



Issue Date: 01 September 2015

In the Matter of:
LINDA KELLEY
Claimant,

v.
SERVICE EMPLOYEES INTERNATIONAL, INC.
Employer

CASE NO.: 2014-LDA-00199
OWCP NOS 02-233144
02-210907

And

INSURANCE COMPANY OF THE STATE OF PA,
C/O AIG CLAIMS
Carrier

Gary Pitts, Esquire
For Claimant
Robert Bamdas, Esquire
For Employer

DECISION AND ORDER
AWARDING BENEFITS

This case arises from a claim for compensation under the Defense Base Act extension to the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. § 901, et. seq., hereinafter referred to as the "LHWCA" or the "Act" and the implementing regulations, 20 C.F.R. parts 701 and 702. See 33 U.S.C. § 905(a). This case was scheduled for hearing on two occasions, but after the parties advised me that they want me to decide this case "on the record." I established a briefing schedule. Both of the parties filed exhibits and briefs. However, In order to achieve clarity on some of the issues, I ordered better briefs. Both of the parties responded.

STIPULATIONS

The parties stipulated:

1. The claimant is covered by the Act which applies to this case.¹
2. The claimant and the employer were in an employee-employer relationship at the relevant times.
3. Claimant's Average Weekly Wage will be established at \$1,918.54, with a corresponding compensation rate of the maximum rate of \$1,256.84. CX 8.

¹ While the parties may not stipulate as to jurisdiction, it appears they may stipulate as to "coverage." See discussion under jurisdiction, *infra*. But see *Foster v. Davison Sand & Gravel Co.*, 31 BRBS 191 (1997).

4. Claimant's neurological and cardio issues are not related to her employment as stipulated by the parties in paragraph 5 of the Revised Joint Stipulation. CX 8.
5. Employer/Carrier has paid and will continue to pay for all medically necessary treatment related to the DVT condition including medications and office visits. CX 8.
6. Employer/Carrier will provide Ms. Kelley with a free choice psychiatrist or psychologist, to treat the Claimant's work-related emotional conditions. CX 8.
7. Employer/Carrier will adjust past payments of TTD. No penalties are due and owing on past adjustments. Compensation at the rate of \$1,256.84 will continue until such time as it is established that Mrs. Kelley is able to return to her usual employment or suitable alternative employment is established. CX 8.

After a review of the evidence, I find that this office has jurisdiction.

As to the average weekly wage and compensation rate, I note that the Employer/Carrier made no contention in the initial brief regarding the average weekly wage, and their initial brief notes the stipulation on average weekly wage and to the compensation rate. Thus, I accept that the parties agree the proper compensation rate, at least for periods of total disability, is the maximum rate pursuant to Section 6 of the Act.

ISSUES

1. Whether Claimant sustained a compensable pulmonary injury arising in and out the scope of her employment.
2. The nature and extent of any disability.
3. Claimant's entitlement to any disability benefits.
4. Claimant's entitlement to medical benefits.

BACKGROUND

Linda Sue Kelley ("Claimant") was an Associate Field Specialist and she alleges injuries as a result of her employment overseas with Services Employees International, Inc. ("Employer"). On or about April 19, 2010, Claimant was deployed by Employer and served as a database specialist assigned to logistics and material management at the central U.S. Armed Forces headquarters.

On November 13, 2013, Claimant filed an amended LS-203 seeking benefits. More specifically, Claimant filed to receive permanent total disability compensation for chronic obstructive lung disease alleged caused by her exposure to environmental toxins in Iraq.

Claimant's Medical Evidence

CX 1 Medical Records

Radiological Examination Report, November 18, 2010: Patient went to be seen for calf pain that had persisted for over a month and started after a plane ride on October 10. The diagnosis was that she had deep venous thrombus. CX 1, pg. 1-3.

Opinion of Dr. Sexton on DVT Development, 12/29/10: Dr. Sexton stated,

“Ms. Kelley relates the initial discomfort as occurring after the long flight. She experienced swelling and tightness as soon as she got out of the plane, which implies the clot was already developing as a result of the flight. Long flights are well known to be an increase risk factor for clot development. Subsequently, the prolong sitting required at her job is also a favorable event for clot development, especially if it had already begun to form. Also, Ms. Kelley has some other risk factors which would all contribute to the chance of clot formation. Her underlying medical conditions of Hyperlipidemia, Hypertension, Diabetes, and her mild obesity (BMI of 34) would all add up as contributors to the development of a DVT. However, the only thing that was changed before initial symptoms were noticed was the long flight back to the middle east. Then her stationary non-ambulatory desk job would have aggravated the already developing clot.” CX 1, pg. 4

Baptist Hospital Report, 01/16/11: Claimant was admitted for what was thought to be possibly recurrent tonic-clonic seizures, but was then thought to be due to posttraumatic stress syndrome or pseudoseizures. Dr. Williams' impressions were that Claimant had mildly abnormal PET scan with evidence of elevated troponins and abnormal EKG, possible pseudoseizures or other nonanatomic urological issues, probable overtreatment with thyroid agents, hypercholesterolemia, and hypertension. CX 1, pg. 13.

Pulmonary Consultation Note 03/28/12:

“Test Results:

CTA chest shows no PE, no consolidation, no ground glass = no evidence for hemorrhage, inflammatory lung disease, etc.

LLE Doppler US shows edema w/o clot (likely venous insufficiency from prior DVT)

PFTs show very severe obstruction, gas trapping with reduced TLC and moderately reduced DLCO.

Labs show essentially normal CBC/diff, BMP except very mildly low Ca (improved from prior at OSH), normal BNP

Impression: this points towards severe exacerbation of COPD although baseline physiology not clear – she reports spirometry in 2010 being normal prior to leaving for Iraq so may be prolonged exacerbation due to LRTI over past 6 months or other stimuli, sounds like did not happen immediately in setting of being in Iraq, and clinical and occupational hx are not suggestive of constrictive bronchiolitis although could consider pending response to treatment.

Plan: Prednisone, Start Spiriva 1 puff a day + Symbicort 2 puffs twice a day + PRN Ventolin, Repeat spirometry when she returns to VUMC in 2 weeks, same day at ECHO and observe whether there is improvement with systemic steroids, Await ECHO, consider Cardiology consultation.” CX 1, pg. 39.

Pulmonary Clinic Visit 05/15/12:

“Impression: 1. Obstructive lung disease with acute exacerbation. 2. Acute bronchitis. 3. Hemoptysis, scant, in setting of infection. Her testing from last visit and follow up PFTs shows very severe obstructive lung disease.” CX 1, pg. 47.

Pulmonary Clinic Visit 05/30/12:

“Impression: 1. Obstructive lung disease, resolved acute exacerbation. 2. Hemoptysis, scant, improving with resolution of exacerbation, in setting of Coumadin 3. Pulmonary embolism, on anticoagulation.”

Dr. Tolle noted, “Her coughing is better, and her sputum less purulent, hemoptysis nearly resolved. This is all consistent with an improving bronchitis. Her pre-bronchodilator FEV1, however, is really not changed. She has a tremendous BD response, but value is 34% of predicted total. The etiology of her obstructive lung disease remains unclear. I have had a patient with SLE-bronchiolitis who had a significant BD response such as this which was subsequently lost, although conventionally immunologic or toxin-mediated small airways injury is not responsive. Deployment status in the Middle East has been associated with both increased rates of asthma as well as the condition constrictive bronchiolitis. PFTs pre-deployment will be helpful at identifying whether there was any obstruction present at time of travel; will seek these records.” Dr. Tolle also considered the possibility of a lung transplantation. CX 1, pg. 51.

Pulmonary Clinic Visit 08/10/12:

“Impression: 1. Obstructive lung disease, current acute exacerbation. 2. Hemoptysis, scant, in setting of coumidin and currently exacerbated OLD 3. Pulmonary embolism, on anticoagulation. Based on symptoms, it seems that she is currently undergoing an exacerbation. The underlying etiology of her OLD is still a bit of a mystery, likely history of smoking and ?exposure in Middle East.” CX 1, pg. 55.

Pulmonary Clinic Visit 10/24/12:

“Impression: Obstructive lung disease – concerning for relation to her exposure in Iraq (buried under building after explosion) 2. Chronic cough, related to her obstructive lung disease by history and improves with higher doses of steroids 3. Hemoptysis, scant, in setting of coumidin and has tracked with exacerbations 4. H/O pulmonary embolism.... The etiology of her disease is unclear – she did smoke in the past, although the severity of her presentation raises question of

exposure while in Iraq and buried under rubble, etc., since her disease course is not c/w COPD. She appears end-stage in terms of pulmonary function but presumably was not close to this level when she was selected for the job. She does not have spirometry from KBR in Houston to assess how impaired so this will likely never be know.” CX 1, pg. 59.

Pulmonary Clinic Visit 11/21/12:

“Impression: Obstructive lung disease – concerning for relation to her exposures in Iraq (buried under building after explosion) 2. Chronic cough, improved with aggressive COPD treatment and chronic low-dose Prednisone w/ addition of Tessalon perles; remains on Lisinopril during this time of improvement 3. Orthopnea, possibly related to untreated OSA but possible diaphragm weakness which needs to be evaluated, 4. Hemoptysis, scant, in setting of coumidin and has tracked with exacerbations of her obstructive lung disease, negative CT – none since her recent improvement, 5. H/O pulmonary embolism.” CX 1. Pg. 65.

