," and that he has not applied for any jobs as a security guard. When questioned regarding the vocational expert's testimony from the first hearing, Claimant recalled, "I remember him saying in court, I can do this; I can do that. But I don't have any written thing." (Tr. 57-58). Claimant stated he did not apply for any of the jobs the vocational expert listed at the first hearing. (Tr. 58).

Claimant testified his chest pains began in late September or early October 2006; he was not experiencing any pains before that time. (Tr. 58). He further testified he did not recall ever suffering a prior head injury. (Tr. 59).

Claimant testified Hawkeye, his military convoy commander from the April 2005 explosion, did not provide a statement regarding the incident. He further stated Darren Hanson, whose truck was actually hit first in the convoy, did not provide a statement, but only because Claimant could not locate him. (Tr. 59).

Claimant testified he was not receiving treatment for traumatic brain injury, histoplasmosis, or hearing loss at the time of the hearing because no one would take his insurance. He stated he was receiving psychiatric help from both a psychiatrist and a psychologist, both of whom were treating him at no charge. (Tr. 60-61). After some memory refreshment, Claimant then testified he was currently seeing Dr. Saraiya for his histoplasmosis. He was also seeing Dr. Campbell, an internal medicine doctor, at the time of the hearing. He had been seen by Dr. Campbell less than two weeks prior to the hearing. (Tr. 62). He stated Dr. Campbell was seeing him "to make sure [he does not] get worse." Claimant stated he was not seeing a physician regarding his hearing loss. (Tr. 63).

Claimant testified he began rehabilitation services in 2008 with the Department of Rehabilitation Services in Texas, but denied ever telling them he was hospitalized with a head injury and second and third degree burns over his entire body. (Tr. 63). He additionally denied telling them he was terminated because he did not return to work after a disability. (Tr. 64).

Claimant testified to birds flying around his home in Texas, "just like everybody else does." (Tr. 64).

On re-direct examination, Claimant testified he did not have a vegetable garden from the time he returned to the United States until he was hospitalized for his lung condition, and that he has not had one since. (Tr. 65). Claimant additionally denied planting flowers in his yard after returning from Iraq, or any time thereafter. He also denied ever mowing the lawn since his return to the United States. He paid a mowing company to mow the lawn, or his son-in-law would do it. He owed the mowing company back payments of two thousand dollars at the time of the hearing. (Tr. 66).

Claimant stated he did not have any pet birds, and that he has not had any since his return to the United States. (Tr. 66).

Claimant testified he renewed his CDL by going to the Department of Motor Vehicles and paying \$24.00, and that he did so because he worked hard for the license and did not want to lose it. (Tr. 66-67). He stated he does not think he will ever be able to get well enough to drive again, but kept his license because he "earned it, and [he] wanted to hold on to it." (Tr. 67).

On re-cross examination, Claimant again denied ever doing any yard work after his return to the United States. (Tr. 68).

Upon questioning by the undersigned, Claimant testified the April 2005 explosion was to his vehicle and he went to the medics at "Key West." He stated the medic "said [he] had a concussion [and]. . .wanted [him] to stay there," but he "wanted to go back with the guys." (Tr. 69).

Upon further questioning by the undersigned, Claimant testified his vehicle was damaged in the September 2005 IED explosion, but he suffered no physical injury and sought no medical treatment. (Tr. 70).

Further upon questioning by the undersigned, Claimant testified he observed mold in the tents. He further stated he was told histoplasmosis could be caused from mold or bird droppings. (Tr. 70). Claimant additionally testified he did not observe the mold for the entire six months he was in the tent, but only for approximately three months after the rainy season. (Tr. 70-71).

On re-direct examination, Claimant testified that the KBR medics from whom he sought treatment after the April 2005 explosion were not doctors. (Tr. 71). Claimant stated the medics were comparable to EMS personnel, and that he never actually saw a doctor after the explosion. (Tr. 71-72).

On re-cross examination, Claimant testified he was told by the medics he had Post Concussion Syndrome, and that he "think[s]" he signed something the day after he saw the medic. (Tr. 72).

On re-direct examination, Claimant testified he was not sure what the medics told him, except that they wanted to keep him there. Claimant stated that Employer has not produced any of KBR's medic's records, and he has not reviewed them. (Tr. 73).

On re-cross examination, Claimant testified that while he was in Iraq for sixteen months, he saw the medics for mandatory immunizations, but had not seen them otherwise except after the April 2005 explosion. (Tr. 74).

## **The Medical Evidence**

### **The Lung Injury**

On September 5, 2003, Claimant reported to Dr. Scott A. Simms for a physical because he was concerned about the effects of smoking and stress on his health. He had complaints of shortness of breath for the past two years, which had been waxing and waning in severity. Upon examination, Claimant showed some dyspnea. He was administered a chest x-ray, which was negative. Claimant was counseled on the need to quit smoking. (EX-11, pp. 1-2).

On August 3, 2004, Claimant reported to Dr. Glenn Genovese at Mayhill Diagnostic Center, with dyspnea. Chest PA and lateral x-ray examinations revealed clear lungs with no active infiltrates. (EX-28, p. 4).

On August 4, 2004, Claimant presented to Dr. Genovese for an evaluation of what Claimant perceived to be "fluid on lungs." Claimant had apparently been told in his DOT physical that "something was not right." He surmised abnormal sounds were heard by auscultation. He admitted to being a heavy smoker, and his drinking was described as heavy. Upon examination, Dr. Genovese's impressions were possible sleep apnea and abnormal chest sounds (at risk for COPD or asthma). (EX-11, pp. 25-26).

On August 30, 2004, Claimant reported to Dr. Genovese regarding abnormal breath sounds. After physical examination and other testing, Dr. Genovese's impressions were unspecified diseases of the upper respiratory tract and mild intrinsic asthma. Claimant was instructed to return for a follow-up examination in one year. (EX-11, pp. 37-38).

On February 1, 2005, Claimant submitted to a pre-employment screening.<sup>3</sup> On his questionnaire, Claimant disclosed prior heartburn and severe sore throat, but no other past or present medical conditions. (CX-1, p. 2). No further medical evaluation was required. (CX-1, p. 3).

On October 26, 2006, Claimant reported to Denton Regional Medical Center Emergency Department and was admitted with complaints of chest pain that started earlier that day but had stopped, with an onset during light activity. Claimant described his chest pain as "squeezing," and stated that it is worsened by deep breaths. He also reported nausea, but no vomiting, difficulty breathing or diaphoresis. Claimant stated he had not had similar symptoms previously. Upon examination, Claimant's cardiac labs were normal, and examination showed no pericardial effusion or masses. The Emergency Room doctor called and spoke with Dr. Allo, who stated he would see Claimant in the morning and give him Lovenox. Chest x-rays indicated Claimant's lungs were clear, and there were no acute findings. Claimant was discharged on October 28, 2006. (CX-1, p. 12; EX-28, pp. 16-17, 28).

On October 29, 2006, Claimant was re-admitted to Denton Regional Medical Center, under the care of Dr. Allo, again with complaints of chest pain. (EX-28, p. 9). On October 30, 2006, he submitted to an exercise stress test, which revealed abnormal cardiogram with inferior reversible defect, suggestive of ischemia, inferior hypokinesia and a normal ejection fraction at sixty-two percent. Myocardial infarction was ruled out after a cardiac catheterization on October 31, 2006, and Claimant was discharged on that date. His discharge medications included Aspirin, Synthroid, Protonix and Advil, with instructions for a follow-up in two weeks and a consultation on the need to quit smoking. (CX-1, pp. 13-18; EX-28, pp. 10-15).

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<sup>3</sup> The record does not indicate which facility performed the physical examination for the screening, but the questionnaire is the product of Halliburton KBR and Associate Companies. (See CX-1, p. 2).

On November 13, 2006, Claimant reported to Dr. Allo for his two-week follow-up, with continued complaints of chest discomfort. Dr. Allo recommended a gastrointestinal evaluation. (CX-1, pp. 19-20).

On December 4, 2006, Claimant presented to Denton Regional Medical Center Emergency Department with a chief complaint of substernal chest pain. Pericarditis was suspected by the emergency room physician. (EX-28, pp. 255-256).

On December 4, 2006, Claimant presented to Dr. Allo with complaints of chest pain. Dr. Allo performed an echocardiogram, which provided normal results. Additionally, Claimant was administered a chest/abdomen CT, which demonstrated abnormal soft tissue density in the right hilum with diffuse adenopathy, mildly enlarged nodes at the distal esophagus and in the right middle lobe, and a small left pleural effusion with posterior pulmonary atelectasis. Claimant's bronchoscopy demonstrated pernicious mucus plugs in the basal segments bilaterally, along with inflammation, but no lesions; his bronchial washings were gram-positive cocci. His EGD showed normal duodenum and stomach, mild peptic esophagitis and a hiatal hernia. Additionally, Claimant's bone scan was negative, but showed mild degenerative changes. Claimant was discharged to go home on December 8, 2006, but was prescribed Levaquin 750 mg, Lortab 5, and Protonix, 40 mg. Additionally, Claimant had been prescribed previously, and was directed to continue to take Clonazepam, Synthroid, Risperdal, Seroquel, Zoloft and Wellbutrin. (CX-1, pp. 21-27; EX-28, pp. 242-245). Chest x-rays showed arteriosclerotic cardiovascular changes, but no failure, and a somewhat poor inspiratory effort with atelectasis in the lower lobes. The chest x-ray was otherwise negative. (EX-28, p. 301).

On December 5, 2006, Dr. Roy Joseph was consulted for Claimant's chest pain, regarding a possible gastroenterologic connection. Claimant reported to Dr. Joseph that "he used to smoke up to 3 packs a day, but has quit and now down to less than ½ pack a day." Dr. Joseph recommended imaging studies of Claimant's chest and abdomen to rule out possible pulmonary/chest wall pathology, as well as gastrology studies to rule out and/or treat possible ulcers. (EX-28, pp. 252-253).

On December 6, 2006, Dr. Mukesh Saraiya was consulted due to Claimant's dyspnea and chest pain. Claimant reported to Dr. Saraiya that he was smoking seven American cigarettes per day at that time. Dr. Saraiya's impressions of Claimant were left lower lobe atelectasis, likely secondary to mucus plugging, atypical

chest pain; history of heavy tobacco use; history of gastroesophageal reflux disease and peptic ulcer disease; PTSD; and hypothyroidism. He recommended bronchodilator therapy with Xopenex, Atrovent and flutter, along with ID corticosteroids. Additionally, he extensively counseled Claimant regarding the need to stop smoking. (EX-28, pp. 248-251). Claimant's chest CT revealed abnormal soft tissue density in the right hilum, suspicious for adenopathy with a mildly enlarged node also present adjacent to the distal esophagus in the mediastinum. Additionally, the chest CT showed a 1.2 cm rounded nodule in the right middle lobe, but no other masses, while apparent atelectasis was noted in the left lower lobe. The chest CT also revealed a small left pleural effusion with bibasilar posterior pulmonary atelectasis. Claimant's abdomen CT showed minimal atherosclerotic calcification of the aorta, but no aneurysm. (EX-28, pp. 264-266).

On December 7, 2006, Claimant submitted to a nuclear medicine whole body bone scan to check for possible cancer. The test revealed a negative bone scan, with the exception of mild degenerative type activity in several locations. (EX-28, p. 241).

On January 9, 2007, because Claimant's complaints of chest pain continued and he had an abnormal CT scan, he reported to Dr. Tung Huu Cai at Denton Regional Medical Center for a right thoracotomy with wedge resection of the right middle lobe mass, and biopsy of the mediastinal mass. Claimant tolerated the procedure well. The pathology showed granulomatous disease. Dr. Javed A. Akram (infectious disease) was consulted because the cause was most likely fungal. Claimant was started on Diflucan, and was discharged on January 12, 2007. (EX-28, pp. 286-287, 294-296).

On January 10, 2007, Claimant's heart and lungs were evaluated by Dr. Cai, status-post right thoracotomy. The evaluation revealed a mild worsening of atelectasis or infiltrate at the right lung base, but no more linear density overlying the left lung. No other significant changes were present since January 9, 2007, the date of the thoracotomy and wedge resection. (EX-28, pp. 298-299).

On January 11, 2007, Claimant's chest x-ray revealed no significant changes since the date of the thoracotomy and wedge resection. (EX-28, p. 297).

On January 13, 2007, Claimant's medical records from Denton Regional Medical Center indicate Dr. Mukesh Saraiya, M.D. was a consulting pulmonary physician. Apparently Claimant had been admitted to the medical center for evaluation of a mediastinal lymphadenopathy, and had undergone a right thoracotomy with a wedge resection of the right little lobe mass, and a biopsy of the mediastinal lesion. The lesion turned out to be necrotizing granuloma, with an unclear etiology. Claimant's culture reports were negative on January 13, 2007, with a negative acid-fast, as well as fungal smear. After the thoracotomy and resection, Claimant was discharged, but was subsequently brought back to the emergency room and admitted to the Intensive Care Unit due to respiratory failure with bilateral infiltrative process. Claimant's medical records indicate that on January 13, 2007, he had "been smoking 5 packs of Indian-made cigarettes rolled in a tobacco leaf." Upon physical examination and x-ray, Dr. Saraiya's impressions were acute respiratory failure with severe hypoxemia, associated with diffuse bilateral infiltrative process, likely secondary to Adult Respiratory Distress Syndrome (ARDS), etiology unclear. Dr. Saraiya noted Claimant had necrotizing granulomatosis, and may also have underlying fungal or mycobacterial disease. Dr. Saraiya admitted Claimant to the ICU and noted he may require intubation if his condition did not rapidly improve. In the interim, Claimant was placed on broad-spectrum antibiotics. (EX-28, pp. 159-161).

