United States Department of Labor
Employees' Compensation Appeals Board

R.W., Appellant **and** **TENNESSEE VALLEY AUTHORITY,** **PARADISE FOSSIL PLANT,** **Drakesboro, KY, Employer**	)))))))))	**Docket No. 07-1760** **Issued: January 17, 2008**

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 20, 2007 appellant filed a timely appeal from October 6, 2006 and March 29, 2007 decisions of the Office of Workers' Compensation Programs denying his occupational disease claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d), the Board has jurisdiction over the merits of the claim.

ISSUE

The issue is whether appellant sustained chronic obstructive pulmonary disease, chronic bronchitis or pneumoconiosis in the performance of duty. On appeal, appellant asserts that the opinion of an impartial medical examiner, Dr. Manoj H. Majmudar, a Board-certified pulmonologist, cannot represent the weight of the medical evidence as he did not examine appellant, did not review the medical record and computerized tomography (CT) scans and did not provide adequate medical rationale. Appellant also asserted that Dr. Majmudar was not a B Reader and was therefore not qualified to evaluate diagnostic studies for the presence of pneumoconiosis.

FACTUAL HISTORY

This is the second appeal before the Board in the case. By decision dated July 20, 2006,[1] the Board set aside a December 15, 2005 decision of the Office finding that appellant failed to establish that he sustained an occupational lung disease. The Board found a conflict of medical opinion between Dr. William C. Houser, an attending Board-certified pulmonologist, and Dr. Kenneth C. Anderson, a second opinion physician specializing in pulmonary medicine. Dr. Houser diagnosed mild chronic obstructive pulmonary disease (COPD) and chronic bronchitis due to occupational exposure to asbestos, coal dust, flue gas, welding fumes, smoke, trichloroethylene and cigarette smoke. Dr. Anderson opined that appellant's mild COPD was caused by smoking and not occupational exposures. The Board remanded the case to the Office for appointment of an impartial medical examiner to resolve the conflict of medical opinion.

On August 14, 2006 the Office referred appellant, the medical record and a statement of accepted facts to Dr. Majmudar, a Board-certified pulmonologist, to resolve the conflict of medical opinion between Dr. Houser, for appellant and Dr. Anderson, for the government. Appellant attended the appointment as scheduled on September 25, 2006.

Dr. Majmudar submitted a September 12, 2006 chart note relating appellant's symptoms of shortness of breath. He noted "COPD changes, old fracture ribs on [right], no plaques seen." In an October 2, 2006 letter, Dr. Majmudar noted reviewing Dr. Anderson's November 17, 2004 report, Dr. Houser's November 20, 2003 report, CT scans, chest x-rays and pulmonary function test reports. Dr. Majmudar opined that appellant's condition was "related to his 40 to 60 pack year smoking causing mild chronic obstructive airway impairment." He noted that Dr. Houser opined that October 16, 2002 studies showed pleural plaque in the left diaphragm. However, an October 4, 2005 CT scan report indicated no pleural plaque or pulmonary fibrosis. Dr. Majmudar opined that chest CT scans were more accurate than x-rays in diagnosing pneumoconiosis. He stated that based on appellant's history, examination and the medical record, appellant had no "evidence suggestive of asbestos or pleural plaque. [Dr. Majmudar] believe[d] all [appellant's] symptoms [were] related to mild chronic obstructive airway impairment from cigarette smoking." He noted that he agreed with Dr. Anderson.

By decision dated October 6, 2006, the Office denied appellant's claim for occupational lung disease on the grounds that causal relationship was not established. The Office found that the weight of the medical evidence rested with Dr. Majmudar who submitted a well-rationalized report based on a complete and accurate history finding that appellant had no work-related lung conditions.

In an October 17, 2006 letter, postmarked October 18, 2006, appellant requested an oral hearing. In a November 7, 2006 letter, his attorney requested copies of Dr. Majmudar's examination report and pulmonary function tests. The Office responded by November 14, 2006 letter, that Dr. Majmudar reviewed previous evidence but did not obtain new studies. The Office noted that it enclosed a copy of a September 12, 2006 x-ray report. There is no copy of the x-ray report of record.

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[1] Docket No. 06-906 (issued July 20, 2006).

At the hearing, held February 6, 2007, appellant asserted that he had daily occupational exposure to coal dust, flue gas and asbestos dust from 1970 through his retirement in January 1999. He asserted that Dr. Majmudar was confused as to why appellant had presented for an examination. Dr. Majmudar used a stethoscope to listen to appellant's breathing and stated "well that [i]s all." Appellant asked if the doctor should obtain a chest x-ray. Dr. Majmudar then said "I guess I could," then had the x-ray taken. Appellant asserted that Dr. Majmudar's opinion could not be accorded the weight of the medical evidence as he did not perform a thorough examination or obtain a complete medical history. Also, Dr. Majmudar did not review the CT films, only the CT report.