Letter from Vanderbilt University Medical Center, 01/25/13: Sleep study showed severe obstructive sleep apnea. CX 1, pg. 37.

Letter from Dr. Tolle at the Vanderbilt University Medical Center, 06/10/13:

“She has been a patient of mine in the Vanderbilt University Medical Center Pulmonary Clinic since March 28, 2012. She has chronic obstructive pulmonary disease with severe airflow obstruction and chronic respiratory failure. She has significant shortness of breath and cough and requires use of supplementary oxygen. As a result of her medical condition, she is not able to safely work abroad.” CX 1, pg. 65.

Work Capacity Evaluation, Form OWCP 5c, 8/28/13, Dr. Tolle:

Dr. Tolle opined that Claimant had reached MMI and was unable to perform her usual job due to her respiratory failure with minimal functional capacity and frequent exacerbations. Underlying dx is COPD.” Dr. Tolle also noted that Claimant has a need for continuous oxygen and that she has minimum physical capacity.” CX 1, p. 66.

Work Capacity Evaluation, Form OWCP 5c, 11/11/13, Dr. Yoneda:

Dr. Yoneda wrote that Claimant had reached MMI and is “unable to perform her usual job.” CX 1, pg. 72. Dr. Yoneda’s opinion was that Claimant is unable to work any hours due to “end-stage COPD with recurrent DVTs without the ability to resolve clots regardless of therapy.” *Id.* Dr. Yoneda also added that Claimant’s movements are limited due to her lung disease and clots that have developed in her legs and arms which cause her significant pain when she moves. *Id.* Dr. Yoneda noted that although Claimant was receiving therapy she was still short of breath and that lung transplantation was no longer an option. *Id.*

CX 2 – LS 203

Claimant filed a claim for compensation on December 1, 2010. Claimant listed date of injury as 11/18/10. Claimant described the injury as “left leg swollen, discolored partial numbness, radiating pain.” Claimant described the accident as “DVT due to flight to and from US due to R/R then sitting at desk working 12 hrs. consecutive daily.”

CX 3- LS 203

Claimant filed an amended claim for compensation on May 26, 2011. Claimant listed date of injury as 11/18/10. Claimant described nature of injury as left leg swollen, discolored partial numbness, radiating pain, and worsening of psychological condition (anxiety and PTSD) and body generally." Claimant described accident as "DVT due to flight to and from U.S."

CX 4 – LS 203

Claimant filed a claim for compensation on September 5, 2012. Claimant listed date of injury as 4/19/10. Claimant described injury as "bronchial [sic] tubes scared and damaged." Claimant described accident as "inhaling toxic fumes."

CX 5 – LS 203

Claimant filed an amended claim for compensation on November 13, 2013. Claimant listed date of injury as "o/a 7/5/10." Claimant changed description of accident to say "inhaling toxic fumes buried in building collapse."

Employer's First Report of Injury or Occupational Illness – LS 202 – Dated 11/24/10. Describe in full how the accident occurred: "On 18/Nov/2010 at approximately 08:05 hours a KBR Expatriate assigned to Task Order 159Y as a Operations Coordinator at F2 North Liberty, Baghdad, Iraq, presented to the company clinic with a medical concern requiring higher level of care." Nature of Injury: DVT.

Employer's First Report of Injury or Occupational Illness – LS 202 – Dated 09/18/12. Describe in full how the accident occurred: "on 17 September 2012 @ unknown time a Former KBR Expat American employee assigned as an Associate Filed specialist at USD – Central East Camp Liberty, Iraq reported an alleged case to Houston CSC. EE alleges inhaling fumes while flying within Iraq on 4-19-2010..." Nature of Injury: Alleged case – "bronchial tubes scared and damaged."

Employer's Medical Evidence

EX 10 - Claimant's Medical Records from Hickman Medical Clinic. Claimant was admitted to the emergency room on July 17, 2011. CT of the chest did not indicate any evidence of recurrent pulmonary embolus but did reveal some mild bilateral pleural effusions not seen on a regular chest x-ray with indistinct interstitial markings suspicious for mild hydrostatic interstitial pulmonary edema.

On September 7, 2011 she was seen for a hand/upper extremity evaluation where it was noted that she had poor coordination, reduced strength and numbness in the left upper extremity. The assessment upon evaluation was that the Claimant was status post CVA and lacked gross and fine motor coordination in the left upper extremity. She was unable to fasten buttons and tie her shoes.

On September 21, 2011 she underwent a chest x-ray which showed atherosclerosis and findings consistent with an old healed granulomatous infection. The x-ray was otherwise negative. The next date of treatment occurred on October 27, 2011. She presented with complaints of shortness of breath and a distended abdomen. She underwent an ultrasound of the abdomen and repeat chest x-rays. The ultrasound revealed findings consistent with hepatic steatosis, or otherwise known as fatty liver disease.

On February 6, 2012 she was seen for a right inguinal lump in the right groin. An ultrasound of the right groin showed no sonographic abnormality at the site of the palpable lump. On February 17, 2012 the Claimant underwent another set of chest x-rays due to a cough and a CT scan of the head due to a headache. The chest x-rays was noted to be a hypoventilatory exam with findings of left basilar atelectasis or infiltrate. The CT scan of the head was noted to be a stable exam with no evidence of acute intracranial disease and no obvious etiology for the Claimant's headache. The only finding was that of calcified atherosclerosis. On March 18, 2012 a follow up CT scan of the head came back as normal with no significant interval change. On March 20, 2012 an ultrasound of the kidneys, ureters and urinary bladder was performed which found no evidence of renal artery stenosis. On April 25, 2013, further chest x-rays found patchy right basilar density, similar to the exam on February 17, 2012, and it was noted that pneumonia or atelectasis should be considered. On April 28, 2013, the Claimant was brought to the emergency room at Hickman via ambulance complaining of nausea throughout the day with a sudden onset of severe vomiting. While admitted in the hospital, a CT scan of the abdomen and pelvis found nondilated loops suggestive of enterocolitis, moderate atherosclerotic changes in the coronary arteries and aorta, very small nonobstructing right renal calculus, stable subcentimeter right adrenal nodule, and colonic diverticula without evidence of diverticulitis. Another CT scan was performed which came back as normal.

On April 28, 2013, AP Chest x-ray found no evidence of acute cardiopulmonary abnormality. On October 6, 2013, a CTA chest for PE performed by Dr. Metzman found no evidence of pulmonary embolus. In addition AP Chest x-ray found no evidence of cardiopulmonary abnormality.

EX 11 - Claimant's Medical Records from Baptist Hospital Medical: The Claimant was admitted to Baptist Hospital on January 16, 2011, for complaints of seizures. During a five day hospital stay, Claimant made no complaints of shortness of breath or respiratory issues. The records reveal normal respiratory and pulmonary findings throughout her stay.

EX 13 - Claimant's Medical Records from Maury Regional Hospital. Claimant was transported by ambulance to the emergency room because of lightheadedness, palpitations, and irregular heartbeat. A computer tomography (CT) study of the chest using a PE protocol failed to reveal any evidence of a pulmonary embolism. Dr. Martin Cheney, a cardiologist, evaluated her and was not able to confirm presence of atrial fibrillation. Although Ms. Kelley reportedly had an episode of atrial fibrillation during the ambulance ride, no EMS monitor strips were available to corroborate the history. An echocardiogram performed on June 12, 2011 revealed normal left ventricular systolic function and size, mild pulmonary hypertension, and mild to moderate aortic valve regurgitation with other trivial valvular lesions.

EX 24 – Claimant’s Deposition, 6/13/14:
Segment taken directly from transcript pages 14-21

Q: Okay, you spoke previously about the dust that you were exposed to over there.

A: Yes, sir.

Q: I’m assuming that was on a constant basis, the dust over there.

A: Uh-huh.

Q: In your job duties and your job capacity, you were inside the container for most of the time?

A: Uh-huh.

Q: Okay. And how often would you be outside? And would it only really be outside to go from point A to point B or –

A. Sometimes it was to go to point A, point B, and other times it was my – my supervisor, Nermina, really had a distaste for Americans because of the war, that we had helped the wrong people, and her family got killed or whatever. Anyways, she had an aversion to Americans, so she sent me on jobs that she didn’t like to do or didn’t want to do. And one of those was flying. She didn’t like flying. So because we were downsizing, some of our FOBs, forward camps, were being closed. I had to go out there and inventory and do all the inventoring of all of the sensitive equipment, like the washers, the dryers, night-vision goggles, our bulletproof vests, our helmets, et cetera, et cetera. I would have to go on a Blackhawk and go fly to these places and spend the day there or overnight and then fly back and report what I --

Q: Okay. And with your time with SEII, approximately how many times did you have to do that?

A: Three. There was a guy that was doing it too that is a Bosnian also. He was on one side of the country. We kind of crisscrossed as we were downsizing.