On January 13, 2007, Claimant was seen at Denton Regional Medical Center (while admitted to the ICU) by Javed A. Akram, a consulting infections disease doctor. Dr. Akram's notes indicate Claimant was a veteran from the Iraq war who had been experiencing chest pain since June 2006. The results of Claimant's biopsy were still pending, but had so far shown granulomatous disease. Dr. Akram started Claimant on Diflucan. His notes indicate Claimant's wife reported he awoke with severe shortness of breath and confusion. Upon admission to the emergency room, Claimant's oxygen saturation was fifty-six percent at room air, which the emergency department suspected was aspiration pneumonia. It is noted Claimant's histopathology showed severe granulomatous disease, with necrotizing and non-necrotizing granulomas. AFB and fungus strains were negative. Dr. Akram's impressions after physical examination and pathological testing were acute respiratory failure, leukocytosis, renal insufficiency, and extensive bilateral pulmonary infiltrates, suggestive of pneumonia or pulmonary edema. Claimant was administered antibiotics for possible aspiration pneumonia. (CX-1, pp. 28-29; EX-28, pp. 162-163).

On January 13, 2007, Claimant was intubated with an endotracheal tube. X-ray examination revealed interval removal of the right-sided chest tube. Infiltrates had worsened, and were suggestive of possible pulmonary edema or ARDS. Additional X-ray examination revealed a bilateral diffuse air space opacity, which was suggestive of severe pulmonary edema, slightly worsened compared with examination earlier that day. (EX-28, pp. 189-190).

On January 14, 2007, Claimant's x-rays indicate there had been interval placement of the NG tube. Also noted was bilateral air space disease. (EX-28, p. 188).

On January 15, 2007, Claimant's x-rays showed the right-sided PICC line had been placed, along with endotracheal and nasogastric tubes. Diffuse hazy infiltrates were seen throughout both lungs, but predominantly in the right lower lung and left mid to lower lung. Claimant's infiltrates had moderately improved since the previous day's examination. (EX-28, pp. 186-187).

On January 16, 2007, Claimant's x-rays showed an endotracheal tube, right sided PICC line, and esophageal tube. Additionally, the x-rays showed persistent perihilar infiltrates with central vascular congestion, suspicious for volume overload or possibly acute cardiac decompensation. (EX-28, p. 185).

On January 17, 2007, Claimant's x-rays showed an endotracheal tube and the right sided PICC line. There had been "interval removal of [the] nasogastric [NG] tube." Additionally, the x-rays showed a right basilar atelectasis or infiltrate. (EX-28, pp. 183-184).

On January 18, 2007, Claimant's x-rays showed an endotracheal tube, right sided PICC line, and NG tube. Additionally, the x-rays showed bibasilar atelectasis or infiltrate. (EX-28, p. 182).

On January 19, 2007, Claimant was "reintubated with [a diagnosis] of ARDS" under the care of attending physician Dr. Cai. (EX-28, p. 165). His x-rays showed low lung volume, atelectasis or infiltrates in the right lung base, and diffuse hazy opacity persistent in the left mid to lower lung, consistent with infiltrate and mild pleural effusion. (EX-28, p. 181).

On January 20, 2007, x-rays of Claimant's chest showed the endotracheal tube and right-sided PICC line. Additionally, the x-rays showed bibasilar infiltrates or atelectasis, along with shallow inspiration and poor lung expansion. (EX-28, p. 180).

On January 22, 2007, x-rays of Claimant's chest were taken and showed an endotracheal tube, NG tube and right sided PICC line in place. Additionally, the x-rays showed atelectasis, which was unchanged from his most recent examination. (EX-28, p. 179).

On January 23, 2007, x-rays of Claimant's chest were taken, but showed no change since the previous January 22, 2007 x-rays. (EX-28, p. 178).

On January 24, 2007, Claimant's endotracheal tube was removed under the care of Dr. Cai, but the nasogastric tube and right PICC line remained in place. His condition had not changed since his previous January 23, 2007 examination. (EX-28, p. 177).

On January 26, 2007, Claimant began occupational therapy. Minimal tasks such as walking across the room, sitting and standing fatigued him, but he was reassured he could rebuild his endurance with therapy. (EX-28, p. 238).

On January 27, 2007, Claimant began physical therapy with Christina Sokolowski, P.T. He began walking without an assistive device, but held on to side rails of the hospital walls momentarily throughout his walking. Physical therapy notes indicated Claimant was a fall risk without an assistive device, and that his balance was impaired. (EX-28, p. 231).

On January 30, 2007, Claimant's esophageal tube was removed under the care of Dr. Cai. After removal, chest and lateral x-rays showed patchy perihilar and bibasilar infiltrates in both lungs; Claimant had not significantly improved since the intubation. Additionally, the x-rays showed pleural thickening on the right, suggestive of pleural fluid and/or reactive pleural changes. Claimant's lungs were not well-expanded, and his aspirations were shallow. (EX-28, p. 176).

Claimant was discharged home from Denton Regional Medical Center on January 30, 2007. (EX-28, p. 232).

On January 31, 2007, Claimant was prescribed eight weeks of pulmonary rehabilitation, to include evaluation and treatment.<sup>4</sup> (CX-1, p. 30).

On February 5, 2007, Claimant took a shortness of breath survey that indicated he experienced severe breathlessness while performing the following activities: walking on a level with others, up a hill, or up stairs; picking up and straightening; doing dishes; sweeping/vacuuming; making the bed; shopping; doing laundry; washing the car; mowing the lawn; watering the lawn; and sexual activities. (CX-1, p. 33).

Claimant's Physical Therapy Evaluation from the Wellness Care Center indicated he reported he began to experience shortness of breath when he was overseas in October 2006.<sup>5</sup> Claimant's biopsy showed pollinated flora, which resulted in Claimant being put in a twelve-day, drug-induced coma. Claimant also apparently experienced a lung collapse, along with respiratory failure. (CX-1, p. 37).

On February 28, 2007, Claimant's physical therapy notes indicated he was progressing toward the short term goals of his care plan. (CX-1, p. 46).

On March 2, 2007, Dr. Joanne Yi of the Mayo Clinic wrote a letter to Dr. Less Ford of the Department of Pathology of Affiliated Pathologists, P.A., agreeing with Dr. Ford's diagnosis of necrotizing granulomatous inflammation. Dr. Yi repeated some of the pathology prior to rendering her opinion. Mayo Clinic's pathology report indicated: "Lung, right upper and middle lobes, wedge resections and hilar mass." The January 9, 2007 biopsy indicated necrotizing granulomatous inflammation with histoplasma organisms identified, and small focus of organizing aspiration pneumonia. (CX-1, pp. 47-53).

On March 7, 2007, Dr. Akram's assessment of Claimant was histoplasmosis and a skin rash. He prescribed Sporonox 200 mg, and told Claimant to follow up in one month. (CX-1, p. 54).

On March 12, 2007, Claimant reported to Dr. Scott Simms. Dr. Simms's assessment was a rash on Claimant's chest, and histoplasmosis with other manifestation. (CX-1, pp. 58-59).

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<sup>4</sup> It is noted the physician that prescribed pulmonary rehabilitation is not listed on the prescription, and the signature line is unreadable.

<sup>5</sup> It is noted Claimant was not overseas in October 2006, but had actually returned to the United States on June 6, 2006.

On March 14, 2007, Dr. Mukesh Saraiya wrote a letter to "whom it may concern," regarding Claimant's granulomatous disease. Dr. Saraiya's letter stated the following: "I suspect the patient has the granulomatous disease related to exposure to fungal elements while working in Iraq." (CX-1, p. 60).

On March 16, 2007, Claimant participated in a voice evaluation at the University of North Texas Speech and Hearing Center because of his need to constantly clear his throat, hoarseness, and a sore throat. Claimant noted differences in his memory and cognitive abilities after his drug-induced coma and intubation in January 2007. The Clinician reported Claimant presented with erythemic fibrotic vocal folds due to a prolonged history of smoking tobacco and acid reflux. (CX-1, pp. 61-62).

On April 4, 2007, Claimant reported to Dr. Akram (infectious disease) for a follow up. Dr. Akram noted Claimant was a little better, and continued him on Sporonox 200 mg. (CX-1, p. 64).

On April 13, 2007, Dr. Akram wrote a letter to "whom it may concern," stating it is possible Claimant might have been exposed to histoplasma in Iraq, and that he is currently undergoing treatment for histoplasmosis. (CX-1, p. 66).

On April 18, 2007, Dr. Akram again saw Claimant and recommended he continue Sporonox 200 mg, with a follow-up visit in four weeks. (CX-1, p. 72).

On May 16, 2007, apparently for his follow-up visit, Dr. Akram assessed that Claimant still had lung histoplasmosis, continued Sporonox, and recommended a CT of his chest. Dr. Akram noted Claimant stated he had money problems and wanted to wait on the CT. (CX-1, p. 74).

On June 4, 2007, Claimant reported to Dr. Debbie Ann Bridges of North Texas Infectious Disease Consultants. Claimant discussed with Dr. Bridges his thoracotomy in January 2007 and his "fifteen-day medical-induced coma." He also reported he was disabled because of PTSD, that he was exposed to significant amounts of dust and contaminated water, and that he was staying in a tent with forty other men; the tent at one time was flooded with river water. Dr. Bridges ordered a C-scan of Claimant's chest to evaluate his progress with the histoplasmosis. (CX-1, pp. 75-77).

On June 8, 2007, Claimant was admitted to Denton Regional Medical Center Emergency Department with a chief complaint of severe pain in the left chest. The pain had occurred for several days prior to admission intermittently, but each time returned progressively worse. Upon examination, Claimant had EKG changes consistent with pericarditis and a small exudative pericardial effusion. He was given medication, which relieved his pain. The emergency room physician noted that after discussion with Claimant's infectious disease specialist and cardiology reports, the pericarditis and pericardial effusions are likely a result of Claimant's histoplasmosis. Claimant was discharged with instructions to take Indomethacin, Protonix, Zoloft, Abilify, Chantix, Singulair, Tylenol, Maalox and Sporanox. Claimant was also instructed to return to Dr. Geetha Ramaswamy for follow-up in two weeks, and to Dr. Saraiya in four weeks. Additionally, Claimant was instructed to return to pulmonary rehabilitation. (EX-28, pp. 129-131).

On June 12, 2007, multiple spiral volumetric images of Claimant's chest were obtained with the use of an IV contrast, by Blue Star Imaging. The images revealed the following: mild linear opacification within the anterior segment of the right upper lobe and right middle lobe likely reflecting atelectasis or scarring; a 5 mm noncalicified nodule approximating the right minor fissure, not specific; minimal pleural based dystrophic calcifications at the right posterior lung base; and additional dystrophic calcifications within the hepatic dome, most likely representing remote granulomatous change. (CX-1, p. 81; EX-28, pp. 133-134).

On June 18, 2007, Claimant was admitted to Denton Regional Medical Center for chest pain, which he described as sharp and mostly localized over the left lower precordial area, with some radiation to his left shoulder. The pain increased when he leaned forward. He was started on morphine, which gave him considerable relief. Claimant's cough was productive of yellowish sputum. Dr. Ramaswamy recommended treatment with anti-inflammatory drugs for pain and an echocardiogram to assess the size of his pericardial effusion. (EX-28, pp. 132-134). Claimant's chest CT revealed a small pericardial effusion and a small left pleural effusion, but no evidence of central pulmonary embolus. Additionally, it showed subpleural densities, most pronounced in the left lower lobe, and most likely

representing atelectasis. Focal airspace disease in the extreme posterior left lower lobe was not entirely excluded. (EX-28, pp. 139-140). Dr. Ramaswamy opined Claimant's histoplasmosis was a possible cause of the pericardial effusion. (EX-28, pp. 132-134).

On June 27, 2007, Claimant returned to Dr. Bridges (North Texas Infectious Disease Consultants) for a follow-up examination. Claimant had been recently hospitalized with pericarditis; his cough had been increasing productive of yellow-green sputum. Hospital cultures of his sputum showed *Ahaemophilus influenzae*. Claimant had stopped taking the Sporonox. Dr. Bridges told Claimant to continue taking the Sporonox until a prescription for Voriconazole could be filled, and that he may take Advil or Tylenol for chest pain. (CX-1, p. 82).

On July 31, 2007, Claimant reported to Denton Regional Medical Center Emergency Room with complaints of dizziness and chest pain. (CX-1, pp. 83-86; EX-28, pp. 121-123). A chest x-ray was administered, which showed no active cardiopulmonary disease. (CX-1, p. 87; EX-28, p. 124).