Appellant submitted new medical evidence. In a February 2, 2007 report, Dr. Glen Baker, a Board-certified pulmonologist and a B Reader,[2] opined that appellant's CT scan "showed mild fibrosis that could be either scarring or due to pneumoconiosis. There [was] no definite pattern of pulmonary fibrosis." In an accompanying form report, he checked a box "no" indicating that there were no pleural abnormalities consistent with pneumoconiosis. Dr. Baker explained that, while the scan was not diagnostic of pneumoconiosis, there were some scattered fibrotic changes present. He explained that a negative CT scan was not dispositive in ruling out pneumoconiosis. Medical literature showed that chest x-rays read as positive for pneumoconiosis by B Readers "frequently had CT scans read as negative."

By decision dated and finalized March 29, 2007, an Office hearing representative affirmed the Office's October 6, 2006 decision finding that appellant had not established that he sustained an occupational lung disease. The hearing representative found that Dr. Majmudar's opinion continued to carry the weight of the medical evidence as it was based on a proper background and was sufficiently rationalized. He further found that Dr. Baker's report was insufficient to outweigh that of Dr. Majmudar on the issue of whether a CT scan could definitively rule out pneumoconiosis. The hearing representative noted that the Office provided appellant with a copy of Dr. Majmudar's September 12, 2006 x-ray report.

LEGAL PRECEDENT

An employee seeking benefits under the Federal Employees' Compensation Act[3] has the burden of establishing the essential elements of his or her claim, including the fact that the individual is an "employee of the United States" within the meaning of the Act; that the claim was filed within the applicable time limitation; that an injury was sustained while 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.[4] These are the essential elements of each and every compensation claim regardless of whether the claim is predicated on a traumatic injury or an occupational disease.[5]

[2] A "B [R]reader" is a radiologist who undergoes specialized training, examination and certification by National Institute of Occupational Safety and Health (NIOSH) in the early detection of asbestosis and pneumoconiosis.

[3] 5 U.S.C. §§ 8101-8193.

[4] *Joe D. Cameron*, 41 ECAB 153 (1989).

[5] *See Irene St. John*, 50 ECAB 521 (1999); *Michael E. Smith*, 50 ECAB 313 (1999).

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 medial 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.[6]

Section 8123 of the Act provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician, who shall make an examination.[7] In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[8] However, in a situation where the Office secures an opinion from an impartial medical examiner for the purpose of resolving a conflict in the medical evidence and the opinion from such examiner requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the examiner for the purpose of correcting the defect in the original opinion.[9]

ANALYSIS

Appellant claimed that he sustained COPD, chronic bronchitis and pneumoconiosis due to occupational exposures to coal dust, flue gas and asbestos. In decisions prior to the first appeal, the Office denied the claim on the grounds that causal relationship was not established. The Board found a conflict of medical evidence between Dr. Anderson, a second opinion physician specializing in pulmonary medicine and Dr. Houser, an attending Board-certified pulmonologist. On remand of the case, the Office obtained an impartial medical opinion from Dr. Majmudar, a Board-certified pulmonologist.

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

[7] 5 U.S.C. § 8123; *see Charles S. Hamilton*, 52 ECAB 110 (2000).

[8] *Jacqueline Brasch (Ronald Brasch)*, 52 ECAB 252 (2001).

[9] *Margaret M. Gilmore*, 47 ECAB 718 (1996).

Dr. Majmudar opined that appellant had COPD due solely to smoking. However, he did not provide sufficient medical rationale explaining the basis for this conclusion. Dr. Majmudar did not provide a health history, note the type and duration of appellant's occupational exposures or provide findings on clinical examination. Thus, his report was incomplete and required clarification.[10] The Office issued its October 6, 2006 decision denying appellant's claim without obtaining a supplemental report from Dr. Majmudar. It affirmed this decision on March 29, 2007 without requesting clarification from Dr. Majmudar.

The Board finds that, since the Office undertook development of the medical evidence, it must obtain a reasoned report as to the nature of appellant's pulmonary conditions and whether they are work related.[11] The Board directs the Office to request a supplemental, clarifying report from Dr. Majmudar on these issues. Following this and all other development deemed necessary, the Office shall issue an appropriate decision in the case.

The Board notes that the Office stated that it provided appellant a copy of Dr. Majmudar's September 12, 2006 x-ray report. The Office hearing representative also mentioned this report. However, the x-ray report is not of record. On remand of the case, the Office shall obtain a copy of this report and associate it with the case record.

CONCLUSION

The Board finds that the case is not in posture for a decision. The case will be remanded for further development.

[10] *Id*.

[11] *See, e.g., Elmer K. Kroggel*, 47 ECAB 557 (1996) (the Board remanded the case for the Office to obtain a supplemental report from the impartial medical specialist).

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Worker's Compensation Programs dated March 29, 2007 and October 6, 2006 are set aside and the case remanded for further action consistent with this opinion.

Issued: January 17, 2008
Washington, DC

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

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

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