Q: And regarding your coughing, was the incident that happened, the mortar, was that the first time that you really started coughing? Had there been any coughing prior to that?

A: Not really a bad, a lot. It has some, but nothing like this, no. And this just progressed. I am now down to right at about 30 percent lung capacity is all I have left.

Q: Aside from that specific incident and the dust overseas, was there any other things that you were exposed to that you think would affect your breathing?

A: According to Dr. Tolle – now, up in Mosul, when I was up there, they had a sulfa mine burning. Sulfa is very toxic, extremely toxic. So you are breathing that smoke. But according to Dr. Tolle, because of the way the earth is upheaved and upheaved in a bombing, mortar attack, or whatever, he says the heavy metals that Saddam used to kill his people are in the ground, and they’re deep in the ground. They’re heavy metals. And he says when there was the bombing or whatever and the container flipping and stuff, he said it upheaved all that. So that time that I was in there, there’s no telling what I was breathing. He can’t say what I was breathing. But it was a lot of stuff.

Q: Okay. Regarding the sulphur mines, how long were you in Mosul for?

A: Just one day.

Q: One day?

A: Not even a full day. You don’t have to go there that long.

Q: Was it like a half a day or just an hour?

A: Yeah, about a half a day.

...

Q: Regarding your work with SEII, you worked indoors. Approximately how many hours a day were you working indoors?

A: 14

Q: 14 hours a day?

A: 12 on, 12 off. But by the time you closed out and got your – your chew, eat, you know, at the DFAC and then get to your chew, it was 14. So it was 14-14.

Q: And it was seven days a week?

A: Seven days a week. The only time you got any time off is if you were sick.

Q: And was the only time you got treatment for your lungs or pulmonary overseas, was that the only time immediately after the incident?

A: Yes.

Q: Okay. And no other treatment?

A: No, sir.

Q: Regarding your past medical history, I know your medical records talk about you formerly used to smoke, but I know there's a reference you haven't smoked for some time.

A: About 20 years.

Q: You have not smoked in 20 years?

A: (The witness nodded her head up and down.)

Q: And prior to that, how long did you smoke for?

A: About ten, 15.

Q: And during those ten, 15 years that you smoked, on what frequency? Was it a pack a day, a half a pack a day?

A: About half a pack. I was never really big on smoking. I did no aids whatsoever to quit; I just threw them away.

Q: And you're presently living with your husband?

A: Yes.

Q: Does he presently smoke?

A: Yes. But he smokes outside. He does not smoke in the house around me.

Q: And has he always smoked outside? Has he ever smoked inside?

A: He smoked inside until Dr. Tolle told him to get out of the house. And we had to get rid of the carpet and go to linoleum floors, special paint, because he said any of that will trigger me.

Q: But the husband smoking outside and changing the carpet and special paint, did you notice some sort of symptom relief?

A: I don't cough as much, but symptom relief, I don't know if you want to call it that or not, because at that same – simultaneously [sic], Dr. Tolle put me on a lot of other medications [sic] to kind of settle things down in my lungs. So I don't know if it was that or if it was the combination of the two. I would say it was all of it coming together, medling [sic] together.

EX 25 - Dr. Thomas Naslund's Medical Examination Report. The IME with Dr. Naslund took place on December 8, 2011. Dr. Naslund's evaluation was focused on deep venous thrombosis and its potential contribution (or lack thereof) to her other symptomatology. He noted that the

Claimant had fluid overload, but all cardiac testing was negative. He also found that DVT did not cause any of the signs or symptoms that developed in January of 2011. There is nothing to indicate that myocardial infarction or myocardial ischemia ever occurred, nor is there evidence of a pulmonary embolism. In the spring of 2010, the PE was excluded on the CT arteriogram of the chest.

In regards to employment, Dr. Naslund found that based on her DVT, Claimant does not have a restriction or impediment to work now or in the future. However, based on her neurologic condition, Claimant is unable to work. He stated, "She has clonus that will prevent any meaningful activity other than perhaps a couple of hours per day of sitting." EX 25, p. 5.

EX 26 - Dr. Hal Roseman's Independent Medical Examination Report.: He opined that the DVT is not an unusual event, and should be considered an isolated clinic issue. Without manifesting as a pulmonary emboli or cardioembolus, DVT is not recognized as clinically capable of causing stroke, syncope or seizure. There is no relationship between the October 2012 DVT and the January 2011 seizure-stroke like activity. Due to anticoagulation therapy prior to the January 2011 incident, it was highly unlikely that Ms. Kelley would have suffered a pulmonary embolism in light of her anti-coagulation at the time of the January incident. She has no limitations for cardiovascular fitness for duty. She does have some mild fluid and heart failure due to personal issues such as obesity, hypertension, insulin resistance and early diabetes, and possibly due to iatrogenic surgical hypoparathyroidism.

EX 27 - Dr. Richard Rubinowitz's Medical Examination Report. Dr. Rubinowicz' diagnosis is dystonia with unknown etiology with work restrictions. There is no evidence of cardiovascular accident or that the DVT resulted in a CVA. There are no objective findings of left sided weakness. Dr. Rubinowicz assigned specific work restrictions for the neurological condition

EX 28 - Dr. Allan Feingold's Medical Examination Report

"The above review documents that the patient has factitious medical disorders. The patient reported, and many physicians repeated in the medical records, multiple diseases from which she did not suffer including bilateral breast cancer, thyroid cancer, seizure disorder, factor V Leiden deficiency, cerebrovascular accident (CVA or "stroke") and bilateral DVT. The patient reported having undergone the placement of Harrington rods in 1980. The latter are normally readily visible on any chest radiology and were not present in this patient. I believe that the patient's self-reported medical history was grossly incorrect and mostly unreliable.

Apparently the patient did have a history of cigarette smoking. CT scans of the chest revealed minimal emphysema. Multiple pulmonary function studies were obtained and these revealed impossibly bad values including a vital capacity of only 1 liter. The respiratory technicians who performed the pulmonary function studies repeatedly described technical difficulty related to severe coughing. The interpreting physicians should have recognized the technical limitations of the studies and the discrepancy between the PFTs and the nearly normal CT scans of the chest.

The patient's CT scans did reveal multiple small calcified pulmonary parenchymal granulomata, small subcarinal calcifications and one small splenic calcification. These findings are indicative of a benign granulomatous disease, probably remote histoplasmosis, and are not an indication for any further investigation or treatment.

The patient certainly does not require lung transplantation.

According to the available records the patient really does have obstructive sleep apnea due to obesity. This condition was appropriately treated with CPAP. Apparently the patient also has hypertension. The latter condition is commonly associated with obesity and sleep apnea and the patient has been treated with anti-hypertensive medications.

In conclusion: it is my opinion, to a reasonable degree of medical certainty that Mrs. Linda Sue Kelley suffers from severe Munchausen syndrome. She also has obesity, hypertension and obstructive sleep apnea. The patient has radiological evidence of remote granulomatous lung disease (probably histoplasmosis) which does not require additional investigation or treatment and questionable mild centrilobular emphysema."

EX 29 - Dr. Allan Feingold's Deposition Transcript. The transcript includes a CV which details Dr. Feingold's training, education and background. Dr. Feingold studied internal medicine and pulmonary medicine and subsequently became board certified in both fields. In his deposition,

Dr. Feingold stated that he did not have an opportunity to examine the Claimant. He reviewed certain records, documents, pleadings, and discovery responses to arrive at a conclusion.

Dr. Feingold discussed the significance of Claimant's past medical history as it relates to her current conditions. In the medical record, Claimant reported having been treated and diagnosed for various conditions. Claimant said she had suffered from bilateral breast cancer. Dr. Feingold found that Claimant did have right breast cancer treated by lumpectomy but the records did not indicate that she had left breast cancer. The records only shown that she had a benign biopsy on the left breast. Claimant also reported that she had thyroid cancer. Dr. Feingold found that a thyroid biopsy was performed and was recorded as benign.

Dr. Feingold addressed the issue of causation relative to Ms. Kelley's claim of toxic exposure while working in Iraq. He testified that Claimant's alleged exposure in Iraq would be insufficient to cause a pulmonary disorder or condition. Notably, he pointed out that Claimant worked in an office building 12 hours a day would have minimal exposure to any toxins. Moreover, her deposition testimony reflected an alleged exposure time of less than one (1) day during the claimed mortar attack (rubble, dust, etc.) and ½ day in Mosul (sulphur mine/burn pit). He noted that such exposure would be minimal, at best, and insufficient to produce the claimed symptomatology and/or conditions alleged in this matter.

Dr. Feingold expressed concern about the abnormality of Claimant's lung function tests. He compared Claimant's pulmonary function tests and her CT scans; stating that the advantage of CT scans is that they are entirely objective. When looking at the CT scans, Dr. Feingold did not see the lung abnormality he would expect with such severe pulmonary function test

abnormalities. Dr. Feingold was asked what type of abnormalities he would expect to see on the CT scan based upon the pulmonary tests performed on Claimant. Dr. Feingold responded:

If the lady had very, very severe obstructive lung disease which is what some of the tests suggest, then she should have had very severe emphysema on her CT scan or at the least, very severe hyperinflation of her chest. That is the lungs would appear much larger than they should be on the CT, and regarding emphysema which the lady may actually have a little bit of, there's a specific pattern on CT that she did not have. So it's not just hyperinflation or larger lungs than normal, it's also a particular pattern on CT which she did not have.