On August 15, 2007, Claimant's wife called Dr. Ramaswamy to report Claimant had been experiencing significant chest pain for four days that had not improved. Dr. Ramaswamy recommended Claimant go to the emergency room at Denton Regional Medical Center. (CX-1, pp. 100, 103). Claimant received Helical imaging of his chest with IV contrast at Denton Regional, which revealed an unchanged small pericardial effusion, unchanged small nonspecific mediastinal, and hilar lymph nodes. The imaging also showed a tiny left pleural effusion and mild lower lobe atelectasis, but no other significant changes or evidence of cardiopulmonary disease. It was noted Claimant's aeration of both lower lungs had improved since June 18, 2007. (CX-1, pp. 93-94). Claimant's chest x-ray showed no evidence of congestive failure, and his heart and mediastinum were within normal limits. The x-ray additionally showed subsegmental atelectasis or scarring in the lung bases, but no active infiltrates, and no pleural effusion. (CX-1, pp. 95-96). Claimant's EKG showed normal sinus rhythm, with an ST elevation, consistent with pericarditis. (CX-1, p. 97). Dr. Ramaswamy's ultimate impressions were chest pain, pericarditis, pulmonary histoplasmosis, and sinus tachycardia. (CX-1, pp. 101, 106; EX-28, pp. 112-116).

On August 20, 2007, Claimant reported to Dr. Bridges (infectious disease) for a hospital follow-up visit regarding his histoplasmosis. Dr. Bridges discussed with Claimant the possibility of starting Amphotericin in an effort to help with his recurrent pericarditis. Dr. Bridges noted, "I am not certain that it is the histoplasmosis that is the cause of [the pericarditis]." (CX-1, pp. 108-110).

On August 28, 2007, Claimant returned to Dr. Bridges for a follow-up of recurrent pericarditis and positive PPD. Dr. Bridges continued Claimant on Sporanox for a total of six months, and noted Claimant's histoplasmosis was clearing up at that time. Dr. Bridges suspected the PPD could be the cause of Claimant's recurrent pericarditis. Claimant showed no other symptoms of active TB, so he recommended treatment for latent TB. Insofar as the recurrent pericarditis, Dr. Bridges stated it could be caused by histoplasmosis, tuberculosis, viral infection or some other cause, but she "do[es] not think that this is histoplasmosis at this point since his pulmonary disease seems to have resolved." (CX-1, pp. 111-115).

On October 10, 2007, Claimant reported to Dr. Bridges for a follow-up examination, and with complaints of sore throat and neck pain for three days the prior week, chest pain within the last two days, and shortness of breath. He complained of no systemic, head, eye, gastrointestinal, hematologic or musculoskeletal symptoms. Dr. Bridges noted no recent flares of pericarditis and that Claimant was taking his medications without problems; she recommended a follow-up visit in three months. (CX-1, pp. 118-121).

On January 9, 2008, Dr. Bridges wrote a letter to "whom it may concern," stating that Claimant had been under her care and had been diagnosed with histoplasmosis and latent TB, both of which Claimant is suspected to have acquired in Iraq. (CX-1, p. 132).

On January 9, 2008, Claimant reported to Dr. Bridges for a follow-up visit. He was instructed to continue taking Itraconazole for the histoplasmosis; there had been no further recurrences of pericarditis for months. He was additionally instructed to continue taking INH for his latent TB for three more months. Dr. Bridges noted Claimant's daughter's PPD was also positive, so she will need "tx" for latent TB. (CX-1, pp. 134-137).

On January 11, 2008, Claimant reported to Dr. Ramaswamy for a follow-up visit and with complaints of chest pain that increased during deep breathing the day before, but that had eased up on the day of the office visit. Claimant was instructed to take Indomethacin on a scheduled basis, and to undergo echocardiographic evaluations. Dr. Ramaswamy attributed Claimant's chest pain to possible activation of pulmonary histoplasmosis, but was also concerned about other causes, particularly rheumatologic factors. Claimant was referred to Dr. Reyes for further evaluation. (EX-28, pp. 320-321).

On January 18, 2008, Claimant reported to Dr. Mukesh Saraiya, complaining of increasing fever with chills and sweats for the previous several weeks. Claimant's medical records indicate that on January 18, 2008, Claimant had quit smoking five packs of cigarettes a day "for a while and went back to smoking a few months ago." Claimant had difficulty breathing with minimal activity and had been unable to take deep breaths. Claimant "reduced his dosage of Sporanox to once a day without informing anybody" because his wife had recently been laid off work. Upon examination, Dr. Sariya's impressions were the following: right-sided pleural effusion possibly with pneumonitis, rule out recurrent histoplasmosis; history of underlying COPD; and PTSD. (CX-1, pp. 140-141). X-ray examination of Claimant's chest revealed right lower lobe pneumonitis and/or atelectasis with an associated right pleural effusion. (EX-28, p. 317). Claimant was not discharged from this visit until January 25, 2008, with a discharge diagnosis of right lower lobe pneumonia with right-sided pleural effusion, likely secondary to pleurisy, along with histories of histoplasmosis, pericarditis, hypothyroidism and PTSD. (CX-1, p. 143).

On January 19, 2008, Claimant's chest x-ray showed an increased right pleural effusion with increased compression atelectasis and/or pneumonitis in the right lung. (EX-28, p. 316).

On January 20, 2008, Claimant's chest x-ray examination revealed a right pleural effusion and compression atelectasis and/or pneumonitis in the right lower lobe. (EX-28, p. 315). Dr. Saraiya performed a thoracentesis on Claimant's pleural effusion. Post-procedural (thoracentesis) x-ray examination revealed an apparent interval decrease in the right pleural effusion with some decrease in compression atelectasis in the right lung. (EX-28, p. 314). Dr. Saraiya thereafter requested an infectious disease consult from Dr. Akram. After examination,

Dr. Akram's impressions were right pleural lobe pneumonia, right pleural effusion, status post thoracentesis, and history of histoplasmosis. (EX-28, pp. 304-305).

On January 21, 2008, Claimant's x-ray examination showed no significant change in the appearance of his chest from the previous examination on January 20, 2008. (EX-28, p. 313).

On January 22, 2008, Claimant's chest PA and lateral exams indicated pleural thickening on the right, suggesting pleural fluid and/or pleural reactive changes. The adjacent parenchymal density may have been due to atelectasis and/or pneumonitis. Cardiomedial silhouette was negative, and the left lung was negative. (EX-28, p. 312).

On January 22, 2008, Dr. Ramaswamy was consulted regarding Claimant's pericarditis. After examination, she noted she would obtain a limited echocardiographic evaluation to look for a recurrent effusion. (EX-28, pp. 308-309).

On February 1, 2008, Claimant was given PA and lateral upright films of the chest, which showed pneumonia on the right upper and middle lobe, along with a small right pleural effusion. (CX-1, p. 145).

On February 1, 2008, Claimant presented to Dr. Saraiya complaining of fatigue, "heavy" lungs, and nausea. Claimant's history showed, "no recent history of headaches, head injuries, or head nodules. . .no recent history of loss of hearing, deafness, tinnitus. . .loss of balance, vertigo. . . ." Claimant only complained of dizziness. After examination, Claimant's diagnoses were as follows: unspecified acute pericarditis; positive tuberculin skin test without active tuberculosis; chronic neoplasm of uncertain behavior of trachea, bronchus, and lung; improved depressive disorder; chronic allergic rhinitis (pollen); and chronic fatigue syndrome. (CX-1, pp. 146-148).

On February 3, 2008, Claimant reported to Denton Regional Medical Center Emergency Department with a chief complaint of chest pain. Claimant was prescribed Lortab for pain, and advised to continue with all other prescription medications. Claimant was also instructed to follow up with Dr. Saraiya. (EX-28, pp. 80-82).

On February 13, 2008, Claimant reported to Dr. Bridges (infectious disease) for a hospital follow-up, complaining of shortness of breath. He had not taken any of his prescribed medication in six weeks because his wife lost her job. His prescriptions on that date included Wellbutrin, Xopenex, Tylenol, Singulair, Zoloft, BuSpar, Isoniazid and Sporanox. Dr. Bridges's plan consisted of assisting Claimant with getting Sporanox and a referral for a second opinion on Claimant's pulmonary issues. (CX-1, pp. 157-160).

On February 13, 2008, Claimant also reported to Dr. Odette Campbell that he acquired histoplasmosis in 2006 while in Iraq. He complained of pleuritic chest pain, shortness of breath, night sweats, non-productive cough, and lethargy. Claimant reported to Dr. Campbell that he had smoked two packs of cigarettes per day for 24 years, but that he had quit smoking in 2007. Dr. Campbell's notes indicate Claimant had a history of severe headaches, memory impairment and brain injury from trauma. Claimant additionally reported to Dr. Campbell that he suffered from no dizziness, vertigo, or tinnitus, but that he did have a loss of hearing in his right ear. Upon examination, Dr. Campbell's assessment included the following: chronic histoplasmosis; traumatic brain injury; PTSD; COPD; right pleural effusion and history of pericarditis, both secondary to histoplasmosis; short term memory loss secondary to brain injury; visual field defect left; chronic headaches; and right shoulder bursitis. Dr. Campbell opined that Claimant was not capable of employment either part-time or full-time, due to his debilitating chronic histoplasmosis infection, lethargy, weakness, and pain. (CX-1, pp. 161-164).

On February 25, 2008, Claimant obtained a chest CT with and without contrast from Clearsky Imaging, which revealed a small right pleural effusion. Additionally, the CT showed small calcific nodular densities representing calcified hilar lymph nodes bilaterally, compatible with sequelae of histoplasmosis. The lungs were otherwise unremarkable. (CX-1, p. 174).

On March 12, 2008, Claimant reported to Dr. Saraiya for a follow-up examination. His unresolved symptoms included snoring, daytime sleeping, weakness, fatigue, aches, dizziness, post-nasal drip, cough, shortness of breath, dyspnea on exertion, pain in lungs for three days, pericarditis, heartburn, back pain, and pain in arm and shoulder. After physical examination, Claimant was diagnosed with acute histoplasmosis, a reaction to tuberculin skin test without active tuberculosis, and chronic

neoplasm of certain behavior of trachea, bronchus and lung. Dr. Saraiya recommended a bronchoscopy to rule out histoplasmosis and a follow-up visit in three months. (CX-1, pp. 177-179).

On March 18, 2008, Dr. Saraiya performed Claimant's bronchoscopy. (CX-1, p. 180).

Claimant's records indicate Dr. Campbell apparently completed a Continuing Disability Form for American Bankers Life Assurance Company of Florida, indicating Claimant had slightly improved, but was unable to return to work. However, it is noted the form is undated. (CX-1, p. 181).

On or after April 3, 2008, Dr. Saraiya completed a multiple impairment questionnaire on behalf of Claimant, which provided the following: (1) Claimant's level of pain was eight to nine on the pain scale, with a fatigue score of seven to eight; (2) Claimant can neither sit nor stand and walk for more than one hour per day; (3) Claimant can never lift or carry zero to five pounds because of chest pain; (4) Claimant's symptoms would likely increase if placed in a competitive work environment; (5) Claimant's condition does not allow him to stay in a constant position; (6) Claimant is incapable of even "low stress;" and (7) Claimant would miss more than three days per month from work as a result of his condition(s). Additionally, Claimant must avoid fumes, gases, temperature extremes, humidity and dust. (CX-1, pp. 182-189).

On April 3, 2008, Claimant reported to Dr. Saraiya for a follow-up visit, with a chief complaint of fatigue. Dr. Sarayia noted Claimant's chronic histoplasmosis had improved with the bronchoscopy. Claimant still had a positive reaction to the tuberculin test without active tuberculosis and chronic neoplasm of uncertain behavior of trachea, bronchus and lung. Additionally, Claimant's depressive disorder had improved, and he was diagnosed with chronic allergic rhinitis due to pollen. Dr. Saraiya recommended re-checking Claimant's fungal cultures in six weeks, and instructed Claimant to schedule a follow-up visit for June 2008. (CX-1, pp. 191-193).

On May 28, 2008, Claimant reported to Dr. Bridges (infectious disease) for a follow-up examination regarding his histoplasmosis. Physical examination was generally normal, except a "decreased BS" on the right lung. Dr. Bridges ordered a urine histo AG, and put a hold on any additional medication for the histoplasmosis. (CX-1, pp. 197-199).

On July 14, 2008, Claimant presented to Denton Regional Medical Center Emergency Department with complaints of altered mental status and dyspnea. Claimant had apparently been cleaning out the garage for eight to ten hours when he collapsed, gasping for air. He was thereafter lethargic and demonstrated an inability to answer questions. Claimant was administered two liters of fluid in the emergency department, but was still admitted thereafter. Claimant denied chest pain or pressure, except right posterolateral chest pain in his prior surgery site. Claimant's history indicated he "smokes off and on." After admission, Claimant began feeling better and requested discharge, which was granted. He was prescribed BuSpar, Indomethacin, Zoloft, Wellbutrin and Xopenex. He was additionally instructed to decrease his caffeine consumption, and follow up with Dr. Saraiya in approximately four weeks. (EX-28, pp. 91-94).

