United States Department of Labor
Employees' Compensation Appeals Board

C.D., Appellant	)	
and	)	**Docket No. 09-329**
	)	**Issued: October 13, 2009**
TENNESSEE VALLEY AUTHORITY, PARADISE FOSSIL FUEL PLANT, Drakesboro, KY, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On November 17, 2008 appellant filed a timely appeal from the September 15, 2008 decision of an Office of Workers' Compensation Programs' hearing representative that affirmed a February 27, 2008 denial of his claim for compensation. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this claim.

ISSUE

The issue is whether appellant met his burden of proof in establishing that he sustained an occupational disease in the performance of duty.

FACTUAL HISTORY

On September 23, 2004 appellant, then a 64-year-old retired maintenance machinist, filed an occupational disease claim alleging that he developed pneumoconiosis as a result of exposure to asbestos fibers and coal dust at work. He first learned of his condition on July 9, 2004 when he received a chest x-ray report from Dr. Glen R. Baker, an attending Board-certified

pulmonologist and a certified B-reader.[1] The employing establishment advised that appellant was last exposed to the conditions alleged to have caused his condition on December 4, 1999, the date that he retired. Evidence from the employing establishment indicated that he worked as a machinist at the employing establishment from March 26, 1987 to December 4, 1999. Appellant was exposed to asbestos of 0.01 to 0.0623 fibers per cubic centimeter of air (fiber/cc) and respirable coal dust of 0.1 to 0.3 milligrams per cubic meter of air (mg/m3), which calculated as an eight-hour weighted average. He also smoked three packs of cigarettes a daily for several years and quit smoking at age 21. Appellant had a history of coughing, with pockets on the bottom of his lungs since 1958. Since December 4, 1999, he was no longer exposed to contaminating materials.

In an August 3, 2004 report, Dr. Baker noted that he examined appellant July 31, 2004. He provided a history that appellant, during his 13 years with the employing establishment, was exposed to asbestos on a frequent basis and coal dust on a daily basis. Dr. Baker indicated that appellant also had previous asbestos exposure and that he smoked for six years at a rate of three packs per day but quit at age 21. He provided findings on physical examination, the results of pulmonary function testing, which was normal and chest x-ray.[2] Dr. Baker diagnosed occupational pneumoconiosis, category 1/0 with multi-factorial etiology and changes secondary to coal dust, asbestos and possibly welding fumes. He opined that appellant had a Class 1 pulmonary impairment based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*). Under the A.M.A., *Guides*, Dr. Baker also opined that appellant had a second impairment with the presence of pneumoconiosis and was totally disabled from working in a dusty environment. Copies of the spirometry report and chest x-ray performed on July 31, 2004 were submitted to the Office.

On September 21, 2006 the Office referred appellant, together with a list of questions and statement of accepted facts to Dr. Kenneth C. Anderson, a Board-certified pulmonologist and certified B-reader,[3] who examined appellant on December 5, 2006 and reviewed the statement of accepted facts. Dr. Anderson provided findings on physical examination, pulmonary function testing and chest x-ray. He reported that the chest x-ray showed "small opacity with a profusion of 0/1 present." Dr. Anderson noted that appellant underwent cardiac surgery in September 2006 and his chest x-ray showed pleural changes in the left lower lung due to postoperative changes in the left lung cavity. The right lung field demonstrated "abnormalities" with a profusion of 0/1. Dr. Anderson advised the pulmonary function test showed a moderate restriction and suggested a possible obstruction with a mild degree of diffusion capacity for carbon monoxide. He compared the pulmonary function test to the pulmonary function tests of 2004 and opined that the changes were most likely consistent with changes following his open heart surgery. Dr. Anderson provided an impression of dyspnea of uncertain exact etiology and opined that it

[1] The National Institute for Occupational Safety and Health has a program to certify physicians to interpret pulmonary x-rays. Physicians so certified are referred to as B-readers.

[2] Dr. Baker indicated that the July 31, 2004 chest x-ray had small opacities at "pt" with a profusion of 1/0. He further indicated that there were no large opacities or any pleural abnormalities consistent with pneumoconiosis.

[3] The statement of accepted facts indicated that appellant had exposure to fumes and dust, either as a welder or a machinist, from 1963 until he began work with the employing establishment and from October 2000 until March 2003, following his retirement from the employing establishment.

was impossible to say how much of his present dyspnea was related to any preexisting federal employment impairment. He noted, however, that the pulmonary function tests in 2004 were normal.

In a February 20, 2007 decision, the Office denied the claim finding that the medical evidence did not support that appellant had a condition causally related to his federal employment. On March 1, 2007 appellant requested an oral hearing. On August 24, 2007 an Office hearing representative set aside the February 20, 2007 decision and remanded the case for additional medical development. She found that Dr. Anderson's opinion was equivocal and to obtain a supplemental report from him.