Since the pulmonary function tests did not correspond with the findings of Claimant's CT scans, Dr. Feingold stated, "I do think that some additional investigation would be appropriate in this lady's case... So I do think that the final determination about whether this lady has any lung disease or not would actually depend on some minor further investigation." Dr. Feingold was asked about his opinion on the positive findings on the pulmonary tests and his response was, "I have difficulty with these tests. It's important to understand that pulmonary function tests are affected by patient effort." Dr. Feingold stated that "to some extent" the Claimant had some control over the tests. Dr. Feingold stated that a plethysmographic functional residual capacity test is not dependent on patient effort. That test was performed on the Claimant on April 5, 2012. According to the results of that test were normal. As a result, Dr. Feingold concluded that the values of the breathing test that indicated very severe airways obstruction were probably not correct. Adding, "The lady had values measured for the forced vital capacity shown as the FVC, and the FE1 which was the forced expiratory volume in one second that were extremely abnormal. It's actually possible to have values so bad but the person would not be able to move, wouldn't be able to – would barely be able to talk, would not have a normal oxygen saturation, which in fact she has, and would not have a normal functional residual capacity which in fact she has." When asked for an explanation of the abnormal values, Dr. Feingold said,

I do not think that there was a machine malfunction issue because several tests were done on this lady and they varied. But they were all markedly abnormal. I think that this was because of incomplete patient effort which certainly is a limitation of testing and it's important to understand again, it's not cheating on the person's part, many people cannot do this test correctly. It requires a certain amount of effort and coordination which many people, particularly elderly and the very young are unable to do. So I think that this is probably because of incomplete patient effort but I would normally want to see some additional investigation done on this patient and particularly I think that a properly performed high resolution CT with the patient both prone and supine should have been done.

Dr. Feingold diagnosed Claimant as having obstructive sleep apnea and a history of granulomatous lung disease, most likely histoplasmosis, and Munchausen syndrome. When describing the syndrome, Dr. Feingold said:

It's a condition in which the patient is convinced that she suffers from real physical ailments but in fact there is no physical basis. Is it is not lying; it's a belief that she has illnesses which she does not have. Now, I cannot entirely exclude the diagnosis of obstructive lung disease, I don't think that's correct to do so on the basis on the incomplete information that I have. But I think that the additional noninvasive testing would be compulsory in order to support that diagnosis.

Dr. Feingold admitted that he had not received all the most recent medical records. As for next steps, Dr. Feingold stated that there needs to be a properly performed high resolution CT scan, another attempt at pulmonary function testing with proper patient effort and if that shows objective evidence of disease, a lung biopsy may be necessary. Dr. Feingold was also asked questions about Claimant's exposures and whether they would be a competent source for lung dysfunction. Dr. Feingold said:

As I understand her exposures, my answer is no... Because I don't think that this lady has evidence of the conditions described as constructive bronchiolitis. I don't know of anybody other than soldiers in the field who actually developed it. She does not have the typical manifestations as described in the King article and I don't know of anything else that she could have been exposed to in her capacity as an indoors computer worker that could have resulted in obstructive lung disease of the severity that some of her tests support.

Moreover, Dr. Feingold said that exposure to sulfur mines which was limited to half a day would not be sufficient.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

An injured person must satisfy four elements in order to receive compensation under the Act. *Chesapeake & Ohio Ry. Co. v. Schwalb*, 493 U.S. 40 (1989). First, the person must be injured in the course of employment. 33 U.S.C. § 902(2). Next, the employer must have employees engaged in maritime employment. § 2(4). Third, the injured person must have "status," that is, be engaged in maritime employment. § 2(3); *Dir., OWCP v. Perini N. River Assocs.*, 459 U.S. 297, 317 (1983). Finally, the injury must occur "upon the navigable waters of the United States (including any adjoining pier, wharf, dry dock, terminal, building way, marine railway, or other adjoining area customarily used by an employer in loading, unloading, repairing, dismantling, or building a vessel)." § 3(a).³ This last element is the "situs" test. *See, e.g., Schwalb*, 493 U.S. at 45. ³ *See Rodriguez v. Bowhead Transp. Co.*, 270 F.3d 1283 (9th Cir. 2001). "Vessel" includes "time charterer."

The Act must be construed liberally in favor of the claimant. *Voris v. Eikel*, 346 U.S. 328 (1953); *J.B. Vozzolo, Inc. v. Britton*, 377 F.2d 144 (D.C. Cir. 1967). However, the United States Supreme Court determined that the true-doubt rule, which resolves factual disputes in favor of claimants when the evidence is evenly balanced, is in violation of § 7(c) of the Administrative Procedure Act, 5 U.S.C. § 556(d). *Dir., OWCP v. Greenwich Collieries*, 512 U.S. 267, 271 (1994). Subsection 7(c) specifies that the proponent of a rule or position has the burden of proof and, thus, the burden of persuasion. *Greenwich Collieries*, 512 U.S. 267. Most recently, in *Ceres Marine Terminals, Inc. v. Green*, 656 F.3d 235 (4th Cir. 2011), the Fourth Circuit held that based on *Greenwich Collieries*, 512 U.S. 267, when evidence is evenly balanced, the claimant must lose.

A. TIMELINESS OF NOTICE²

Section 912 sets out the requirements for timely notice to an employer of injury or death.³ 33 U.S.C. § 912. Generally, an employee has 30 days to provide notice, and the clock starts to run when reasonable diligence would have disclosed the relationship between his injury and his employment. 33 U.S.C. § 912(a); 20 C.F.R. § 702.212(a). Although it is the claimant's burden to establish timely notice, § 920(b) creates a presumption that sufficient notice of the claim has been given.⁴ An employer may rebut the presumption by presenting substantial evidence that it did not have knowledge of the employee's work-related injury or death. See *Blanding v. Dir., OWCP [Oldham Shipping]*, 186 F.3d 232 (2d Cir. 1999) (citing *Stevenson v. Linens of the Week*, 688 F.2d 93, 98 (D.C. Cir. 1982)). Failure to give timely notice as required by § 12(a) bars a claim, unless excused under § 12(d). See *Kashuba v. Legion Ins. Co.*, 139 F.3d 1273 (9th Cir. 1998); *Addison v. Ryan-Walsh Stevedoring Co.*, 22 BRBS 32 (1989). Under § 12(d), failure to provide timely written notice will not bar the claim if the claimant shows either that the employer had knowledge of the injury during the filing period (§ 12(d)(1)) or that the employer was not prejudiced by the failure to give timely notice (§ 12(d)(2)).⁵ See *Addison v. Ryan-Walsh Stevedoring Co.*, 22 BRBS 32, 34 (1989); *Sheek*, 18 BRBS 151.

² See 20 C.F.R. § 701.401(c) regarding certain workers and their dependents covered by state compensation acts.

³ Section 12(a) of the Act provides:

Notice of an injury or death in respect of which compensation is payable under this Act shall be given within thirty days after the date of such injury or death, or thirty days after the employee or beneficiary is aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of a relationship between the injury or death and the employment, except that in the case of an occupational disease which does not immediately result in a disability or death, such notice shall be given within one year after the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the employment, the disease, and the death or disability. Notice shall be given (1) to the deputy commissioner in the compensation district in which the injury or death occurred, and (2) to the employer.

33 U.S.C. § 912(a). When one injury arises out of an accident that has been reported, the claimant does not have to give separate notice of other injuries resulting from the same incident. *Thompson v. Lockheed Shipbuilding & Constr. Co.*, 21 BRBS 94 (1988).

⁴ The Fifth, Eighth, and D.C. Circuits have held that the § 20(b) presumption applies equally to § 12 and § 13. *Stevenson v. Linens of the Week*, 688 F.2d 93 (D.C. Cir. 1982), *rev'g* 14 BRBS 304 (1981); *United Brands Co. v. Melson*, 594 F.2d 1068, 1073 (5th Cir. 1979); *Duluth, Missabe & Iron Range Ry. Co. v. U.S. Dept. of Labor*, 553 F.2d 1144 (8th Cir. 1977).

⁵ Section 12(d) of the Act provides:

In the case of an occupational disease which does not immediately result in disability or death, appropriate notice shall be given within one year after the employee or claimant becomes aware or in the exercise of reasonable diligence or by reason of medical advice, should have been aware, of the relationship between the employment, the disease, and the death or disability.⁶ 33 U.S.C. § 912(a); 20 C.F.R. § 702.212(b); *Lewis v. Todd Pacific Shipyards Corp.*, 30 BRBS 154 (1996).⁷ Thus, the notice period does not begin to run until the employee is actually disabled.