On August 18, 2008, Claimant reported to Denton Regional Medical Center Emergency Department with chief complaints of chest pain and discomfort, chills, and a cough, but no fever. (EX-28, pp. 68-69). A chest x-ray was taken, which revealed right midlung scarring, suggestive of Claimant's previous wedge resection. (EX-28, p. 73). The Emergency Room physician prescribed Naproxen, Prednisone and Protonix, and advised Claimant to follow up with his infectious disease physician. (EX-28, p. 75).

On September 17, 2008, Claimant reported to Kaye Kendall, R.N. a Family Nurse Practitioner at Citywide I.D. Associates, Inc., working under the supervision of Dr. Allen G. Reuben. His chief complaint was histoplasmosis. Ms. Kendall's clinical impression was chronic pulmonary histoplasmosis and pericarditis. Labwork was requested and performed. (EX-29, pp. 109-111).

On September 25, 2008, Dr. Reuben wrote a note to the chart, which stated, "I think that more likely than not he has had histo and now has some recurrent pericarditis as an issue. Treatment with antifungals probably will not be helpful. . . ." (EX-29, p. 112).

On October 2, 2008, Claimant again reported to Kaye Kendall, R.N. of Citywide I.D. Associates for a histoplasmosis follow-up. After physical examination, Ms. Kendall's impression was again chronic histoplasmosis. Claimant was to return to the clinic in one month for further testing, and to Dr. Reuben in five weeks. (EX-29, pp. 116-118).

On November 19, 2008, Claimant reported to Denton Regional Medical Center Emergency Department complaining of moderate dyspnea for the past two weeks, which had been waxing/waning. His dyspnea was worsened by exertion and improved by rest. Claimant had experienced sweating and chest soreness, his cough was productive of green sputum, and his chest x-ray revealed a small right pleural effusion. He was discharged to go home the same day, in stable condition, with instructions to return to the emergency room if symptoms became worse or if new problems/concerns arose. (EX-28, pp. 49-53).

On June 3, 2009, Dr. Saraiya completed a Work Capacity Evaluation for the U.S. Department of Labor (DOL). In that evaluation, Dr. Saraiya opined Claimant had limitations sitting, walking, standing, reaching, twisting, bending, stooping, and operating a motor vehicle both at work and to and from work. He further stated that Claimant's restrictions will apply for the remainder of his life. He also opined that Claimant had reached maximum medical improvement by June 3, 2009. (CX-1A, p. 19).

On July 22, 2009, Dr. Lenoard J. Landesberg, FCCP, performed a peer review of Claimant's histoplasmosis.<sup>6</sup> He opined that "the diagnosis of histoplasmosis is plausible." Dr. Landesberg was not provided with any serological data for the review. In any event, he opined that "[a]lthough histoplasmosis has been described worldwide, Iraq is not listed as a highly endemic area." Thus, he opined that "while it is not certain where the claimant acquired histoplasmosis, it was more likely acquired in the United States, in or near his home area. He further stated that he concluded, to a reasonable degree of medical certainty, that the Claimant was diagnosed with histoplasmosis in January 2007, and was suffering from chronic histoplasmosis. However, he stated that the evidence was insufficient to suggest a connection between the histoplasmosis and his former employment in Iraq. (EX-30, pp. 1-6).

### **The Hearing Loss**

On February 1, 2005, Claimant submitted to an individual hearing test, which classified his speech frequencies as normal in both ears, high frequency normal in his left ear, but mild hearing loss of high frequency in his right ear. (CX-1, p. 9).

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<sup>6</sup> Dr. Landesberg's credentials can be found at EX-30, p. 7. It is noted Dr. Landesberg never treated or spoke with Claimant.

On April 9, 2006, Claimant reported to University of North Texas clinic for a complete audiological evaluation. He reported he suspected his hearing changed after becoming the victim of several IED attacks in Iraq. Claimant stated his hearing was normal prior to deployment, but had worsened in the last two years after returning to the United States. Upon examination, the Clinical Audiologist Kevin Guess, M.S. and Student Clinician Will Helton, B.A.'s impressions upon examination were bilateral, noise-induced hearing loss with a normal to moderately severe high frequency sensorineural hearing loss in the right ear, and a normal to moderate high frequency sensorineural hearing loss in the left ear. They opined that Claimant's "amount of hearing loss would cause [him] to have difficulty hearing in noisy or group situations, as well as making it impossible to hear any high frequency fricatives, such as [f,s,th] in either ear when presented at a normal conversational level without amplification." It was recommended Claimant wear hearing protection when exposed to loud noises, undergo a hearing aid evaluation at his discretion, and return for annual examinations. (CX-1, p. 67).

On July 22, 2009, Dr. Michael K. Ditkoff, FACS, of Progressive Ear, Nose and Throat Associates, reviewed Claimant's medical records.<sup>7</sup> Dr. Ditkoff opined Claimant did not suffer hearing loss as a result of his employment in Iraq. He stated Claimant had high frequency hearing loss in both ears prior to working for Employer, which may be associated with heredity, prebycusis, or possible noise exposure. "The normal trends of aging and heredity hearing loss continued over the 26 months from the 1<sup>st</sup> to the 2<sup>nd</sup> audiogram." Claimant showed no "severe shift" in hearing loss regarding either ear as a result of employment in Iraq. According to AMA guidelines, Claimant has a zero percent impairment in the right and left ears monaurally, bilaterally and binaurally. (EX-31, pp. 1-3).

### **The Traumatic Brain Injury (TBI)**

On June 12, 2007, routine images of Claimant's brain were taken from the skull base to the vertex, with and without contrast, by Blue Star Imaging. Claimant had apparently been complaining of a headache. The images showed "no evidence for acute intracranial abnormality or abnormal contrast enhancement." (CX-1, p. 80).

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<sup>7</sup> Dr. Ditkoff's credentials are located at EX-31, pp. 4-5. He is a board-certified Otolaryngologist. It is noted, however, that Dr. Ditkoff never treated or physically examined Claimant.

On July 31, 2007, Claimant reported to Denton Regional Medical Center Emergency Room with complaints of dizziness, but no nausea, vomiting or tinnitus. After a head CT that yielded normal results, and a physical examination by the emergency room physician, Claimant was discharged. (CX-1, pp. 83-86, 88; EX-28, pp. 121-123, 125).

On September 7, 2007, Claimant reported to Dr. Bridges (infectious disease) complaining of tiredness. Claimant's wife reported Claimant experienced several episodes of unresponsiveness and shallow breathing, and one episode where he fell asleep on the toilet and she had a difficult time waking him up. He additionally complained of left flank pain on and off for the last few weeks, along with persistent dizziness. Claimant denied any recent chest pain. His daughter reported Claimant's slurring words and his eyes pointing in two different directions. His recent CT showed cerebral volume loss, but nothing otherwise irregular. Upon physical examination, Dr. Bridges noted no tenderness in Claimant's flank area. Claimant exhibited poor insight and judgment by suggesting he stop taking all of his medications "cold turkey." To aide in stopping the dizziness, Dr. Bridges suggested Claimant lower his BuSpar medication to a lower dose because it interacted with the Sporanox. (CX-1, pp. 116-117).

On November 6, 2007, Claimant reported to Dr. Simon S. Tan that he had a history of headaches since his concussion in April 2005. Claimant reported when his truck met the explosion, he was disoriented and confused, but he did not lose consciousness. Claimant stated he had a second concussion in October 2005 when his truck was the subject of a second explosion. He also reported hearing loss after the October 2005 explosion. Claimant reported to Dr. Tan that he suffered from chronic daily headache since he was "discharged and came home" from Iraq. Claimant additionally reported his diagnosis of PTSD, from which he is "feeling better," pulmonary histoplasmosis causing pericarditis, and vertigo that sometimes causes unconsciousness upon positional change. Upon examination, Dr. Tan opined that Claimant's chronic headache is likely a tension-type headache and/or a vertiginous migraine. He recommended an MRI of the brain to check for brain injury and will schedule Claimant for videonystagmogram to assess vertigo and balance difficulty. Claimant was prescribed Topamax and was to be re-evaluated after the MRI and VNG. (CX-1, pp. 122-125). Claimant's MRI revealed no acute intracranial processes, but his mild cerebral volume loss was greater than expected for his stated age. (CX-1, pp. 126-127).

On December 17, 2007, Claimant reported to Dr. Tan for a follow-up visit. Claimant reported dizziness, worse with positional change, particularly with standing up suddenly, along with right ear ringing since the Iraq explosion, and a headache, seemingly worse when he lies down on the left side. Claimant also reported he had tenderness in his zygomatic arch ever since his injury in Iraq. Upon examination, Dr. Tan opined Claimant suffered from benign positional vertigo that could be the result of trauma, but other considerations included Meniere's disease because of the ringing in the ear. However, Dr. Tan noted Claimant stated the ringing only lasts for a few seconds, which is not typical of Meniere's. Claimant also suffered from consistent migraine, which may have been caused by post-concussion syndrome. Additionally, Claimant suffers from trigeminal neuralgia, left. Claimant's medication was adjusted, and he was to be re-evaluated in one month. (CX-1, pp. 130-131).

On January 15, 2008, Claimant reported to Dr. Tan for a follow-up, reporting that his headaches have been better, but the vertigo was still present with sudden head movement on the right, along with ringing of the right ear. Claimant additionally complained of tingling and numbness of the tongue, along with pain on the cheekbone when exposed. Dr. Tan's impressions were benign paroxymal positional vertigo, possibly triggered by head trauma or Meniere's disease, classic migraine currently improving, and pain in the zygomatic arch that may be secondary to scar tissue. Dr. Tan's additional considerations included trigeminal neuralgia. (CX-1, pp. 138-139).

On January 18, 2008, Dr. Tan wrote a letter to "whom it may concern," stating that trauma to the head can cause benign paroxymal positional vertigo, with which Claimant has been diagnosed. (CX-1, p. 142).

On February 18, 2008, Claimant reported to Dr. Kathryn Oden, Ph.D., for a neurocognitive evaluation. He reported that he was involved in two explosions in Iraq, wherein "soldiers he knew well died in both explosions." He additionally reported that after his return to the United States in June 2006, "he had lots of nightmares and also intrusive daytime memories of explosions and fighting." After a series of tests, Claimant's intellectual functioning was assessed in the average to high average range, and included a strong vocabulary. His nonverbal reasoning was high average. However, Claimant had difficulty in a visually guided manual construction task, and was in the high borderline range. Dr. Oden stated that because Claimant used to

build movie sets for years, his high borderline ability to perform the manual construction task likely indicated brain injury. Claimant additionally had difficulty remembering the names of creatures and objects, and his memory for details was poor. There was no indication of exaggeration of his memory problems. (CX-1, pp. 165-173).

Visually, Claimant's line bisection task suggested some diminishment in the right visual attention. She recommended Claimant be evaluated by a neuro-ophthalmologist or neuro-optometrist to determine whether he can drive a vehicle. Dr. Oden also stated that the presence of benign paroxysmal positional vertigo "is certainly an indicator of at least mild brain trauma." Additionally, Claimant may have evinced some psychomotor slowing during testing; his right hand was faster than his left, possibly suggestive of right hemisphere dysfunction. However, Claimant's right hand had more difficulty leading the tapping task than his left hand, suggestive of left frontal dysfunction. (CX-1, pp. 165-173).

Apparently, Claimant would make remarks when he perceived he was doing well, and "seemed anxious to convince the examiner that he is not brain injured." Claimant was diagnosed with "[c]ognitive changes secondary to 2 TBIs including diminished visual-spatial skills, possible right visual inattention, spatial confusion, word finding issues, constructional praxis problems" on Axis I. There was no diagnosis on Axis II. On Axis III, Claimant reported "2 TBIs secondary to explosions (2004 and 2005); cardiac problems and histoplasmosis of the lung (possibly chemical) leading to bouts of respiratory failure." On Axis IV, Claimant's stressors included "2 potentially deadly explosions; loss of job; financial stress (mortgage near foreclosure); extended legal issues." (CX-1, pp. 165-173).

On March 6, 2008, Claimant reported to Dr. Tan for a follow-up visit, reporting he had been doing much better. Claimant's cognitive rehabilitation had helped, but his vertigo was still "on and off." His headaches had become less frequent. Claimant additionally complained of a "fussy mental feeling" and tinnitus. Upon examination, Dr. Tan's impressions were PTSD, post-concussion syndrome, and vertigo with tinnitus, "consider Meniere's versus vestibulopathy from previous traumatic brain injury." (CX-1, pp. 175-176).

On April 24, 2008, Claimant reported to Dr. Tan for a follow-up visit. He reported that his headaches had improved, but he was experiencing dizziness, particularly when looking up, turning his head, and changing positions. After physical examination, Dr. Tan's impression was that Claimant's description of dizziness suggested benign paroxysmal positional vertigo, likely secondary to trauma. Dr. Tan's impressions additionally included post-concussion syndrome (though currently improving), PTSD and migraine headaches (improving). Dr. Tan recommended Claimant undergo a canalith-repositioning maneuver, continue his medication, and follow-up in one to two months. (CX-1, pp. 194-195).

