United States Department of Labor
Employees' Compensation Appeals Board

J.B., Appellant	)	
	)	**Docket No. 06-1556**
and	)	**Issued: April 19, 2007**
DEPARTMENT OF THE ARMY, O&M HEAT SHOP, Fort Polk, LA, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 27, 2006 appellant filed a timely appeal from the Office of Workers' Compensation Programs' merit decision dated June 6, 2006, which denied appellant's claim that he developed asbestosis and silicosis while in the performance of duty. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue on appeal is whether appellant has met his burden of proof in establishing that he developed asbestosis and silicosis while in the performance of duty.

FACTUAL HISTORY

On August 27, 2002 appellant, then a 54-year-old boiler plant operator, filed an occupational disease claim alleging that he developed asbestosis and silicosis while working as a boiler plant operator. He became aware of his condition on August 10, 2002. Appellant did not stop work but was removed from all contact with asbestos.

Appellant submitted a statement noting that he was exposed to asbestos and silica while employed with the U.S. Navy from July 1965 to July 1969 as a boiler tender, from August 1971 to December 1975 as a boilermaker apprentice and from July 1978 to the present as a boiler plant operator at Fort Polk. He submitted a chest x-ray report from Dr. Richard B. Levine, a Board-certified radiologist, dated May 2, 2002, which revealed bilateral pleural thickening and bilateral interstitial fibrosis consistent with mixed interstitial round and irregular opacity. Appellant was diagnosed with asbestosis and silicosis. He also submitted a report from Dr. Loi Dai Vo, a Board-certified internist, dated August 20, 2002, who treated appellant for asbestos exposure. Dr. Vo noted that appellant's history was significant for exposure to asbestos and silica while at work. He indicated that a chest x-ray revealed pulmonary fibrosis, asbestosis and silicosis and recommended appellant avoid the chemical environment at work.

In a statement dated August 27, 2002, the employing establishment concurred with appellant's description of his work duties and exposure to asbestos while employed as a boiler plant operator. The employing establishment noted that appellant was removed from his environment when his screening results were positive. The employing establishment indicated that safety clothing and respirators were available for each employee; however, some employees were not medically cleared for respirators.

On January 14, 2003 the Office referred appellant for a second opinion to Dr. Douglas W. Jenkins, a Board-certified internist with a specialty in pulmonary medicine. The Office provided Dr. Jenkins with appellant's medical records, a statement of accepted facts as well as a detailed description of appellant's employment duties. In a March 20, 2003 report, Dr. Jenkins noted reviewing the records provided to him, stated appellant's history and examined appellant. He noted findings upon physical examination of normal breath sounds without rales or rhonchi. Dr. Jenkins noted that chest x-ray revealed an elevated right diaphragm consistent with a congenital or traumatic interruption of the right phrenic nerve and pleural densities which most likely represented pleural fat. He noted that the computerized tomography (CT) scan of the chest performed in December 2002 did not reveal parenchymal abnormality or pleural density. The pulmonary function test revealed restrictive defect without evidence of obstruction. Dr. Jenkins opined that appellant had a history of asbestos exposure and possible silica exposure; however, there was no evidence of parenchymal densities that would qualify as asbestosis or silicosis. Rather, he indicated that the pleural density represented fat and opined that appellant's symptoms were most likely related to the effects of deconditioning, obesity and a paralyzed right hemidiaphragm. A March 17, 2003 chest x-ray revealed markedly elevated right hemidiaphragm.

In a decision dated April 22, 2003, the Office denied appellant's claim as the evidence was not sufficient to establish that appellant sustained an injury as defined by the Federal Employees' Compensation Act.[1]

[1] 5 U.S.C. §§ 8101-8193.

Following a hearing request, a hearing representative, in a February 25, 2004 decision, set aside the April 22, 2003 decision and remanded the case for further development. The hearing representative determined that there was a medical conflict between Drs. Levine and Vo, appellant's treating physicians, and Dr. Jenkins, the Office referral physician, as to whether appellant had asbestosis.