The trier of fact must determine the date of awareness. *Gregory v. Southeastern Maritime Co.*, 25 BRBS 188 (1991) (regarding traumatic injury cases); *Horton v. Gen. Dynamics Corp.*, 20 BRBS 99 (1987) (dealing with occupational disease cases). Ordinarily, the date on which a claimant was told by a doctor that he had a work-related injury is the controlling date establishing awareness, but a claimant is required, in the exercise of reasonable diligence, to seek a professional diagnosis only when he has reason to believe that his condition would, or might, reduce his wage-earning capacity. *Osmundsen v. Todd Pacific Shipyard*, 755 F.2d 730, 732, 733 (9th Cir. 1985); see *Lindsay v. Bethlehem Steel Corp.*, 18 BRBS 20 (1986); *Cox v. Brady Hamilton Stevedore Co.*, 18 BRBS 10 (1985); *Jackson v. Ingalls Shipbuilding Div., Litton Systems, Inc.*, 15 BRBS 299 (1983); *Stark v. Lockheed Shipbuilding & Constr. Co.*, 5 BRBS 186 (1976). The relevant inquiry is the date of awareness of the relationship among the injury, employment and disability. *Thorud v. Brady-Hamilton Stevedore Co.*, 18 BRBS 232 (1986); see also *Bath Iron Works Corp. v. Galen*, 605 F.2d 583 (1st Cir. 1979); *Geisler v. Columbia Asbestos, Inc.*, 14 BRBS 794 (1981).⁸

(d) Failure to give such notice shall not bar any claim under this Act (1) if the employer . . . or the carrier had knowledge of the injury or death, (2) the deputy commissioner determines that the employer or carrier has not been prejudiced by failure to give such notice, or (3) if the deputy commissioner excuses such failure on the ground that (i) notice, while not given to a responsible official designated by the employer . . . was given to an official of the employer or the employer's insurance carrier, and that the employer or carrier was not prejudiced due to the failure to provide notice to a responsible official . . . or (ii) for some satisfactory reason such notice could not be given; nor unless objection to such failure is raised before the deputy commissioner at the first hearing of a claim for compensation in respect of such injury or death.

33 U.S.C. § 912(d).

⁶ See 20 C.F.R. § 702.212(a)(3) (30 days from employee's receipt of audiogram and accompanying report indicating employment-related hearing loss). The Supreme Court has held, "Occupational hearing loss . . . is not an occupational disease that does not 'immediately result in . . . disability.'" *Bath Iron Works v. Dir., OWCP*, 506 U.S. 153, 163 (1993) (quoting 33 U.S.C. § 910(i)). Therefore, under *Bath*, § 12(a) requires notice within 30 days for hearing loss claims. *Jones Stevedoring Co. v. Dir., OWCP [Taylor]*, 133 F.3d 683 (9th Cir. 1997). The statute of limitations periods in hearing loss cases does not begin to run until the employee is given a copy of the audiogram and the accompanying report. *Vaughn v. Ingalls Shipbuilding, Inc.*, 28 BRBS 129 (1994) (en banc); *Grace v. Bath Iron Works Corp.*, 21 BRBS 244, 247 (1988); *Swain v. Bath Iron Works Corp.*, 18 BRBS 148 (1986) (holding that the claim is not time-barred because, even though claimant received audiometric testing, there is no evidence he ever received the audiograms and accompanying report). See § 908(c)(13)(D) concerning "tolling" pending receipt of an audiogram. Contrary to *Vaughn*, *Taylor* held claimant's attorney's receipt of an audiogram was "constructive receipt" under § 908(c)(13)(D). *Jones Stevedoring Co. v. Dir., OWCP [Taylor]*, 133 F.3d 683 (9th Cir. 1997).

⁷ For an occupational disease, the Section 12 and 13 time periods do not commence until claimant is aware of an actual disability, rather than a potential disability. *Love v. Owens-Corning Fiberglass Co.*, 27 BRBS 148 (1993).

⁸ The Board has held that the date on which a claimant is informed by a doctor of the relationship between his work and his injury is significant, but not always controlling.⁸ See *Pryor v. James McHugh Constr. Co.*, 18 BRBS 273 (1986); *Geisler v. Columbia Asbestos, Inc.*, 14 BRBS 794 (1981). The Board stated in *Welch v. Pennzoil*, 23 BRBS

Claimant filed her claim of pulmonary injury on September 5, 2012, which is less than six months after her first visit with Dr. Tolle, and is within one year of the time she became aware of the relationship between his occupational illness and his employment. She was exposed to sand and dust as ambient air pollution throughout her service in Iraq.

I find the employer has submitted no evidence that establishes rebuttal of the presumption, under § 20(b).

B. TIMELINESS OF CLAIM

Section 913(a) of the Act provides:

Except as otherwise provided in this section, the right to compensation for disability or death under this Act shall be barred unless a claim therefore is filed within one year after the injury or death. If payment of compensation has been made without an award on account of such injury or death, a claim may be filed within one year after the date of the last payment. . . . The time for filing a claim shall not begin to run until the employee or beneficiary is aware, or by the exercise of reasonable diligence should have been aware, of the relationship between the injury or death and the employment.

33 U.S.C. § 913(a); *see* 20 C.F.R. § 702.221. For prescription to run, the employee “must know (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.”⁹ *Marathon Oil Co. v. Lunsford*, 733 F.2d 1139, 1141 (5th Cir. 1984); *Stancil v. Massey*, 436 F.2d 274 (D.C. Cir. 1970) (holding that the limitation period does not begin to run until the employee reasonably believes he is suffering from a work related harm which would probably diminish his capacity to earn a living).

The 1984 Amendments to the Act have changed the statute of limitations for a claimant with an occupational disease. Section 13(b)(2) provides a separate statute of limitations for claims for death or disability due to an occupational disease that does not immediately result in disability. Such claims are

timely if filed within two years after the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the employment, the disease, and the

295 (1990) that the claimant is not “aware” of the likely impairment of earning capacity or of the true nature of the condition when the treating physician is advising that the work-related condition will improve. In *Lewis*, the Board held that the time period for filing did not commence to run where the claimant was advised by a physician of the “possibility” he had a work-related disease because of the opinion’s inconclusive nature. *Lewis*, 30 BRBS 154. Where a claimant receives a misdiagnosis which reasonably leads him to believe his condition is not work-related or will not affect his wage-earning capacity, the claimant is not “aware” until he secures a correct diagnosis. *Caudill v. Sea Tac Alaska Shipbuilding*, 22 BRBS 10 (1988).

⁹ The fact a claimant’s physician never misdiagnosed or misinformed him or her is not determinative. *Jones Stevedoring Co. v. Nickson*, 141 F.3d 1176 (9th Cir. 1999) (Table).

death or disability, or within one year of the date of the last payment of compensation, whichever is later.

§ 913(b)(2).¹⁰ Section 13(b)(2) explicitly requires “awareness” of the relationship between the disease, employment, and death or disability. Thus, in an occupational disease claim, the filing period does not begin to run until the employee is deceased or disabled, or in the case of a retired employee, until a permanent impairment exists.¹¹ 20 C.F.R. § 702.222. The Board discussed the pertinent elements of an occupational disease in *Gencarelle v. General Dynamics Corp.*, 22 BRBS 170 (1989), *aff’d*, 892 F.2d 173 (2d Cir. 1989). In traumatic injury cases, where the statute requires “awareness” of the relationship between the injury or death and employment, the courts have held that an employee is not aware of an “injury” until he is aware of work-related impairment resulting in a likely impairment of earning capacity. *See, e.g., Paducah Marine Ways v. Thompson*, 82 F.3d 130 (6th Cir. 1996); *Duluth, Missabe & Iron Range Ry. Co. v. Dir., OWCP*, 43 F.3d 1206 (8th Cir. 1994); *Abel v. Dir., OWCP*, 932 F.2d 819 (9th Cir. 1991); *Newport News Shipbuilding & Dry Dock Co. v. Parker*, 935 F.2d 20 (4th Cir. 1991).

Section 20(b) provides claimant with a presumption that his claim was timely filed. In order to rebut the presumption, employer must produce evidence that the claim was not filed within the required time after claimant’s “awareness.” 33 U.S.C. § 920(b); *see Bath Iron Works Corp. v. U.S. Dept. of Labor [Knight]*, 336 F.3d 51 (1st Cir. 2003); *E.M. [Mechler] v. Dyncorp Int’l*, 42 BRBS 73 (2008), *aff’d sub nom. Dyncorp. Int’l v. Dir., OWCP*, 658 F.3d 133 (2d Cir. 2011); *Martin v. Kaiser Co., Inc.*, 24 BRBS 112 (1990) (Dolder, J., concurring in the result only).

The Claimant had until March 28, 2014 to file her respiratory claim.¹² The Claimant became aware of an association between her respiratory condition, her employment, and any resulting disability when she visited Dr. Tolle on March 28, 2012. The Claimant filed her claim on September 5, 2012. I find the employer has not met the burden of establishing that the respiratory claim was not timely filed.

B. INJURY

Pursuant to Section 1 of the Defense Base Act, the provisions of the Longshore and Harbor Workers’ Compensation Act apply to claims for injury or death under 42 U.S.C. § 1651 *et seq.* The Longshore Act defines an injury as an “accidental injury or death arising out of and in the course of such employment, and such occupational disease or infection as arises naturally out of such employment or as naturally and unavoidably results from such accidental injury. . .” 33 U.S.C. §902(2).