On July 20, 2009, Dr. Alon Mogilner, M.D., Ph.D., Chief, Section of Functional Neurosurgery of Northshore-LIJ Health System, performed a peer review regarding Claimant's traumatic brain injury.<sup>8</sup> After viewing multiple records, Dr. Mogilner opined Claimant "suffered a mild traumatic brain injury, namely a mild concussion and post-concussive syndrome from working for . . . [E]mployer," which may contribute to his chronic headache and vertigo. Insofar as the findings of "diminished visual spatial skills, possible visual right inattention, spatial confusion, word finding issues and constructional praxis problems," Dr. Mogilner opined they were not connected to any events that occurred in Iraq. However, he does admit that a traumatic brain injury can cause such findings, and that the evaluation was performed without a baseline. As such, it is possible Claimant had such difficulty prior to his employment in Iraq. Dr. Mogilner further opined that although mild headaches would not likely preclude Claimant from driving a truck, significant gait balance difficulty and visual spatial difficulty "may affect his ability to drive a truck, and thus must be assessed further." However, he did note that Claimant's mild cerebral volume loss findings "are nonspecific and much more likely to be associated with [Claimant's] history of . . . alcohol use as opposed to the explosions." (EX-32, pp. 1-9).

### **The Surveillance Evidence<sup>9</sup>**

Four video surveillance discs were offered by Employer/Carrier. The first surveillance video was made on September 4, 2006, the last on December 17, 2006. (EX-18). Only portions of eleven days are reflected in the four videos.

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<sup>8</sup> Dr. Mogilner's credentials can be found at EX-32, pp. 10-17. It should be noted Dr. Mogilner never physically examined or even spoke with Claimant.

<sup>9</sup> See Case No. 2007-LDA-49, Decision and Order.

On September 4, 2006, Claimant's residence was filmed from approximately 8:00 a.m. to 6:00 p.m., with no apparent activity. On September 5, 2006, surveillance was conducted of Claimant's residence from 9:00 a.m. to 7:00 p.m. The only activity filmed is Claimant retrieving an empty recycling bin from his front yard at approximately 5:00 p.m. (EX-18, Disc 3).

Surveillance was conducted between 10:00 a.m. and 6:00 p.m. on September 6, 2006. Between 10:20 and 10:39 a.m., Claimant is filmed cleaning out a black car parked on the street outside his residence. He is also filmed filling a tire with air on a blue truck with a red tank. The blue truck is parked in Claimant's driveway next to a red truck; he later places the red tank in the bed of the red truck. During this period, Claimant interacts with a younger male, apparently his stepson, who is mowing the yard. At 10:39 a.m., Claimant leaves his residence driving the red truck. At 10:45 a.m., Claimant is filmed leaving an automotive garage carrying the red tank, apparently having had the tank filled. Between 10:48 and 10:50 a.m., Claimant is filmed at a gas station. (EX-18, Disc 3).

At 10:57 a.m., the red truck is filmed back in the driveway of Claimant's residence. Between 10:57 and 11:36 a.m., Claimant is filmed interacting with the younger male and another male beside the blue truck parked in Claimant's driveway. The men perform maintenance on the blue truck. Between 11:52 a.m. and 12:20 p.m., the same three men are filmed working on the black car parked on the street and then loading it onto a trailer. During this period, Claimant is filmed directing the other man as he drives the car onto the trailer. At 12:03 p.m., Claimant is filmed getting into the black car and repositioning it on the trailer. The men then secure the car to the trailer. (EX-18, Disc 3).

At 12:28 p.m., the third male is filmed driving the black car away on the trailer and Claimant is filmed driving the red truck away from his residence. He subsequently goes on a series of errands. At 12:37 a.m., Claimant's truck is filmed parked outside a bank. Two minutes later, he is filmed getting into the truck. At 12:52 p.m., Claimant is filmed getting into his truck after apparently leaving what appears to be a "Pack 'N' Mail" store. At 12:58 p.m., Claimant is filmed standing outside what appears to be the same bank. At 1:08 p.m., he is filmed driving away from the bank. At 1:14 p.m., Claimant's truck is again filmed outside what appears to be the "Pack 'N' Mail" store. At 1:15 p.m., Claimant is filmed getting into the truck and driving away. At 1:28 p.m., Claimant's red truck is parked

in the driveway; Claimant appears to remain in his residence for the remainder of the surveillance period, ending at 6:00 p.m. (EX-18, Disc 3).

Surveillance was also conducted on Claimant's residence between October 18, 2006 and October 20, 2006. Claimant's residence was filmed between 7:55 a.m. and 6:00 p.m. on October 18, 2006. Between 2:04 p.m. and 3:30 p.m., Claimant is filmed performing yard work with a younger male, apparently his stepson. On October 19, 2006, surveillance was conducted between 9:00 a.m. and 7:00 p.m. with no apparent activity. Claimant's residence was also filmed between 8:00 a.m. and 5:00 p.m. on October 20, 2006. The only activity captured was Claimant retrieving the mail in his pajamas at 2:50 p.m. (EX-18, Disc 2).

Another round of surveillance was conducted between November 14 and 16, 2006. On November 14, 2006, surveillance was conducted between 8:55 a.m. and 5:00 p.m. At 9:26 a.m., Claimant is filmed getting out of the driver's side of the red truck at his residence along with a passenger, who appears to be his wife. The two talk for a moment and then go into the home. At 9:33 a.m., Claimant walks his wife back out to the truck, she drives away, and he goes back into his home. Claimant is filmed taking out the trash at 9:46 a.m. At 11:46 a.m., a white car is filmed in motion, but the driver is unidentifiable. At 11:52 a.m., the same white car is parked on the street outside Claimant's home. Claimant is filmed next to the car, apparently having just exited the car, and is filmed going into his home. Claimant leaves his home at 12:51 p.m. and stands in the driveway. He is picked up by a driver in a silver car several minutes later. At 1:25 p.m., the silver car is filmed outside what appears to be a dentist's office. At 2:23 p.m., the silver car is filmed outside a gas station. At 2:34 p.m., the silver car pulls up to Claimant's residence. Claimant exits from the rear passenger side, checks the mail, and goes inside. He apparently remained in his residence until 5:00 p.m., when surveillance was ended.

On November 15, 2006, surveillance was conducted between 8:00 a.m. and 6:00 p.m. with no apparent activity. Surveillance was also conducted on November 16, 2006, between 8:53 a.m. and 5:00 p.m. At approximately 9:00 a.m., Claimant is filmed sitting in a green/blue car for several minutes and then getting out of the car and walking to the side of his residence. At 10:19 a.m., the same car is filmed driving to Claimant's mailbox. Claimant is shown collecting the mail, walking towards

his residence, then walking back to the car and entering the driver's seat. At 10:29 a.m., the same car is filmed at another location which appears to be in Claimant's neighborhood. No other activity was filmed until surveillance was ended at 5:00 p.m. (EX-18, Disc 1).

Surveillance was conducted on Claimant's residence between 8:00 a.m. and 4:00 p.m. on December 16, 2006. The only activity captured was at 9:32 a.m., when Claimant took out the garbage in his pajamas. Surveillance was also conducted between 8:00 a.m. and 5:00 p.m. on December 17, 2006, with no apparent activity. (EX-18, Disc 4).

### **The Contentions of the Parties**

Claimant contends he contracted histoplasmosis and latent tuberculosis while in the course and scope of his employment in Iraq. Further, Claimant claims he suffered hearing loss as a result of his employment in Iraq. Claimant additionally contends he suffered a traumatic brain injury while in the course and scope of his employment for Employer in Iraq when his convoy truck was involved with IED explosions in April 2005 and September 2005. Finally, Claimant contends he reached maximum medical improvement on June 3, 2009. Given the foregoing, Claimant contends he is entitled to temporary total disability compensation from October 28, 2006 through June 2, 2009, and permanent total disability compensation from June 3, 2009, and continuing.<sup>10</sup>

Employer/Carrier contend Claimant contracted histoplasmosis and tuberculosis after returning to the United States. Employer/Carrier additionally contend Claimant did not suffer hearing loss as a result of his work with Employer. Finally, Employer/Carrier assert Claimant's claim for compensation for traumatic brain injury is time barred. In the alternative, Employer/Carrier contend Claimant did not suffer a disabling traumatic brain injury during his employment in Iraq.

### **IV. DISCUSSION**

It has been consistently held that the Act must be construed liberally in favor of the Claimant. Voris v. Eikel, 346 U.S. 328, 333 (1953); J. B. Vozzolo, Inc. v. Britton, 377

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<sup>10</sup> Even though Claimant's last day of employment with Employer was June 6, 2006, Claimant's post-hearing brief urges temporary total disability benefits are due beginning on October 28, 2006, the date of Claimant's first hospital visit for chest pain after his return to the United States.

F.2d 144 (D.C. Cir. 1967). However, the United States Supreme Court has determined that the "true-doubt" rule, which resolves factual doubt in favor of the Claimant when the evidence is evenly balanced, violates Section 7(c) of the Administrative Procedure Act, 5 U.S.C. Section 556(d), which specifies that the proponent of a rule or position has the burden of proof and, thus, the burden of persuasion. Director, OWCP v. Greenwich Collieries, 512 U.S. 267, 114 S.Ct. 2251 (1994), aff'g. 990 F.2d 730 (3rd Cir. 1993).

#### **A. Credibility**

I have considered and evaluated the rationality and internal consistencies of the testimony of the witnesses, including the manner in which the testimony supports or detracts from the other record evidence. In so doing, I have taken into account all relevant, probative and available evidence, while analyzing and assessing its cumulative impact on the record. See Indiana Metal Products v. National Labor Relations Board, 442 F.2d. 46, 52 (7<sup>th</sup> Cir. 1971). An administrative law judge is not bound to believe or disbelieve the entirety of a witness's testimony, but may choose to believe only certain portions of the testimony. Mijangos v. Avondale Shipyards, Inc., 948 F.2d 941 (5<sup>th</sup> Cir. 1991).

Moreover, in arriving at a decision in this matter, it is well-settled that the finder of fact is entitled to determine the credibility of witnesses, to weigh the evidence and draw his own inferences therefrom, and is not bound to accept the opinion or theory of any particular medical examiners. Duhagon v. Metropolitan Stevedore Company, 31 BRBS 98, 101 (1997); Avondale Shipyards, Inc. v. Kennel, 914 F.2d 88, 91 (5th Cir. 1988); Atlantic Marine, Inc. and Hartford Accident & Indemnity Co. v. Bruce, 551 F.2d 898, 900 (5th Cir. 1981); Banks v. Chicago Grain Trimmers Association, Inc., 390 U.S. 459, 467, reh'g denied, 391 U.S. 929 (1968).

It is also noted that the opinion of a treating physician may be entitled to greater weight than the opinion of a non-treating physician under certain circumstances. Black & Decker Disability Plan v. Nord, 538 U.S. 822, 830, 123 S.Ct. 1965, 1970 n.3 (2003) (in matters under the Act, courts have approved adherence to a rule similar to the Social Security treating physicians rule in which the opinions of treating physicians are accorded special deference) (citing Pietrunti v. Director, OWCP, 119 F.3d 1035 (2d Cir. 1997) (an administrative law judge is bound by the expert opinion of a treating physician as to the

existence of a disability "unless contradicted by substantial evidence to the contrary"); Rivera v. Harris, 623 F.2d 212, 216 (2d Cir. 1980) ("opinions of treating physicians are entitled to considerable weight"); Loza v. Apfel, 219 F.3d 378 (5th Cir. 2000) (in a Social Security matter, the opinions of a treating physician were entitled to greater weight than the opinions of non-treating physicians).

In the present matter, I again find Claimant's credibility is lacking. It is noted Claimant's statements to his medical providers regarding his social history are internally inconsistent. On December 5, 2006, Claimant told his physician Dr. Joseph, "he used to smoke up to 3 packs a day," while he stated to Dr. Saraiya on January 13, 2007, that he smoked five packs per day rolled in a tobacco leaf. Claimant thereafter stated to Dr. Campbell on February 13, 2008, he smoked two packs per day for twenty-four years. Additionally, at the hearing, Claimant testified he smoked one to two packs per day before going to Iraq, then four packs per day while in Iraq, but decreased to approximately two packs per day and quit smoking cigarettes in January 2007. Claimant did, however, admit to having "a few slips here and there" since January 2007.

Claimant's subjective complaints to his providers are also internally inconsistent. The record indicates that on February 1, 2008, Claimant reported to Dr. Saraiya that he had **no** recent history of headaches, head injuries, hearing loss, vertigo or tinnitus. Meanwhile, he reported to Dr. Tan on December 15 and 17, 2007, that he had been suffering with tinnitus in his right ear since the 2005 explosions in Iraq. Additionally, he reported to Dr. Campbell on February 13, 2008, that he suffered from severe headaches, memory impairment, brain injury and hearing loss in his right ear.

Claimant's testimony itself is also fraught with inconsistencies, which brings his veracity into further question. He testified that he spent ten months in a tent that contained mold "growing up the walls." However, on cross-examination, Claimant stated he lived in the tent for nine months, then six or seven months. Additionally, Claimant testified he did not observe the mold for the entire six months he was in the tent, but only for approximately three months after the rainy season, while he later implied by his testimony that the mold was likely caused by the tent flooding with river water.