To resolve the conflict on August 25, 2004, the Office referred appellant to Diagnostic Imaging Services.

In a September 24, 2004 letter, Dr. Jenkins, the Office referral physician, referred appellant to Diagnostic Imaging Services to perform a CT scan of the chest. In a report dated September 24, 2004, Dr. Christopher Lawrence, a Board-certified radiologist associated with Diagnostic Imaging Services, indicated that he performed a CT scan of the chest but did not perform a physical examination of appellant. He indicated that Dr. Jenkins was the referring physician. Dr. Lawrence noted a clinical history of asbestos exposure. He diagnosed asymmetrical elevation of the right hemidiaphragm, multiple low attenuation lesions identified within the right and left lobes of the liver suspicious for simple cysts and atherosclerotic calcifications within the coronary arteries.

In a decision dated October 12, 2004, the Office denied appellant's claim on the grounds that the weight of the evidence as established by the Office referral physician did not demonstrate that appellant developed the diagnosed conditions as a result of his employment duties.

On October 20, 2004 appellant requested an oral hearing and questioned why Dr. Lawrence did not perform a physical examination.

By decision dated November 4, 2004, the hearing representative set aside the October 12, 2004 decision and remanded the case for further development. The hearing representative determined that Dr. Lawrence was not a referee examination because the second opinion physician, Dr. Jenkins, provided the Office with the referral to Dr. Lawrence. The hearing representative advised that appellant would be referred to a referee physician to resolve the conflict in opinion between Drs. Levine and Vo, appellant's treating physician and Dr. Jenkins, the Office referral physician, as to whether appellant had asbestosis which was causally related to his employment.

To resolve the conflict on November 17, 2004, the Office referred appellant to Discovery Diagnostics Western Imaging Center for a determination as to whether appellant's conditions of asbestosis or silicosis was due to his employment.

Appellant submitted several statements dated November 4, 2004 to March 21, 2005, which indicated that he would not attend the referee examination because he was informed that he would not be examined by a physician but would undergo another CT scan of the chest. He asserted that the Office was not handling his claim properly.

On November 29, 2004 the Office notified appellant that a referring physician was needed in order to perform the CT scan required in his clam. The Office noted that it was discovered that Dr. Jenkins was the referring physician for the referee examination and,

therefore, the results of the examination were deemed invalid. The Office advised that appellant would be rescheduled for another referee examination.

In a report dated January 3, 2005, Dr. Jenkins, the Office referral physician, noted that he reviewed the CT scan performed on September 24, 2004 and opined that there was no evidence of changes that would be attributed to asbestos or silica. He indicated that the CT scan demonstrated coronary calcifications which were the result of aging and perhaps genetic factors but not the result of asbestos exposure.

In a decision dated April 12, 2005, the Office denied appellant's claim as the evidence was not sufficient to establish that appellant sustained an injury under the Act. The Office noted that there was no true conflict between Dr. Vo, appellant's treating physician and Dr. Jenkins, the Office referral physician. The Office determined that Dr. Vo's opinion was of diminished probative value because he was not a Board-certified pulmonologist and he had no specialized training that would make him qualified to make a determination of asbestosis or silicosis. The Office further noted that Dr. Vo failed to provide a history of the claimed work exposure. The Office noted that Dr. Jenkins was a Board-certified pulmonologist and provided a comprehensive, rationalized medical report which was the weight of the evidence that appellant did not develop asbestosis or silicosis as a result of his workplace exposure to asbestos.

On April 14, 2005 appellant requested an oral hearing before an Office hearing representative. He submitted a report from Dr. Glenn Gomes, a Board-certified pulmonologist, dated May 2, 2005, who noted a history of exposure to asbestos while appellant was employed as a boiler plant operator. Dr. Gomes examined that CT scan of the chest dated September 24, 2004 and noted that the film showed bilateral pleural plaques, increased interstitial markings in the lower lungs and evidence of a partial collapse of the right lower lobe. He noted that the radiologist report was not available. Dr. Gomes opined that these findings were consistent with asbestosis and asbestos-related pleural plaques. He noted that a pulmonary function test revealed significant restrictive impairment of lung function. Dr. Gomes diagnosed pulmonary asbestosis with bilateral pleural thickening, interstitial changes, right diaphragmatic dysfunction, cardiomegaly and diabetes.