¹⁰ Being informed by physician of possible work-related lung disease does not start statute of limitations. *Lewis v. Todd Pacific Shipyards Corp.*, 30 BRBS 154 (1996).

¹¹ In a survivor’s claim, it begins with the claimant’s knowledge, not the decedent’s. *Jones v. Aluminum Co. of Am.*, 35 BRBS 37 (2001); *see also Bath Iron Works v. U.S. Dept. of Labor*, 336 F.3d 51 (1st Cir. 2003).

¹² The timeliness of Claimant’s DVT claim will not be discussed because it has already been stipulated to by the parties.

This case involves two claims of injury, the DVT and respiratory claims. By stipulation Employer/Carrier has paid and will continue to pay for all medically necessary treatment related to the DVT condition including medications and office visits. CX 8. Therefore I accept that the DVT is compensable.

Employer/Carrier disputes the compensability of the respiratory claim.

To establish a *prima facie* claim of entitlement to compensation, a claimant must establish that: (1) he/she sustained physical harm or pain; and (2) an accident occurred in the course of employment, or conditions existed at work, which could have caused, aggravated, or accelerated the harm or pain. See *Merrill v. Todd Pac. Shipyards Corp.*, 25 BRBS 140 (1991); *Kier v. Bethlehem Steel Corp.*, 16 BRBS 128, 129 (1984). Where an employment-related injury aggravates or combines with a preexisting impairment to produce a disability greater than that which would have resulted from the employment injury alone, the entire resulting disability is compensable. *Strachan Shipping v. Nash*, 782 F.2d 513, 517 (5th Cir. 1986).

Under the “aggravation rule,” where an employment-related injury contributes to, combines with, or aggravates a pre-existing disease or underlying condition, the entire resultant condition is compensable; the relative contributions of the work-related injury and the prior condition are not weighed to determine claimant’s entitlement. *Id*; see also *Lamon v. A-Z Corp.*, -- BRBS --, BRB No. 11-0322 (Dec. 15, 2011), slip op. at 3, citing, *inter alia*, *Marinette Marine Corp. v. Dir.*, *OWCP*, 431 F.3d 1032, 39 BRBS 82 (CRT) (7th Cir. 2005) and *Crum v. Gen. Adjustment Bureau*, 738 F.2d 474, 16 BRBS 115 (CRT) (D.C. Cir. 1984)). However, if the disability results solely from the natural progression of the prior injury, it is not compensable. See, e.g., *Metropolitan Stevedore Company v. Crescent Wharf and Warehouse*, 339 F.3d 1102, 1105 (9th Cir. 2003), *cert. den.*, 543 U.S. 940 (2004). “The only legally relevant question is whether the work injury is a cause of the disability,” not whether it is the sole cause. *Director, OWCP v. Vessel Repair, Inc. [Vina]*, 168 F.3d 190, 33 BRBS 65(CRT) (5th Cir. 1999).

Once a *prima facie* case is established, a presumption is created under section 20(a) of the Act that the employee’s injury or death arose out of his employment. 33 U.S.C. §920(a). Once the presumption is invoked, the burden shifts to the employer to establish by specific and comprehensive medical evidence that the claimant’s condition was not caused or aggravated by the employment. *Manship v. Norfolk & Western Ry. Co.*, 30 BRBS 175 (1996); *Holmes v. Universal Maritime Serv. Corp.*, 29 BRBS 18 (1995); *Hampton v. Bethlehem Steel Corp.*, 24 BRBS 141, 144 (1990); *Ranks v. Bath Iron Works Corp.*, 22 BRBS 302, 305 (1989); *Conoco, Inc. v. Dir.*, *OWCP*, 194 F.3d 684 (5th Cir. 1999); *Parsons Corp. of Cal. v. Dir.*, *OWCP*, 619 F.2d 38 (9th Cir. 1980). If the presumption is rebutted, it no longer controls and the record as a whole must be evaluated to determine the issue of causation. *Holmes v. Universal Mar. Serv. Corp.*, 29 BRBS 18, 20 (1995). When the evidence as a whole is considered, it is the claimant who has the burden of proof. See *Dir., OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994).

Claimant asserts she suffers from a lung condition that arose due to circumstances surrounding her employment as an equipment specialist. Claimant testified that she was constantly exposed to dust while in Iraq. E/C EX-24, pg. 13-15. Claimant testified that on a few occasions she was flown to different bases for work and was once flown to Mosul, where there

was a sulfur mine fire. *Id.* at pg. 15-16. Claimant also testified that a rocket once “blew our office apart and we were stuck in there for eight hours before they got us out.” E/C EX-23, pg. 42. Claimant testified that she was taken to a Romanian hospital for her injuries; she had some bruises and coughing. E/C EX 24, pg. 10-11. Claimant testified that the doctor told her that the cough would resolve as she breathed in more oxygen, however, although her cough diminished it did not disappear. *Id.* When Claimant returned home in October 2010 due to her deep vein thrombosis (“DVT”), her primary care physician, Dr. Mirza referred her to Dr. James Tolle, a pulmonologist and assistant professor of medicine at Vanderbilt University Medical Center, for a consultation regarding her chronic lung disease. CX 1, pg. 39.

Dr. Tolle initially assessed Claimant as having dyspnea and chronic bronchitis. CX1, p. 42. In Dr. Tolle’s report dated May 15, 2012, Dr. Tolle wrote, “Impression: 1. Obstructive lung disease with acute exacerbation. 2. Acute bronchitis. 3. Hemoptysis, scant, in setting of infection. Her testing from last visit and follow up PFTs shows very severe obstructive lung disease.” CX 1, pg. 47. On May 30, 2012, Dr. Tolle noted that Claimant’s condition had improved, stating “Her coughing is better, and her sputum less purulent, hemoptysis nearly resolved. This is all consistent with an improving bronchitis. Her pre-bronchodilator FEV1, however, is really not changed. She has a tremendous BD response, but value is 34% of predicted total.” In regards to the etiology of the disease, Dr. Tolle recorded that was still unclear. Dr. Tolle stated that “deployment status in the Middle East has been associated with both increased rates of asthma as well as the condition constrictive bronchiolitis. PFTs pre-deployment will be helpful at identifying whether there was any obstruction present at time of travel; will seek these records.” Dr. Tolle also considered the possibility of lung transplantation. CX 1, pg. 51.

Dr. Tolle’s clinic notes from October 24, 2012 discussed the etiology of Claimant’s disease as follows:

The etiology of her disease is unclear – she did smoke in the past, although the severity of her presentation raises question of exposure while in Iraq and buried under rubble, etc., since her disease course is not c/w COPD. She appears end-stage in terms of pulmonary function but presumably was not close to this level when she was selected for the job. She does not have spirometry from KBR in Houston to assess how impaired so this will likely never be known. CX 1, pg. 59.

In Claimant’s deposition, she details numerous instances in which she was exposed to dust while on the job as well as an instance in which she was exposed to a sulphur mine while traveling for work.

I find that Claimant has established that she has suffered a harm or pain. Also, based on the evidence, it has been established that surroundings existed in Claimant’s work setting that could have caused her lung condition. Accordingly, Claimant has established a *prima facie* case and is entitled to the presumption that her condition is causally related to her employment.

Burdens Shifts to Employer

Pursuant to Section 20(a), a claimant does not have the initial burden of establishing a causal relationship between his injury and employment. 33 U.S.C. §920(a). The burden shifts to the employer to “rebut the presumption with substantial evidence that the [claimant’s injury] . . . was not caused or aggravated by his employment.” *Bath Iron Works Corp. v. Dir.*, OWCP, 109 F.3d 53, 56 (1st Cir. 1997); *Rainey v. Dir.*, OWCP, 517 F.3d 632, 634 (2d Cir. 2008) (citing *Am. Stevedoring Ltd. v. Marinelli*, 248 F.3d 54, 64-65 (2d Cir. 2001)). Evidence is “substantial” if it is the kind that a reasonable mind might accept as adequate to support a finding that the workplace conditions did not cause the injury. *Bath Iron works Corp. v. Preston*, 380 F.3d 597, 605 (1st Cir. 2004); *Rainey*, 517 F.3d at 637. Under the substantial evidence standard, an employer does not have to exclude any possibility of a causal connection to employment; it is enough that it produce medical evidence of “reasonable probabilities” demonstrating lack of causation. *Bath Iron Works Corp. v. Dir.*, OWCP, 137 F.3d 673, 675 (1st Cir. 1998); see also *Ortco Contractors, Inc. v. Charpentier*, 332 F.3d 283, 289 (5th Cir. 2003), cert. den., 540 U.S. 1056 (2003) (rejecting requirement that an employer “rule out” causation or submit “unequivocal” or “specific and comprehensive” evidence to rebut the presumption and reaffirming that “the evidentiary standard for rebutting the § 20(a) presumption is the minimal requirement that an employer submit only ‘substantial evidence to contrary’”). When an employer offers sufficient evidence to rebut the presumption, only then is the presumption overcome. *Conoco, Inc. v. Dir.*, OWCP, 194 F.3d 684, 690 (5th Cir. 1999) (citing *Noble Drilling v. Drake*, 795 F.2d 478, 481 (5th Cir. 1986)). If the presumption is rebutted, it no longer controls and the record as a whole must be evaluated to determine the issue of causation. *Holmes*, 29 BRBS at 20.