Additionally, while repeatedly denying performing any type of yard work at his home in Corinth, Texas, at any time after he returned from Iraq, Claimant stated in a shortness of breath survey in February 2007, that he experienced breathlessness when doing things such as mowing or watering the lawn. Additionally, surveillance video revealed that on October 18, 2006, between 2:04 p.m. and 3:30 p.m., Claimant was filmed performing yard work with a younger male, apparently his stepson.

As further evidence of Claimant's questionable credibility, he testified that he refused to take a breathalyzer test when he was terminated. He later testified, however, that he was never asked to take one. When questioned regarding the inconsistency, Claimant simply said, "I guess you can call me a liar, but, see, to tell you the truth, I don't remember. So you can say what you want."

Additionally, Claimant testified that no one died in either the April 2005 or the September 2005 explosion. However, Claimant stated to Kathryn Oden, Ph.D., during his neurocognitive evaluation, that "soldiers he knew well died in both explosions." Additionally, Dr. Oden's notes indicate that Claimant stated "[a]fter the first bomb exploded, witnesses reported that [Claimant] was getting into and out of the cab of his truck repeatedly (while it was on fire)." However, Claimant suffered no burns from either the April 2005 or the September 2005 explosion. (EX-11, p. 129).

Claimant testified he was no longer receiving any medical treatment for his traumatic brain injury, histoplasmosis, or hearing loss, because no one would take his insurance. However, Claimant thereafter testified he was currently seeing Dr. Saraiya, and that he had seen Dr. Campbell less than two weeks prior to the hearing.

While the undersigned concedes Claimant was likely exposed to trauma while employed in Iraq, I am not convinced of Claimant's embellished and/or inconsistent accountings of the incidents that occurred overseas with such employment, and at home thereafter. Nor am I convinced with his failure to be consistent with his physicians when giving them his personal history. Accordingly, I find Claimant's veracity is wanting, and as such, I find him to be an incredible witness.

## B. The Compensable Injury

Section 2(2) of the Act defines "injury" as "accidental injury or death arising out of or in the course of employment." 33 U.S.C. § 902(2). Section 20(a) of the Act provides a presumption that aids the Claimant in establishing that a harm constitutes a compensable injury under the Act. Section 20(a) of the Act provides in pertinent part:

In any proceeding for the enforcement of a claim for compensation under this Act it shall be presumed, in the absence of substantial evidence to the contrary—that the claim comes within the provisions of this Act.

33 U.S.C. § 920(a).

The Benefits Review Board (herein the Board) has explained that a claimant need not affirmatively establish a causal connection between his work and the harm he has suffered, but rather need only show that: (1) he sustained physical harm or pain, and (2) an accident occurred in the course of employment, or conditions existed at work, which could have caused the harm or pain. Kelaita v. Triple A Machine Shop, 13 BRBS 326 (1981), aff'd sub nom. Kelaita v. Director, OWCP, 799 F.2d 1308 (9<sup>th</sup> Cir. 1986); Merrill v. Todd Pacific Shipyards Corp., 25 BRBS 140 (1991); Stevens v. Tacoma Boat Building Co., 23 BRBS 191 (1990). These two elements establish a **prima facie** case of a compensable "injury" supporting a claim for compensation. Id.

Under the Defense Base Act, an employee need not establish a causal relationship between his actual employment duties and the event that occasioned his injury. O'Leary v. Brown-Pacific-Mason, Inc., 340 U.S. 504, 506-507 (1951). "All that is required is that the 'obligations or conditions' of employment create the 'zone of special danger' out of which the injury arose. Id. The zone of special danger is well-suited to cases, like this one, arising under the Defense Base Act, since conditions of the employment place the employee in a foreign setting where he is exposed to dangerous conditions. See N. R. v. Halliburton Services, 42 BRBS 56 (June 30, 2008). An employer's direct involvement in the injury-causing incident is not necessary for any injury to fall within the zone of special danger. Id., (slip opinion, p. 9). The specific purpose of the zone of special danger doctrine is to extend coverage in overseas employment such that considerations including time and space limits or whether the activity is related to the nature of

the job do not remove an injury from the scope of employment. O'Leary, 340 U.S. at 506; see Cardillo v. Liberty Mutual Insurance Co., 330 U.S. 469, 481 (1947).

### 1. Claimant's Prima Facie Case

Claimant's **credible** subjective complaints of symptoms and pain can be sufficient to establish the element of physical harm necessary for a **prima facie** case and the invocation of the Section 20(a) presumption. See Sylvester v. Bethlehem Steel Corp., 14 BRBS 234, 236 (1981), aff'd sub nom. Sylvester v. Director, OWCP, 681 F.2d 359, 14 BRBS 984 (CRT) (5th Cir. 1982).

On the other hand, uncorroborated testimony by a discredited witness is insufficient to establish the second element of a **prima facie** case that the alleged injury occurred in the course and scope of employment, or conditions existed at work which **could** have caused the harm. Bonin v. Thames Valley Steel Corp., 173 F.3d 843 (2<sup>nd</sup> Cir. 1999) (unpub.) (upholding an ALJ ruling that the claimant did not produce credible evidence that a condition existed at work which could have caused his alleged injury); Alley v. Julius Garfinckel & Co., 3 BRBS 212, 214-215 (1976).

### The Lung Injury

Claimant contends he contracted histoplasmosis and latent tuberculosis while in the course and scope of his employment in Iraq. It is noted the undersigned has discredited Claimant as a witness. However, it is undisputed that Claimant was employed in Iraq for a period exceeding one year, and that Claimant was exposed to dust and other elements during his employment. It is also undisputed that Claimant suffers from histoplasmosis and latent tuberculosis, and the objective medical evidence supports such a conclusion.

Claimant's **prima facie** case requires only that he establish conditions existed at work that **could** have caused the harm. In this matter, the medical evidence supports Claimant's contention that his employment in Iraq could have caused the histoplasmosis and tuberculosis. Dr. Mukesh Saraiya, Claimant's treating physician, opined, "I suspect the patient has the granulomatous disease related to exposure to fungal elements while working in Iraq." Additionally, Dr. Akram, Claimant's infectious disease physician, stated the following: "Reviewing the above history and CT-Scan and biopsy reports, it is **possible** that Mr. Larkin might have been exposed to Histoplasma in Iraq. He is currently

on treatment for Histoplasmosis." Furthermore, on January 9, 2008, Claimant's other infectious disease physician, Dr. Bridges, wrote a letter stating: "[Claimant] has been under my care for the last several months. He has been diagnosed with both histoplasmosis and latent TB which we suspect were both acquired during his service in Iraq."

Considering the foregoing, I find the medical evidence supports the conclusion that Claimant's histoplasmosis and tuberculosis **could** have been caused by conditions of his employment. Accordingly, Claimant has established a **prima facie** case that he suffered an "injury" under the Act, having established that he suffered a harm or pain while employed in Iraq for Employer, and that his working conditions and activities could have caused the harm or pain sufficient to invoke the Section 20(a) presumption. Cairns v. Matson Terminals, Inc., 21 BRBS 252 (1988).

### **The Hearing Loss**

Claimant contends he suffered hearing loss as a result of his employment. Specifically, he contends his hearing loss occurred after becoming the victim of several IED attacks in Iraq. In support of his contention, Claimant submitted medical evidence of a February 1, 2005 hearing examination, and an April 9, 2006 audiological evaluation. The February 1, 2005 examination indicated Claimant had normal speech frequencies in both ears, normal high frequency in his left ear, and mild hearing loss of high frequency in his right ear. The April 9, 2006 audiological report indicated Claimant suffered from bilateral, noise-induced hearing loss with a normal to moderately severe high frequency sensorineural hearing loss in the right ear, and normal to moderate high frequency sensorineural hearing loss in the left ear.

Therefore, I find Claimant has shown that his employment in Iraq could have caused hearing loss. Thus, Claimant has made a **prima facie** case, sufficient to invoke the 20(a) presumption under the Act.

### **The Traumatic Brain Injury**

Claimant contends he suffered a traumatic brain injury (TBI) while in the course and scope of his employment, specifically when his truck was involved in IED explosions in

April 2005 and September or October 2005. Employer/Carrier contend such a claim is time barred. In the alternative, they contend that Claimant did not suffer a TBI as a result of his employment.

Because the statute of limitations is different for injuries and occupational diseases under Section 13 of the Act, the undersigned must first determine whether Claimant's alleged TBI is an occupational disease or an injury. Should the undersigned find the TBI is an injury, the statute of limitations for filing the claim is one year from the date of injury; if the TBI is found to be an occupational disease, the statute of limitations is extended to two years from Claimant's actual or constructive knowledge of the relationship between the disease and employment. 33 U.S.C. § 913.

An occupational disease extends to "any disease arising out of exposure to harmful conditions of the employment when those conditions are present in a peculiar or increased degree by comparison with employment generally." Gencarelle v. Gen. Dynamics Corp., 892 F.2d 173, 176 (2d Cir. 1989) (quoting 1B A. Larson, The Law of Workmen's Comp., 41.00, at 7-353 (1987 & Supp. 1988)). Thus, to meet the definition of occupational disease, three elements must be satisfied: (1) the employee must suffer from a disease, which has been interpreted as a "serious derangement of health or disordered state of an organism or organ;" (2) the disease is caused by hazardous conditions of the employment; and (3) the hazardous conditions are "peculiar to" the employee's particular form of employment. Gencarelle, supra at 176-77.

Occupational diseases "include only those diseases contracted through exposure to dangerous substances." LeBlanc v. Cooper T./Smith Stevedoring, Inc., 130 F.3d 157, 160 (5<sup>th</sup> Cir. 1997). Additionally, an occupational disease results from "an inherent hazard from continued exposure to conditions of a particular employment," and exhibits "a gradual, rather than sudden onset." Bunge Corp. v. Carlisle, 227 F.3d 934, 938-99 (7<sup>th</sup> Cir. 2000).

A Traumatic Brain Injury (TBI) does not fit under the jurisprudential definition of occupational disease. Unlike conventional occupational diseases, Claimant's alleged TBI was not contracted through exposure to dangerous substances. Instead, according to his own contention, Claimant's alleged TBI is the direct result of the April 2005 and/or September/October 2005 explosions. Further, assuming, arguendo, I was to agree

with Claimant's contention, his TBI would have occurred contemporaneously with the explosion; thus, the injury would be a sudden, rather than a gradual onset. Therefore, I find Claimant's alleged TBI to be a traumatic injury, and not an occupational disease.

Under Section 13 of the Act, "the right to compensation for disability. . .under this Act shall be barred unless a claim therefor is filed within one year after the injury." 33 U.S.C. § 913(a). The Fifth Circuit has dictated that the statute of limitations is not tolled until a claimant knows or should know "the true nature of his condition, i.e., that it interferes with his employment by impairing his capacity to work, and its causal connection with his employment." Ceres Gulf, Inc. v. Director, OWCP, 111 F.3d 17, 18 (5<sup>th</sup> Cir. 1997); Marathon Oil Co. v. Lunsford, 733 F.2d 1139, 1141 (5<sup>th</sup> Cir. 1984).

Claimant contends Employer/Carrier have made no showing he had awareness of the connection between his TBI and its interference with his employment. Claimant concedes he had personal knowledge of the explosion, a possible concussion, and that he missed three weeks of work due to the possible concussion. However, he avers there is no evidence to suggest he believed the explosions or possible concussions had the potential to adversely affect his earning capacity.

Here, Claimant had knowledge of his injuries at the time they occurred. "His lack of knowledge of all the claimed consequences of his injury does not justify a departure from the time of event rule which establishes that the statutory limitations period begins to run at the time of the trauma. Pretus v. Diamond Offshore Drilling, Inc., 571 F.3d 478, 483 (5<sup>th</sup> Cir. 2009) (citing Marathon, supra).

It is specifically noted that Claimant testified he felt like he had a concussion in April 2005 when he was "blown up" because he was "[t]hrowing up and everything like that." (Tr. 34). Additionally, he went to the medics at "Key West" after the explosion. He stated he was forced to go to the medic because he was "blabbering" and walking unbalanced. He stated the medic "said [he] had a concussion [and]. . .wanted [him] to stay there," but he "wanted to go back with the guys." (Tr. 69). Further, Claimant stated to Dr. Tan that he had a history of headaches since his April 2005 concussion in Iraq, and that he suffered a second concussion in October 2005. He additionally reported he suffered from chronic daily headaches since he returned to the United States on June 6, 2006. (CX-1, pp. 126-

127). Moreover, Claimant stated to Mr. Guess and Mr. Helton during his April 9, 2009 audiological evaluation, that he had suffered a closed head injury in Iraq. (EX-11, p. 111).

Given the foregoing, I find Claimant was aware of the "true nature" of his alleged TBI at the time it occurred, which was during the April 2005 and/or September/October 2005 explosions. Therefore, Claimant did not file his claim for disability compensation regarding his alleged TBI within a year after he became or should have become aware of the TBI and its connection to his employment. Accordingly, I find Claimant's claim for compensation regarding his alleged TBI is barred by the statute of limitations provided in Section 13 of the Act.