The Office requested Dr. Anderson to clarify his opinion on a whether appellant had a pulmonary condition or pneumoconiosis as a result of his federal employment. In an October 30, 2007 report, Dr. Anderson reiterated that when he saw appellant the worsening dyspnea was secondary to his recent heart surgery and postoperative course. He explained that appellant reported dyspnea prior to his September 2006 heart surgery and since the 2004 pulmonary function test was normal, appellant demonstrated no functional impairment. Dr. Anderson stated that it was possible that appellant's dyspnea could have been related to the undiagnosed heart disease. He offered to perform an independent B-reading of Dr. Baker's chest x-ray from 2004, noting that if it was abnormal then appellant had radiographic pneumoconiosis.

A copy of Dr. Baker's July 31, 2004 chest x-ray was sent to Dr. Anderson for review. On January 14, 2008 Dr. Anderson noted that the film quality was underexposed and mottle. He stated that the x-ray showed "s" shaped primary small opacities and "p" shaped secondary opacities in the upper, middle and lower zones of both lungs in a 1/0 profusion. No large opacities were noted nor were there any pleural abnormalities consistent with pneumoconiosis. In a February 24, 2008 report, Dr. Anderson opined that appellant did not appear to have pneumoconiosis. He referenced the American Thoracic Society article "The Diagnosis of Nonmalignant Diseases Related to Asbestos," from 1986, which noted that a finding of pneumoconiosis required a chest x-ray with a profusion of 1/1 or greater in addition to other appropriate findings. Dr. Anderson advised that appellant did not have pneumoconiosis at this time as his 2004 chest x-ray had a profusion of 1/0 and the pulmonary function tests obtained prior to his heart surgery demonstrated no functional impairment.

By decision dated February 27, 2008, the Office denied appellant's claim. It accorded determinative weight to Dr. Anderson's opinion that appellant's current condition was not related to the established work-related event.

On March 6, 2008 appellant, through his attorney, disagreed with the Office decision. He requested an oral hearing before an Office hearing representative, which was held July 30, 2008. Following the hearing, the Office received additional evidence. On July 29, 2008 Dr. Baker reported the results of a July 22, 2008 x-ray. He indicated that there were small opacities at the primary and secondary in the middle and lower zones in both lungs with a 1/0 profusion. Dr. Baker found no large opacities and indicated that there were no pleural abnormalities consistent with pneumoconiosis. The Office additionally received other diagnostic testing performed on July 22, 2008.

In a March 22, 2007 report, Dr. Matthew Vuskovich, Board-certified in occupational medicine and a certified B-reader, read the July 31, 2004 x-ray. He noted that there were small opacities in the "p" zones at the upper, middle and lower zones in both lungs with a 0/1 profusion. Dr. Vuskovich advised that there were no large opacities or any pleural abnormalities consistent with pneumoconiosis.

By decision dated September 15, 2008, an Office hearing representative affirmed the Office's February 27, 2008 decision denying appellant's claim.

LEGAL PRECEDENT -- ISSUE 1

To establish that an injury was sustained in the performance of duty in a claim for an occupational disease claim, an employee must submit the following: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; (2) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the employee.[4] Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on whether there is a causal relationship between the employee's diagnosed condition and the compensable employment factors. The opinion of the physician must be based on a complete factual and medical background of the employee, must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the employee.[5]

ANALYSIS -- ISSUE 1

Appellant alleged that he developed dyspnea and pneumoconiosis as a result of exposure to coal dust and asbestos during his federal employment. The employing establishment provided evidence as to specific levels of his exposure to coal dust and asbestos.

In an August 3, 2004 report, Dr. Baker provided a history of appellant's exposure to coal dust and asbestos during his 13 years at the employing establishment and his smoking history. He provided findings on physical examination, noted that pulmonary function testing was normal and the chest x-ray showed pneumoconiosis category 1/0. Dr. Baker diagnosed occupational pneumoconiosis with multi-factorial etiology and changes secondary to coal dust, asbestos and possibly welding fumes. He opined that appellant had a Class 1 pulmonary impairment and a second impairment because of the pneumoconiosis and was totally disabled from working in a dusty environment. The Board notes that, under Table 5-12, page 107 of the A.M.A., *Guides*, a Class 1 impairment classification based on pulmonary function studies is zero percent impairment. Zero percent impairment for respiratory disorder is consistent with normal

[4] *See Roy L. Humphrey*, 57 ECAB 238, 241 (2005); *Ruby I. Fish*, 46 ECAB 276, 279 (1994).