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).

Employer selected Dr. Allan Feingold to evaluate Claimant’s pulmonary condition. Dr. Feingold reviewed Claimant’s medical records, Dr. Roseman’s report, and Claimant’s deposition testimonies, and Claimant’s answers to interrogatories. EX 28, p. 1. Dr. Feingold concluded that Claimant has factitious medical disorders and a severe Munchausen syndrome. EX 28, p. 73-74. Dr. Feingold also surmised that the calcified granulomata found on the CT scan probably indicated remote histoplasmosis and did not need further investigation or treatment. *Id.* Dr. Feingold diagnosed Claimant with obstructive sleep apnea and hypertension. *Id.* Dr. Feingold also opined that Claimant did not need lung transplantation. *Id.*

Dr. Feingold reported that the CT Scan showed no evidence of COPD or pulmonary obstruction and that Claimant’s oxygen levels, measured during Pulmonary Function Testing, were within normal limits. Employer’s Brief pg. 10. Dr. Feingold also relied on a

Plethysmographic Functional Residual Capacity test which showed normal pulmonary function. Unlike a Pulmonary Function Test, this test does not depend on patient effort or control. Employer's Brief pg. 11.

In his deposition, Dr. Feingold stated his fields of study were internal medicine and pulmonary medicine and that he was certified in both. Dr. Feingold has no experience in psychology and thus his psychological diagnosis of Claimant having Munchausen syndrome will not be given any weight. A thorough review of the record reveals that Claimant may have embellished or exaggerated her symptoms, however, no evidence from a psychologist has been admitted diagnosing Claimant with a mental illness that would lead her to fabricate her symptoms.

Furthermore, Dr. Feingold states in his deposition multiple times that he needs further information in order to evaluate whether or not Claimant has COPD or any other lung condition. In fact, Dr. Feingold diagnosed Claimant with obstructive sleep apnea, which has a respiratory component. Therefore, I find that this opinion is equivocal.

Moreover, Dr. Feingold refuted the accuracy of the PFTs that indicated Claimant had COPD by stating that PFTs depend on the patient's effort and are thus subjective tests. There is no evidence provided that Claimant did not produce the effort required of her for each of the PFTs nor is there any evidence that the individuals administering the tests did not know how to tell whether or not a patient was providing an adequate amount of effort. I find that this part of the rationale is flawed and renders his opinion flawed and unreasoned.

Dr. Feingold also noted that Claimant's exposure to toxins in Iraq were insufficient to cause a pulmonary disorder or condition. Dr. Feingold noted that the fact that Claimant worked indoors for 12 hours a day and had less than a day of exposure during the alleged mortar attack and half a day of exposure to the sulphur fire/burn pit were insufficient to cause the Claimant's condition. Claimant testified that she was constantly exposed to dust while in Iraq. E/C EX-24, pg. 13-15 However, I find that Dr. Feingold limited the exposure to the exposure to Sulphur and to the incident when Claimant was trapped after an explosion.

Dr. Feingold does not state that Claimant does not have a lung condition nor does he say that Claimant's work environment could not have caused her condition. Dr. Feingold merely noted that Claimant's exposure was insufficient to produce the claimed symptomatology and conditions alleged in this matter. However, this is mere conjecture incorporating what Dr. Feingold believed Claimant's day to day job entailed and speculation as to the honesty of the statements she made about her exposures. Moreover, it must be noted that Dr. Feingold never examined the Claimant himself and only relied on a review of the medical records provided to him to make his evaluation.

I find that as the treating physician, Dr. Tolle has obtained better insight about the Claimant than Dr. Feingold. Although Dr. Feingold is a pulmonologist, I find that he is not persuasive in his allegations concerning the validity of spirometry testing. Moreover, he disregarded the stipulated existence of DVT.

I find that Dr. Feingold selectively elevated certain facts, to diagnose an alleged psychiatric condition – Munchausen syndrome, in an effort to undermine claimant’s credibility. In fact, he never met or examined the claimant. Dr. Feingold is not a psychiatrist. He did not provide evidence of any special qualifications or expertise in psychiatry or psychology. He did not recommend psychiatric or psychiatric testing.

I find that Dr. Feingold’s opinions do not constitute substantial evidence in this record. **Pietruni v. Director**, OWCP, 119 F.3d 1035, (2d Cir. 1997) (I may accept the expert opinion of a treating physician as to the existence of a disability unless contradicted by substantial evidence to the contrary). See also **Todd Shipyards Corp. v. Donovan**, 300 F.2d 741 (5th Cir. 1962).

Because Dr. Feingold did not present substantial evidence that Claimant’s employment could not have caused, aggravated or accelerated her pulmonary condition, the Employer did not meet its burden.

D. DISABILITY

Extent and Nature of Disability

Disability under the Act is defined as “incapacity because of injury 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). To establish a *prima facie* case of total disability, Claimant must show that he cannot return to his regular or usual employment due to his work-related injury. **Blake v. Bethlehem Steel Corp.**, 21 BRBS 49 (1988). “Usual” employment is defined as the claimant’s regular duties at the time that he was injured. **Ramirez v. Vessel Jeanne Lou, Inc.**, 14 BRBS 689 (1982). The burden of proving the nature and extent of disability rests with the claimant. **Trask v. Lockheed Shipbuilding Construction Co.**, 17 BRBS 56, 59 (1985). If a claimant can show that he is unable to return to his prior employment, the burden shifts to the employer to show that suitable alternative employment is available; if so, the claimant is only deemed partially disabled. **New Orleans (Gulfwide) Stevedores v. Turner**, 661 F.2d 1031, 1038 (5th Cir. 1981). A claimant may be presumed to be totally disabled if he cannot go back to work. Even a relatively minor injury may lead to a finding of total disability if it prevents the employee from engaging in the only type of gainful employment for which he is qualified. **Pietruni v. Director, OWCP**, 119 F.3d 1035, 31 BRBS 84(CRT) (2d Cir. 1997); **American Mutual Ins. Co. of Boston v. Jones**, 426 F.2d 1263 (D.C. Cir. 1970).

An award of temporary total disability is proper where a physician opines that the employee will be able to return to his usual employment full-time in the near future, but not immediately. **Martinez v. St. John Stevedoring Co.**, 15 BRBS 436 (1983). Similarly, temporary total disability is the appropriate award when claimant is capable of undergoing rehabilitation but cannot yet work and has not yet reached maximum medical improvement. **Pernell v. Capitol Hill Masonry**, 11 BRBS 532 (1979). See also **Monta v. Navy Exchange Service Command**, 39 BRBS 104 (2005) (the Board affirmed the administrative law judge’s award of temporary total disability benefits as the claimant was undergoing treatment with a view toward improvement). The statute provides that compensation for permanent and temporary total disability under Section 8(a), (b) is paid “during the continuance of” such disability. Thus, an award of benefits

continuing beyond the date of the hearing and into the future may be made. *Admiralty Coatings Corp. v. Emery*, 228 F.3d 513, 34 BRBS 91(CRT) (4th Cir. 2000).

Total Disability Due to DVT

Dr. Yoneda stated that Claimant had reached MMI and is “unable to perform her usual job.” CX 1, pg. 72. Dr. Yoneda’s opinion was that Claimant is unable to work any hours due to “end-stage COPD with recurrent DVTs without the ability to resolve clots regardless of therapy.” *Id.* Dr. Yoneda also added that Claimant’s movements are limited due to her lung disease and clots that have developed in her legs and arms which cause her significant pain when she moves. *Id.* Dr. Yoneda noted that although Claimant was receiving therapy she was still short of breath and that lung transplantation was no longer an option. *Id.* Dr. Yoneda concluded that DVT as well as Claimant’s respiratory condition resulted in her being totally disabled.

Total Disability Due to Respiratory Condition

In Dr. Tolle’s letter dated June 10, 2013, Dr. Tolle stated that Claimant has chronic obstructive pulmonary disease with severe airflow obstruction and chronic respiratory failure and that as a result of her significant shortness of breath, cough, and requisite use of supplementary oxygen, she is not able to work safely abroad. CX 1, pg. 65. Dr. Tolle only opined on the effect of Claimant’s respiratory condition on her ability to work; concluding that it would prohibit Claimant from working safely abroad.

Dr. Tolle and Dr. Yoneda are treating physicians. Dr. Tolle saw the Claimant multiple times whereas the Drs. Naslund and Roseman only saw the Claimant once. Respiratory conditions such as the one in question in this case are regarded as latent and progressive; therefore, I give more weight to the opinions of Drs. Tolle and Yoneda because they saw the Claimant more than once and thus their opinions are more reliable.

In view of the medical opinions finding her unfit to work, I find that Claimant has established a *prima facie* case of total disability.