For the limited purpose of medical payments under Section 7 of the act, I will assume, arguendo, that Claimant's claim for disability compensation for his TBI has not been barred by the Section 13 statute of limitations.<sup>11</sup>

Claimant was diagnosed with benign paroxymal positional vertigo (BPPV) on December 17, 2007, after complaining of recurrent headaches, tinnitus, and dizziness to Dr. Tan. Subsequent to the diagnosis, Dr. Tan wrote a letter on January 18, 2008, which provided that head trauma can cause BPPV. Additionally, Dr. Oden's neurocognitive evaluation stated that Claimant's BPPV, difficulty performing the manual construction task, and evident psychomotor slowing were suggestive of brain injury. Even the employer's physician, Dr. Mogilner opined Claimant "suffered a mild traumatic brain injury, namely a mild concussion and post-concussive syndrome from working for . . . [E]mployer."

Therefore, for the limited purpose of medical payments, I find Claimant has made a **prima facie** showing that his TBI could have been caused by his employment in Iraq.

## **2. Employer's Rebuttal Evidence**

Once Claimant's **prima facie** case is established, a presumption is invoked under Section 20(a) that supplies the causal nexus between the physical harm or pain and the working conditions which could have caused them.

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<sup>11</sup> See Section F of this Decision and Order for further discussion on medical payments.

The burden shifts to the employer to rebut the presumption with substantial evidence to the contrary that Claimant's condition was neither caused by his working conditions nor aggravated, accelerated or rendered symptomatic by such conditions. See Conoco, Inc. v. Director, OWCP [Prewitt], 194 F.3d 684, 33 BRBS 187 (CRT) (5th Cir. 1999); Gooden v. Director, OWCP, 135 F.3d 1066, 32 BRBS 59 (CRT) (5th Cir. 1998); Louisiana Ins. Guar. Ass'n v. Bunol, 211 F.3d 294, 34 BRBS 29 (CRT) (5th Cir. 1999); Lennon v. Waterfront Transport, 20 F.3d 658, 28 BRBS 22 (CRT) (5th Cir. 1994).

Substantial evidence is evidence that provides "a substantial basis of fact from which the fact in issue can be reasonably inferred," or such evidence that "a reasonable mind might accept as adequate to support a conclusion." New Thoughts Finishing Co. v. Chilton, 118 F.3d 1028, 1030 (5th Cir. 1997); Ortco Contractors, Inc. v. Charpentier, 332 F.3d 283 (5th Cir. 2003) (the evidentiary standard necessary to rebut the presumption under Section 20(a) of the Act is "less demanding than the ordinary civil requirement that a party prove a fact by a preponderance of evidence").

Employer must produce facts, not speculation, to overcome the presumption of compensability. Reliance on mere hypothetical probabilities in rejecting a claim is contrary to the presumption created by Section 20(a). See Smith v. Sealand Terminal, 14 BRBS 844 (1982). The testimony of a physician that no relationship exists between an injury and a claimant's employment is sufficient to rebut the presumption. See Kier v. Bethlehem Steel Corp., 16 BRBS 128 (1984).

When aggravation of or contribution to a pre-existing condition is alleged, the presumption still applies, and in order to rebut it, Employer must establish that Claimant's work events neither directly caused the injury nor aggravated the pre-existing condition resulting in injury or pain. Rajotte v. General Dynamics Corp., 18 BRBS 85 (1986). A statutory employer is liable for consequences of a work-related injury which aggravates a pre-existing condition. See Bludworth Shipyard, Inc. v. Lira, 700 F.2d 1046 (5th Cir. 1983); Fulks v. Avondale Shipyards, Inc., 637 F.2d 1008, 1012 (5th Cir. 1981). Although a pre-existing condition does not constitute an injury, aggravation of a pre-existing condition does. Volpe v. Northeast Marine Terminals, 671 F.2d 697, 701 (2d Cir. 1982). It has been repeatedly stated employers accept their employees with the frailties which predispose them to bodily hurt. J. B. Vozzolo, Inc. v. Britton, supra at 147-148.

### **The Lung Injury**

Employer/Carrier have made an unsuccessful attempt to rebut the 20(a) presumption regarding Claimant's histoplasmosis by submitting the peer review of Dr. Landesburg. In fact, Dr. Landsburg's opinion was more favorable to the Claimant than the Employer/Carrier. Dr. Landesburg stated that histoplasmosis occurs worldwide, but Iraq is not a **highly endemic** area. Be that as it may, Dr. Landesburg never stated it was **impossible or improbable** for Iraq to house the histoplasma organism. In fact, he admitted "it is not certain where [C]laimant acquired histoplasmosis." Dr. Landsburg did, however, state that it was more likely Claimant's histoplasmosis was contracted in the United States. However, mere speculation is not sufficient to overcome Claimant's presumption of compensability.

Employer/Carrier failed to address in any form Claimant's diagnosis of tuberculosis and/or its connection to Claimant's employment in Iraq. Thus, they have not rebutted Claimant's 20(a) presumption of compensability regarding tuberculosis.

Considering the foregoing, I find Employer/Carrier have failed to rebut Claimant's presumption of compensability for either histoplasmosis or tuberculosis.

### **The Hearing Loss**

In an effort to rebut Claimant's 20(a) presumption of compensability for hearing loss, Employer/Carrier submitted the July 22, 2009 peer review by Dr. Michael Ditkoff. To form his medical opinion, Dr. Ditkoff reviewed numerous records, including Claimant's hearing evaluations on February 1, 2005, and April 9, 2006.

Dr. Ditkoff opined Claimant did not suffer hearing loss as a result of his employment in Iraq. "Claimant had a progression of his pre-employment hearing loss after his work exposure in Iraq consistent with normal shifts in thresholds with age and progressive deterioration to the cochlea function. . . . He had no severe shift in either ear as a result of his employment or exposure to noise that could be seen." "[Claimant] had a normal trend of decreasing hearing along all low and high frequencies and not only a shift in high frequencies which would be typically seen with noise exposure."

Given the foregoing, I find Employer/Carrier have successfully rebutted Claimant's presumption of compensability for hearing loss.

### **The Traumatic Brain Injury**

Assuming, arguendo, Claimant's claim for TBI had been timely, Employer/Carrier were unsuccessful in rebutting Claimant's presumption of compensability for such an injury. Employer/Carrier submitted the peer review of Dr. Mogliner in rebuttal. However, just as with Claimant's lung injury, Dr. Mogliner's opinion was, in fact, more favorable to the Claimant than the Employer/Carrier. Dr. Mogilner opined Claimant "suffered a mild traumatic brain injury, namely a mild concussion and post-concussive syndrome from working for . . . [E]mployer." Further, Dr. Mogilner admitted that a TBI can cause diminished visual spatial skills, possible visual right inattention, spatial confusion, word finding issues and constructional praxis problems, from all of which Claimant's neurocognitive evaluation states he suffers.

Considering these facts, I find Employer/Carrier have failed to rebut Claimant's presumption of compensability for the TBI he suffered as a result of the IED explosions in Iraq.

### **3. Weighing All the Evidence**

If an administrative law judge finds that the Section 20(a) presumption is rebutted, he must weigh all of the evidence and resolve the causation issue based on the record as a whole. Universal Maritime Corp. v. Moore, 126 F.3d 256, 31 BRBS 119(CRT) (4th Cir. 1997); Hughes v. Bethlehem Steel Corp., 17 BRBS 153 (1985); Director, OWCP v. Greenwich Collieries, supra.

Employer/Carrier have successfully rebutted the Section 20(a) presumption of compensability regarding Claimant's hearing loss. The record as a whole regarding this issue extends to the February 1, 2005 and April 9, 2006 evaluations, Dr. Ditzkoff's peer review, and Claimant's reported subjective complaints of hearing loss to physicians and in his testimony. As Claimant has been discredited, any subjective complaints he may have, without corroborating objective evidence, are unpersuasive. Therefore, in making my determination, I have taken into consideration only objective evidence, which is limited here to the evaluations and the peer review.

While the April 9, 2006 evaluation provides Claimant's hearing loss was noise-induced, it cannot be ignored that the evaluation began with Claimant's subjective complaints of his hearing becoming worse after the IED attacks. Moreover, the report never made any comparison to the February 1, 2005 report, except to note that Claimant provided he took a prior hearing test, which revealed normal results.<sup>12</sup> Employer/Carrier's evidence, on the other hand, was a medical opinion based solely on objective evidence, and without regard to any of Claimant's subjective complaints. As such, I afford more weight to Dr. Ditkoff's opinion than that of the April 9, 2006 audiology report, which indicates Claimant suffered no measurable hearing loss as a result of his employment in Iraq.

Accordingly, after considering the record as a whole, I find Claimant has failed to make a sufficient showing that any hearing loss he suffers is the result of his employment in Iraq.

### **C. Nature and Extent of Disability**

Having found that Claimant suffers from a compensable respiratory injury (histoplasmosis and tuberculosis), the burden of proving the nature and extent of his disability rests with the Claimant. Trask v. Lockheed Shipbuilding Construction Co., 17 BRBS 56, 59 (1980).

Disability is generally addressed in terms of its nature (permanent or temporary) and its extent (total or partial). The permanency of any disability is a medical rather than an economic concept.

Disability is defined under the Act as an "incapacity to earn the wages which the employee was receiving at the time of injury in the same or any other employment." 33 U.S.C. § 902(10). Therefore, for Claimant to receive a disability award, an economic loss coupled with a physical and/or psychological impairment must be shown. Sproull v. Stevedoring Servs. of America, 25 BRBS 100, 110 (1991). Thus, disability requires a causal connection between a worker's physical injury and his inability to obtain work. Under this standard, a claimant may be found to have either suffered no loss, a total loss or a partial loss of wage earning capacity.

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<sup>12</sup> It is noted Claimant's February 1, 2005 hearing evaluation did not yield normal results, but, in fact, showed Claimant suffered a mild hearing loss in his right ear. (CX-1, p. 11).

Permanent disability is a disability that has continued for a lengthy period of time and appears to be of lasting or indefinite duration, as distinguished from one in which recovery merely awaits a normal healing period. Watson v. Gulf Stevedore Corp., 400 F.2d 649, pet. for reh'g denied sub nom. Young & Co. v. Shea, 404 F.2d 1059 (5th Cir. 1968) (per curiam), cert. denied, 394 U.S. 876 (1969); SGS Control Services v. Director, OWCP, 86 F.3d 438, 444 (5th Cir. 1996). A claimant's disability is permanent in nature if he has any residual disability after reaching maximum medical improvement. Trask, supra, at 60. Any disability suffered by Claimant before reaching maximum medical improvement is considered temporary in nature. Berkstresser v. Washington Metropolitan Area Transit Authority, 16 BRBS 231 (1984); SGS Control Services v. Director, OWCP, supra, at 443.

The question of extent of disability is an economic as well as a medical concept. Quick v. Martin, 397 F.2d 644 (D.C. Cir. 1968); Eastern S.S. Lines v. Monahan, 110 F.2d 840 (1st Cir. 1940); Rinaldi v. General Dynamics Corporation, 25 BRBS 128, 131 (1991).

To establish a **prima facie** case of total disability, the claimant must show that he is unable to return to his regular or usual employment due to his work-related injury. Elliott v. C & P Telephone Co., 16 BRBS 89 (1984); Harrison v. Todd Pacific Shipyards Corp., 21 BRBS 339 (1988); Louisiana Insurance Guaranty Association v. Abbott, 40 F.3d 122, 125 (5th Cir. 1994).

Claimant's present medical restrictions must be compared with the specific requirements of his usual or former employment to determine whether the claim is for temporary total or permanent total disability. Curit v. Bath Iron Works Corp., 22 BRBS 100 (1988). Once Claimant is capable of performing his usual employment, he suffers no loss of wage earning capacity and is no longer disabled under the Act.

In the instant case, the record shows Claimant was employed as a truck driver in Iraq at the time he was injured. On June 3, 2009, Claimant's treating physician, Dr. Saraiya, completed a Work Capacity Evaluation for the DOL. In that evaluation, Dr. Saraiya opined Claimant has limitations sitting, walking, standing, reaching, twisting, bending, stooping, and operating a motor vehicle both at work and to and from work. He further stated that Claimant's restrictions will apply for the remainder of his life. Employer/Carrier have submitted nothing to rebut

Dr. Saraiya's evaluation. Therefore, I find Claimant has sufficiently satisfied his burden in showing he is not capable of performing his usual or former employment as a truck driver in Iraq.

Accordingly, I find Claimant is totally disabled due to a persistent work-related injury in his lungs (histoplasmosis and tuberculosis), and that he is entitled to total disability compensation benefits based on his average weekly wage of \$1,574.39 from June 6, 2006, (date he was no longer employed with Employer), to present and continuing.

#### **D. Maximum Medical Improvement (MMI)**

The traditional method for determining whether an injury is permanent or temporary is the date of maximum medical improvement. See Turney v. Bethlehem Steel Corp., 17 BRBS 232, 235, n. 5 (1985); Trask v. Lockheed Shipbuilding Construction Co., *supra*; Stevens v. Lockheed Shipbuilding Company, 22 BRBS 155, 157 (1989). The date of maximum medical improvement is a question of fact based upon the medical evidence of record. Ballesteros v. Willamette Western Corp., 20 BRBS 184, 186 (1988); Williams v. General Dynamics Corp., 10 BRBS 915 (1979).