By decision dated September 8, 2005, the hearing representative set aside the April 12, 2005 decision and remanded the case for further development. The hearing representative determined that there was conflict in opinion between Dr. Gomes, appellant's treating physician and Dr. Jenkins, the Office referral physician, as to whether appellant had asbestosis which required further development.

On September 17, 2005 appellant appealed his claim to the Board. In an order dated February 7, 2006, the Board dismissed his appeal for lack of jurisdiction over an adverse decision.[2] On February 13, 2006 appellant again appealed to the Board. In an order dated May 18, 2006, the Board dismissed the appeal.[3]

[2] Docket No. 05-1968 (issued February 7, 2006).

[3] Docket No. 06-948 (issued May 18, 2006).

To resolve the conflict, on February 27, 2006, the Office referred appellant to a referee physician, Dr. Vanessa Holland, a Board-certified pulmonologist, who indicated that in a report dated March 30, 2006, that she reviewed the records provided to her and performed a physical examination of appellant. Dr. Holland noted a history of appellant's work-related injury. She noted that pulmonary function tests performed on March 24, 2006 revealed mild restrictive defect without a significant response to bronchodilators. Dr. Holland noted that chest radiographs performed on March 24, 2006 revealed good inspiratory effort, a normal cardiac silhouette and mediastinum, the pulmonary parenchyma revealed no infiltrates or increase interstitial markings, the right hemidiaphragm was markedly elevated, there appeared to be bilateral pleural thickening versus bilateral fat pads, there was no evidence of diaphragmatic plaques and some apical pleural thickening. She advised that appellant underwent multiple examinations that included radiographic evaluation with chest x-rays and CT scans of the chest, which had not been interpreted consistently in regards to the diagnosis of asbestosis or silicosis. Dr. Holland recommended a high resolution CT scan which should be based on the Johns Hopkins Hospital protocol for pneumoconiosis.

On April 27, 2006 appellant underwent a CT scan of the chest at River Oaks Imaging and Diagnostic Center with high resolution imaging which revealed minimal perihilar bronchial thickening without evidence for bronchiectasis, there was no evidence of interstitial lung disease or focal parenchymal lesions and multiple cysts in the liver. In a report dated April 27, 2006, the Johns Hopkins Hospital, Department of Radiology -- Pneumoconiosis Section, reviewed the CT scan and noted findings consistent with moderate arteriosclerosis left main and left coronary circumflex artery/check for angina pectoris, at least moderate obesity in the intraabdominal and mediastinal with minimal extrapleural fat on the lateral chest walls, a nine centimeter lobulated cyst in the right lobe of the liver and several small ones in both lobes, focal arteriosclerosis aorta, minimal degenerative arthritis of the thoracic spine and fatty infiltration pancreas.

In a supplemental report dated May 8, 2006, Dr. Holland noted that a high resolution CT scan was performed based on the Johns Hopkins Pneumoconiosis protocol with two independent readings performed on the CT scan results. She indicated that both of the independent readings of the high resolution CT scan of the chest were negative for pneumoconiosis and there was no asbestos or silicosis found by either of the two independent radiologists. Dr. Holland opined that appellant did not have asbestosis or silicosis based on the high resolution CT scan of the chest performed on April 27, 2006. She opined that appellant had restrictive lung defect which was not work related.

In a decision dated June 6, 2006, the Office denied appellant's claim on the grounds that the weight of the evidence as established by the referee physician failed to establish that appellant's pulmonary condition was the result of asbestosis or silicosis and that his condition was not causally related to his work exposure.