Nature of Disability/Maximum Medical Improvement

Having established that Claimant is totally disabled, I must determine whether his disability is temporary or permanent in nature. A permanent disability exists when a “condition has continued for a lengthy period, and it 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, 854 (5th Cir. 1968), *cert. denied*, 394 U.S. 976 (1969). Viewed another way, a disability is permanent when the employee reaches “maximum medical improvement” (“MMI”). *See, e.g., Luce v. Bath Iron Works Corp.*, 12 BRBS 162 (1979). Whereas the extent of a disability—total versus partial—involves both a medical and an economic analysis, the determination of whether a disability is permanent is based on medical evidence alone. *Id.* Where a claimant’s condition is still improving, MMI has not been reached and the disability is not yet permanent. *Dixon v. John J. McMullen & Assoc.*, 19 BRBS 243, 1986 WL 66395 (1986). If a claimant is disabled and MMI has not yet been reached, the

appropriate remedy is an award of temporary total or partial disability. *Hoodye v. Empire/United Stevedores*, 23 BRBS 341 (1990).

On form OWCP 5c, dated August 28, 2013, Dr. Tolle opined that Claimant had reached MMI and was “unable to perform her usual job due to her respiratory failure with minimal functional capacity and frequent exacerbations. Underlying dx is COPD.” CX 1, p. 66. On form OWCP 5c, dated November 11, 2013, Dr. Yoneda wrote that Claimant had reached MMI and is “unable to perform her usual job.” CX 1, pg. 72. Dr. Yoneda’s opinion was that Claimant is “unable to work any hours due to end-stage COPD with recurrent DVTs without the ability to resolve clots regardless of therapy.” *Id.* Dr. Yoneda also added that Claimant’s movements are limited due to her lung disease and clots that have developed in her legs and arms which cause her significant pain when she moves. *Id.* Dr. Yoneda noted that although Claimant was receiving therapy she was still short of breath and that lung transplantation was no longer an option. *Id.*

Employer’s doctors, Dr. Naslund and Dr. Rubinowicz, found the Claimant would be restricted from work due to her neurological condition. Employer also did not provide any evidence of any suitable alternative employment.

In conclusion, based on the credible testimony of the Claimant and fully supported by the opinions of Drs. Tolle and Yoneda, I find that the Claimant is entitled to permanent total disability benefits.

MEDICAL EXPENSES AND BENEFITS

Pursuant to Section 7(a) of the Act, an 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 Board has interpreted this provision to require an employer to reimburse a claimant for all reasonable and necessary medical treatment related to his work injury. *See Kelley v. Bureau of Nat’l Affairs*, 20 BRBS 169 (1988). Furthermore, a claimant is entitled to these medical benefits regardless of whether his injury is economically disabling as long as treatment is necessary. *See Ingalls Shipbuilding, Inc. v. Dir.*, OWCP [*Baker*], 991 F.2d 163, 27 BRBS 14 (CRT) (5th Cir. 1993).

Section 7(b) of the Act vests the authority to supervise medical care with the Secretary of Labor. 33 U.S.C. §907(a), (b). Under the regulations, “[t]he Director, OWCP, through the district directors and their designees shall actively supervise the medical care of an injured employee covered by the Act.” 20 C.F.R. § 702.407. The District Directors’ supervisory functions include requiring periodic medical reporting; determining the necessity, sufficiency, and character of medical care furnished; determining whether change in service providers is necessary; and evaluating medical questions regarding the nature and extent of the covered injury and medical care required. 20 C.F.R. § 702.407; *see also* §702.401-702.422.

Claimant raised the issue of medical benefits in her closing statement, and has offered evidence of medical payments she has made out of pocket. Therefore, as I have determined that

the causation of Claimant's lung condition is work-related, she is entitled to reimbursement of all related past and future medical treatment that is reasonable and necessary. 33 U.S.C. § 907(a). Likewise, costs incurred for transportation for medical purposes, such as mileage and parking fees, are recoverable under Section 7(a). *Day v. Ship Shape Maint. Co.*, 16 BRBS 98 (1983). These matters will be addressed by the District Director, who is responsible for overseeing medical care.

INTEREST

Although not specifically authorized in the Act, it has been accepted practice that interest at the rate of six (6) percent per annum is assessed on all past due compensation benefits. *Avallone v. Todd Shipyards Corp.*, 10 BRBS 724 (1978). The Benefits Review Board and the Federal Courts have previously upheld interest awards on past due benefits to ensure that the employee receives the full amount of compensation due. *Watkins v. Newport News Shipbuilding & Dry Dock Co.*, 8 BRBS 556 (1978), *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); *Santos v. Gen. Dynamics Corp.*, 22 BRBS 226 (1989); *Adams v. Newport News Shipbuilding*, 22 BRBS 78 (1989); *Smith v. Ingalls Shipbuilding*, 22 BRBS 26, 50 (1989); *Caudill v. Sea Tac Alaska Shipbuilding*, 22 BRBS 10 (1988); *Perry v. Carolina Shipping*, 20 BRBS 90 (1987); *Hoey v. Gen. Dynamics Corp.*, 17 BRBS 229 (1985). The Board concluded that inflationary trends in our economy have rendered a fixed six percent rate no longer appropriate to further the purpose of making claimant whole, and held that "...the fixed six percent rate should be replaced by the rate employed by the United States District Court under 29 U.S.C. § 1961 (1982). This rate is periodically changed to reflect the yield on United States Treasury Bills...." *Grant v. Portland Stevedoring Co.*, 16 BRBS 267, 270 (1984), *modified on recon.*, 17 BRBS 20 (1985). Section 2(m) of Pub. L. 97-258 provided that the above provision would become effective October 1, 1982. This Order incorporates by reference this statute and provides for its specific administrative application by the District Director. The appropriate rate shall be determined as of the filing date of this Decision and Order with the District Director.

INFLATION

The District Director will calculate any adjustments for post-injury wage levels to the levels paid pre-injury in order to neutralize the effects of inflation. See *Richardson v. General Dynamics Corp.*, 23 BRBS 327 (1990); *Cook v. Seattle Stevedore Cor.*, 21 BRBS 4 (1988); *Bethard v. Sun Shipbuilding & Dry Dock Co.*, 12 BRBS 691 (1980).

ATTORNEY'S FEES AND COSTS

As Claimant has substantially prevailed on the disputed issues, reasonable and necessary attorney's fees are awarded. 33 U.S.C. § 928; 20 C.F.R. §§ 702.131-702.135. Costs may also be awarded, including witness fees and expenses for transcripts. 33 U.S.C. § 928(d). Claimant's attorney shall have 30 days to submit a fee petition and bill of costs, after which Employer shall have 30 days to file any objections. In the fee petition, Claimant's attorney shall advise whether an informal conference was held and its significance. The issue of attorneys' fees and costs will be addressed in a supplemental decision and order.

ORDER

IT IS HEREBY ORDERED that Claimant's claim against Employer, Service Employees International, and its Carrier, Insurance Company of the State of PA c/o AIG, for compensation and medical benefits, is **GRANTED**.

It is therefore **ORDERED** that:

1. Employer/Carrier shall pay Claimant temporary total disability benefits for Claimant's DVT based upon an average weekly wage of \$1,918.54, at the compensation rate as set forth by 33 U.S.C. §§ 906 and 908(b), from November 18, 2010 until November 11, 2013, with interest on accrued benefits and penalties, to the extent not already paid.
2. Employer/Carrier shall pay Claimant permanent total disability benefits for Claimant's respiratory condition based upon an average weekly wage of \$1,918.54, at the compensation rate as set forth by 33 U.S.C. §§ 906 and 908(b), from August 28, 2013 and continuing during the period of disability, with interest on accrued benefits and penalties, to the extent not already paid.
3. The District Director is authorized to make and adjust any calculations necessary to implement this Order.
4. All awards shall include annual adjustments pursuant to 33 U.S.C. § 910(h) and interest on any past due compensation at the rate applicable under 28 U.S.C. § 1961. The appropriate rate shall be determined as of the filing date of this Decision and Order with the District Director. The Director shall determine the exact amount, and will calculate the effect of inflation, as set forth above.
5. The Employer shall receive a credit for all compensation already paid to the Claimant.
6. Employer/Carrier shall pay for reasonable and appropriate medical, surgical, and related expenses, including transportation and prescription costs, for Claimant's respiratory condition, as overseen by the District Director.
7. Employer/Carrier will provide Claimant with a free choice psychiatrist or psychologist, to treat the Claimant's work-related emotional conditions.
8. Employer/Carrier will continue to pay for all medically necessary treatment related to the DVT and psychiatric conditions including medications and office visits. The Claimant will submit any unpaid bills to the Employer/Carrier for payment, including their medical mileage related to the covered injury.

9. Jurisdiction is retained so that Claimant's attorney shall file a fully supported and itemized petition for attorney's fees and costs within thirty (30) days of the service of this Decision and Order, and that Employer/Carrier shall file any objections within thirty (30) days of service of Claimant's petition.

SO ORDERED

DANIEL F. SOLOMON
ADMINISTRATIVE LAW JUDGE