An employee reaches maximum medical improvement when his condition becomes stabilized. Cherry v. Newport News Shipbuilding & Dry Dock Co., 8 BRBS 857 (1978); Thompson v. Quinton Enterprises, Limited, 14 BRBS 395, 401 (1981).

In the present matter, nature and extent of disability and maximum medical improvement will be treated concurrently for purposes of explication.

Claimant contends he has reached MMI as of June 3, 2009, regarding his lung injury. Employer/Carrier argue Claimant's lung injury was only temporary in nature and that it has completely resolved.

In support of his contention, Claimant submitted his Form OWCP-5c dated June 3, 2009, wherein Dr. Saraiya, Claimant's treating physician, assessed that Claimant had reached MMI. Employer/Carrier, on the other hand, have not provided any medical opinions to contradict Dr. Saraiya's medical opinion as to Claimant's assessed MMI date.

Additionally, contrary to Employer/Carrier's assertion, Claimant's current lung problems include recurrent pleural effusions and pericarditis. Dr. Ramaswamy's June 18, 2007 notes indicate Claimant's histoplasmosis is a possible cause of Claimant's recurrent pericardial effusions. Additionally, Dr. Bridges's August 28, 2007 notes indicate Claimant's pericarditis could be caused by histoplasmosis, tuberculosis, or some other cause. Further, Dr. Campbell's notes from February 13, 2008 indicate Claimant's pleural effusion and pericarditis are secondary to Claimant's histoplasmosis. Thus, the Employer/Carrier have not shown Claimant's condition to be temporary; nor have they shown Claimant's condition has resolved.

Accordingly, I find Claimant's lung or respiratory condition is neither temporary nor resolved. Additionally, I find Claimant reached MMI on June 3, 2009, for his lung or respiratory condition, and is thus entitled to total disability compensation benefits from June 4, 2009, to present and continuing.

#### **E. Suitable Alternative Employment**

If the claimant is successful in establishing a **prima facie** case of total disability, the burden of proof is shifted to employer to establish suitable alternative employment. New Orleans (Gulfwide) Stevedores v. Turner, 661 F.2d 1031, 1038 (5th Cir. 1981). Addressing the issue of job availability, the Fifth Circuit has developed a two-part test by which an employer can meet its burden:

(1) Considering claimant's age, background, etc., what can the claimant physically and mentally do following his injury, that is, what types of jobs is he capable of performing or capable of being trained to do?

(2) Within the category of jobs that the claimant is reasonably capable of performing, are there jobs reasonably available in the community for which the claimant is able to compete and which he reasonably and likely could secure?

Id. at 1042. Turner does not require that employers find specific jobs for a claimant; instead, the employer may simply demonstrate "the availability of general job openings in certain fields in the surrounding community." P & M Crane Co. v. Hayes, 930 F.2d 424, 431 (1991); Avondale Shipyards, Inc. v. Guidry, 967 F.2d 1039 (5th Cir. 1992).

However, the employer must establish **the precise nature and terms** of job opportunities it contends constitute suitable alternative employment in order for the administrative law judge to rationally determine if the claimant is physically and mentally capable of performing the work and that it is realistically available. Piunti v. ITO Corporation of Baltimore, 23 BRBS 367, 370 (1990); Thompson v. Lockheed Shipbuilding & Construction Company, 21 BRBS 94, 97 (1988).

The administrative law judge must compare the jobs' requirements identified by the vocational expert with the claimant's physical and mental restrictions based on the medical opinions of record. Villasenor v. Marine Maintenance Industries, Inc., 17 BRBS 99 (1985); See generally Bryant v. Carolina Shipping Co., Inc., 25 BRBS 294 (1992); Fox v. West State, Inc., 31 BRBS 118 (1997). Should the requirements of the jobs be absent, the administrative law judge will be unable to determine if claimant is physically capable of performing the identified jobs. See generally P & M Crane Co., supra at 431; Villasenor, supra. Furthermore, a showing of only one job opportunity may suffice under appropriate circumstances, for example, where the job calls for **special skills** which the claimant possesses and there are few qualified workers in the local community. P & M Crane Co., supra at 430. Conversely, a showing of one unskilled job may not satisfy Employer's burden.

Once the employer demonstrates the existence of suitable alternative employment, as defined by the Turner criteria, the claimant can nonetheless establish total disability by demonstrating that he tried with reasonable diligence to secure such employment and was unsuccessful. Turner, supra at 1042-1043; P & M Crane Co., supra at 430. Thus, a claimant may be found totally disabled under the Act "when physically capable of performing certain work but otherwise unable to secure that particular kind of work." Turner, supra at 1038, quoting Diamond M. Drilling Co. v. Marshall, 577 F.2d 1003 (5th Cir. 1978). The claimant's obligation to seek work does not displace

the employer's **initial** burden of demonstrating job availability. Roger's Terminal & Shipping Corp. v. Director, OWCP, 784 F.2d 687, 691, 18 BRBS 79, 83 (CRT) (5th Cir.), cert. denied, 479 U.S. 826 (1986); Manigault v. Stevens Shipping Co., 22 BRBS 332 (1989).

The Benefits Review Board has announced that a showing of available suitable alternate employment may not be applied retroactively to the date the injured employee reached MMI and that an injured employee's total disability becomes partial on the earliest date that the employer shows suitable alternate employment to be available. Rinaldi v. General Dynamics Corporation, 25 BRBS 128, 131 (1991).

In the present matter, the record is devoid of any showing of suitable alternative employment by Employer/Carrier. Therefore, I find there has been no showing of suitable alternative employment, and thus, I find Claimant permanently and totally disabled.

#### **F. Average Weekly Wage**

Here, the parties have stipulated, and I find, that Claimant's average weekly wage at the time of the injury was \$1,574.39.

#### **G. Entitlement to Medical Care and Benefits**

Section 7(a) of the Act provides that:

The employer shall furnish such medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus, for such period as the nature of the injury or the process of recovery may require.

33 U.S.C. § 907(a).

The Employer is liable for all medical expenses which are the natural and unavoidable result of the work injury. For medical expenses to be assessed against the Employer, the expense must be both reasonable and necessary. Pernell v. Capitol Hill Masonry, 11 BRBS 532, 539 (1979). Medical care must also be appropriate for the injury. 20 C.F.R. § 702.402.

Section 7 does not require that an injury be economically disabling for claimant to be entitled to medical benefits, but only that the injury be work-related and the medical treatment be appropriate for the injury. Ballesteros v. Willamette Western Corp., 20 BRBS 184, 187.

An employer is not liable for past medical expenses unless the claimant first requested authorization prior to obtaining medical treatment, except in the cases of emergency, neglect or refusal. Schoen v. U.S. Chamber of Commerce, 30 BRBS 103 (1997); Maryland Shipbuilding & Drydock Co. v. Jenkins, 594 F.2d 404, 10 BRBS 1 (4<sup>th</sup> Cir. 1979), rev'g 6 BRBS 550 (1977). Once an employer has refused treatment or neglected to act on claimant's request for a physician, the claimant is no longer obligated to seek authorization from employer and need only establish that the treatment subsequently procured on his own initiative was necessary for treatment of the injury. Pirozzi v. Todd Shipyards Corp., 21 BRBS 294 (1988); Rieche v. Tracor Marine, 16 BRBS 272, 275 (1984).

The employer's refusal need not be unreasonable for the employee to be released from the obligation of seeking his employer's authorization of medical treatment. See generally 33 U.S.C. § 907(d)(1)(A). Refusal to authorize treatment or neglecting to provide treatment can only take place after there is an opportunity to provide care, such as after the claimant requests such care. Mattox v. Sun Shipbuilding & Dry Dock Co., 15 BRBS 162 (1982). Furthermore, the mere knowledge of a claimant's injury does not establish neglect or refusal if the claimant never requested care. Id.

Entitlement to medical benefits is never time-barred where a disability is related to a compensable injury. Weber v. Seattle Crescent Container Corp., 19 BRBS 146 (1980); Wendler v. American National Red Cross, 23 BRBS 408, 414 (1990). Thus, even when the claim for compensation is, itself, time-barred, a claimant is entitled to medical expenses if the claimant establishes that medical treatment for the work-related injury is both reasonable and necessary. Mayfield v. Atlantic & Gulf Stevedores, 16 BRBS 28; Parnell v. Capitol Hill Masonry, 11 BRBS 532, 239 (1979); Turner v. Chesapeake & Potomac Telephone Co., 16 BRBS 225, 257-58 (1984). Thus, even though I have found Claimant's TBI claim to be time-barred, Claimant is entitled to medical expenses if his treatment for the TBI was both reasonable and necessary.

Claimant has established the treatment he sought, as recommended by his physicians, regarding both his lung injury and his traumatic brain injury, which was related to either the April 2005 or the September/October 2005 explosion, was both reasonable and necessary. Therefore, Employer/Carrier are responsible for Claimant's medical care and treatment from April 2005, and they continue to be responsible for such care which is reasonable, necessary, and associated with his work-related injuries, to include his lung/respiratory injury (histoplasmosis and tuberculosis) and his TBI.

#### **V. INTEREST**

Although not specifically authorized in the Act, it has been an accepted practice that interest at the rate of six per cent per annum is assessed on all past due compensation payments. Avallone v. Todd Shipyards Corp., 10 BRBS 724 (1974). The Benefits Review Board and the Federal Courts have previously upheld interest awards on past due benefits to insure that the employee receives the full amount of compensation due. Watkins v. Newport News Shipbuilding & Dry Dock Co., aff'd in pertinent part and rev'd on other grounds, sub nom. Newport News v. Director, OWCP, 594 F.2d 986 (4th Cir. 1979). The Board concluded that inflationary trends in our economy have rendered a fixed six per cent rate no longer appropriate to further the purpose of making Claimant whole, and held that ". . . the fixed per cent rate should be replaced by the rate employed by the United States District Courts under 28 U.S.C. § 1961 (1982). This rate is periodically changed to reflect the yield on United States Treasury Bills . . . ." Grant v. Portland Stevedoring Company, et al., 16 BRBS 267 (1984).

Effective February 27, 2001, this interest rate is based on a weekly average one-year constant maturity Treasury yield for the calendar week preceding the date of service of this Decision and Order by the District Director. This order incorporates by reference this statute and provides for its specific administrative application by the District Director.

#### **VI. ATTORNEY'S FEES**

No award of attorney's fees for services to the Claimant is made herein since no application for fees has been made by the Claimant's counsel. Counsel is hereby allowed thirty (30) days from the date of service of this decision by the District

Director to submit an application for attorney's fees.<sup>13</sup> A service sheet showing that service has been made on all parties, including the Claimant, must accompany the petition. Parties have twenty (20) days following the receipt of such application within which to file any objections thereto. The Act prohibits the charging of a fee in the absence of an approved application.

#### VIII. ORDER

Based upon the foregoing Findings of Fact, Conclusions of Law, and upon the entire record, I enter the following Order:

1. Employer/Carrier shall pay Claimant compensation for temporary total disability from June 6, 2006 to June 3, 2009, based on Claimant's average weekly wage of \$1,573.39, in accordance with the provisions of Section 8(b) of the Act. 33 U.S.C. § 908(b).

2. Employer/Carrier shall pay Claimant compensation for permanent total disability from June 4, 2009, to present and continuing thereafter based on Claimant's average weekly wage of \$1,573.39, in accordance with the provisions of Section 8(a) of the Act. 33 U.S.C. § 908(a).

3. Employer/Carrier shall pay to Claimant the annual compensation benefits increase pursuant to Section 10(f) of the Act effective October 1, 2009, for the applicable period of permanent total disability.

4. Employer/Carrier shall pay all reasonable, appropriate and necessary medical expenses arising from Claimant's work-related traumatic brain injury and lung injury (histoplasmosis and tuberculosis) pursuant to the provisions of Section 7 of the Act.

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<sup>13</sup> Counsel for Claimant should be aware that an attorney's fee award approved by an administrative law judge compensates only the hours of work expended between the close of the informal conference proceedings and the issuance of the administrative law judge's Decision and Order. Revoir v. General Dynamics Corp., 12 BRBS 524 (1980). The Board has determined that the letter of referral of the case from the District Director to the Office of the Administrative Law Judges provides the clearest indication of the date when informal proceedings terminate. Miller v. Prolerized New England Co., 14 BRBS 811, 813 (1981), aff'd, 691 F.2d 45 (1<sup>st</sup> Cir. 1982). Thus, Counsel for Claimant is entitled to a fee award for services rendered after **January 16, 2009**, the date this matter was referred from the District Director.

5. Employer/Carrier shall receive credit for all compensation heretofore paid, if any, as and when paid.

6. Employer/Carrier shall pay interest on any sums determined to be due and owing at the rate provided by 28 U.S.C. § 1961 (1982); Grant v. Portland Stevedoring Co., et al., 16 BRBS 267 (1984).

7. Claimant's attorney shall have thirty (30) days from the date of service of this decision by the District Director to file a fully supported fee application with the Office of Administrative Law Judges; a copy must be served on Claimant and opposing counsel who shall then have twenty (20) days to file any objections thereto.

**ORDERED** this 29<sup>th</sup> day of December, 2009, at Covington, Louisiana.

**A**

LEE J. ROMERO, JR.  
Administrative Law Judge