LEGAL PRECEDENT

An employee seeking benefits under the Act has the burden of establishing the essential elements of his or his claim including the fact that the individual is an "employee of the United States" within the meaning of the Act, that the claim was timely filed within the applicable time limitation period of the Act, that the injury was sustained in the performance of duty as alleged

and that any disability and/or specific condition for which compensation is claimed are causally related to the employment injury. These are the essential elements of each and every compensation claim regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[4]

To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit the following: (1) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; (2) factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; and (3) medical evidence establishing that the employment factors identified by the claimant were the proximate cause of the condition for which compensation is claimed or, stated differently, medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant. The medical evidence required to establish causal relationship is generally rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[5]

ANALYSIS

On August 27, 2002 appellant filed an occupational disease claim alleging that he developed asbestosis and silicosis as a result of workplace exposure to asbestos while working as a boiler plant operator. The Office found that, a conflict of medical opinion existed between the second opinion physician, Dr. Jenkins, a Board-certified pulmonologist, who opined that appellant did not have asbestosis or silicosis which was causally related to his employment and the attending physician, Dr. Gomes, a Board-certified pulmonologist, who opined that appellant had asbestosis and silicosis which was causally related to his workplace exposure to asbestos. As there was a conflict in the medical opinion evidence, the Office properly referred appellant for an impartial medical examination by Dr. Holland, a Board-certified pulmonologist.[6]

Where there exists a conflict of medical opinion and the case is referred to an impartial specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, is entitled to special weight.[7]

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[4] *Gary J. Watling*, 52 ECAB 357 (2001).

[5] *Solomon Polen*, 51 ECAB 341 (2000).

[6] 5 U.S.C. § 8123(a), in pertinent part, provides: "If there is a disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."

[7] *Solomon Polen, supra* note 5.

In her March 30, 2006 report, Dr. Holland reviewed the entire case record and statement of accepted facts. She examined appellant thoroughly and related her clinical findings. Dr. Holland indicated that pulmonary function tests performed on March 24, 2006 revealed mild restrictive defect without a significant response to bronchodilators. She noted that chest radiographs performed on March 24, 2006 revealed good inspiratory effort, no infiltrates or increase interstitial markings in the pulmonary parenchyma, possible bilateral pleural thickening versus bilateral fat pads, there was no evidence of diaphragmatic plaques and some apical pleural thickening. Dr. Holland advised that appellant underwent multiple examinations that included radiographic evaluation with chest x-rays and CT scans of the chest which had not been interpreted consistently in regards to the diagnosis of asbestosis or silicosis and recommended a high resolution CT scan. In a supplemental report dated May 8, 2006, she noted that a high resolution CT scan was performed on April 27, 2006 and was based on the Johns Hopkins Pneumoconiosis protocol with two independent readings performed on the CT scan by the River Oaks Imaging Center and the Johns Hopkins Hospital. Dr. Holland advised that the readings were negative for pneumoconiosis and there was no asbestos or silicosis found by either of the two independent radiologists. She opined that appellant did not have asbestosis or silicosis based on the high resolution CT scan of the chest performed on April 27, 2006.

The Board finds that, under the circumstances of this case, the opinion of Dr. Holland is sufficiently well rationalized and based upon a proper factual background such that it is entitled to special weight and establishes that appellant's pulmonary condition was not the result of asbestosis or silicosis and was not causally related to his workplace exposure to asbestos. She had reviewed the entire case record and statement of accepted facts and had examined appellant. Dr. Holland additionally provided well-reasoned rationale as to why appellant's current pulmonary condition was not causally related to his workplace exposure to asbestos.

The Board finds that Dr. Holland's opinion constitutes the weight of the medical evidence and is sufficient to justify the Office's denial of appellant's claim for compensation.

CONCLUSION

The Board finds that appellant failed to meet his burden of proof to establish that he developed asbestosis or silicosis causally related to factors of employment.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated June 6, 2006 is affirmed.

Issued: April 19, 2007
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board