[5] *I.J.*, 59 ECAB ___ (Docket No. 07-2362, issued March 11, 2008); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

pulmonary studies Dr. Baker reviewed. Dr. Baker, however, did not provide medical rationale explaining how the accepted employment exposures caused a secondary impairment because of the pneumoconiosis. The Board has held that a medical opinion not supported by medical rationale is of little probative value.[6] While Dr. Baker opined that appellant had occupational pneumoconiosis, a review of Dr. Baker's reading of the July 31, 2004 chest x-ray does not support such diagnosis. The A.M.A., *Guides* provide that the criteria for assessing impairment due to pneumoconiosis are found at Table 5-12.[7] As noted, Dr. Baker indicated that appellant had Class one or zero percent impairment. He did not explain this apparent inconsistency. In his July 31, 2004 reading of the chest x-ray, Dr. Baker found small opacities at "pt" with a profusion of 1/0, but stated that there were no large opacities or any pleural abnormalities consistent with pneumoconiosis. This is supported by Dr. Vuskovich's reading of the July 31, 2004 chest x-ray, who also opined that, while there were small opacities at the "p" zones in both lungs with a 0/1 profusion, there were no large opacities or any pleural abnormalities consistent with pneumoconiosis. On appeal, appellant's attorney argues that Drs. Baker and Vuskovich established the diagnosis of pneumoconiosis as they both answered affirmatively to the question "Any parenchymal abnormalities consistent with pneumoconiosis" on the x-ray interpretation form. The Board notes that, when an affirmative answer is provided to the above question, the form directs the reviewer to proceed to the next question which asks whether there are any pleural abnormalities consistent with pneumoconiosis. Both physicians indicated that there were no pleural abnormalities consistent with pneumoconiosis. Thus, Dr. Baker's report is insufficient to establish appellant's burden of proof.

Dr. Anderson, also a Board-certified pulmonologist and certified B-reader, reviewed a statement of accepted facts noting appellant's exposure and smoking history, examined him and provided findings on physical examination as well as his review of chest x-rays and pulmonary function tests taken on December 5, 2006 and from 2004. He indicated that the December 5, 2006 chest x-ray showed "small opacities with a profusion of 0/1" and the pleural changes in the left lower lung were due to postoperative changes from appellant's September 2006 cardiac surgery. Dr. Anderson also advised the December 4, 2006 pulmonary function test showed a moderate restriction which, when compared to the normal pulmonary function tests in 2004, were most likely consistent with changes following the open heart surgery. In reports dated October 30, 2007 and February 24, 2008, he opined that appellant's worsening dyspnea was secondary to his recent heart surgery and postoperative course. Dr. Anderson explained that appellant demonstrated no functional impairment as the 2004 pulmonary functional tests were normal and appellant reported dyspnea prior to his September 2006 heart surgery. He also opined that appellant did not have radiographic evidence of pneumoconiosis as his 2004 chest x-ray had a profusion of 1/0 and the pulmonary function tests obtained prior to his heart surgery demonstrated no functional impairment. Dr. Anderson referenced medical literature indicating that a pneumoconiosis finding required a chest x-ray of 1/1 profusion or greater in addition to other appropriate findings.

The Board finds that Dr. Anderson's opinion is sufficiently well rationalized and based upon a proper factual background such that it is the weight of the evidence on the issue of

[6] *Caroline Thomas*, 51 ECAB 451 (2000).

[7] A.M.A., *Guides* at 106-07 (5th ed. 2001).

whether appellant sustained a lung condition causally related to his federal employment. The Board has noted that in assessing medical evidence the weight of such evidence is determined by its reliability, its probative value and its convincing quality and the factors which enter in such an evaluation include the opportunity for and thoroughness of examination, the accuracy and completeness of the physician's knowledge of the facts and medical history, the care of the analysis manifested and the medical rationale expressed in support of the physician's opinion.[8] The Board has carefully reviewed Dr. Anderson's reports and notes that it has such reliability, probative value and convincing quality. Dr. Anderson examined appellant and had the benefit of a statement of accepted facts as well as chest x-ray and pulmonary function testing performed in 2004 and 2006. He provided a proper analysis of the factual and medical history and objective test findings of record and reached conclusions regarding the employee's condition which comported with this analysis. Dr. Anderson found no basis on which to attribute appellant's condition to his federal employment.

The Board finds that appellant has not submitted rationalized medical evidence establishing that his claimed lung conditions were causally related to the accepted employment exposures. Thus, he did not meet his burden of proof. On appeal, appellant asserts that the medical evidence is sufficient to support his claim or, in the alternative, that there is a conflict in the medical evidence for this referral to an impartial specialist is required. However, as noted, the medical evidence is insufficient to establish his claim. Furthermore, there is no medical conflict as there is no medical opinion supporting causal relationship that is of virtually equal weight with Dr. Anderson's report, which does not support causal relationship.[9]

CONCLUSION

The Board finds that appellant failed to meet his burden of proof in establishing that he sustained a medical condition causally related to exposure during his federal employment.

[8] *See Melvina Jackson*, 38 ECAB 443, 449-50 (1987); *Naomi Lilly*, 10 ECAB 560, 573 (1959).

[9] *See* 5 U.S.C. § 8128; *M.S.*, 58 ECAB ___ (Docket No. 06-797, issued January 31, 2007) (when there are opposing reports of virtually equal weight and rationale, the case will be referred to an impartial medical specialist, pursuant to section 8123(a), to resolve the conflict in the medical evidence).

ORDER

IT IS HEREBY ORDERED THAT the September 15 and February 27, 2008 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: October 13, 2009
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

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