United States Department of Labor
Employees' Compensation Appeals Board

J.S., Appellant	)	
and	)	
DEPARTMENT OF THE NAVY, PUGET SOUND NAVAL SHIPYARD, INTERMEDIATE MAINTENANCE FACILITY, Bremerton, WA, Employer	)	**Docket No. 09-36** **Issued: August 24, 2009**

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
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On October 8, 2008 appellant filed a timely appeal from July 29 and September 25, 2008 nonmerit decisions of the Office of Workers' Compensation Programs' as well as the April 24, 2008 merit decision denying his claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merit and nonmerit decisions.

ISSUES

The issues are: (1) whether appellant has met his burden to establish that he sustained an injury in the performance of duty causally related to his federal employment; and (2) whether the Office properly refused to reopen appellant's case for further consideration of the merits pursuant to 5 U.S.C. § 8128(a).

FACTUAL HISTORY

On July 10, 2007 appellant, a 63-year-old retired pipefitter[1] filed an occupational disease claim (Form CA-2) for chronic obstructive pulmonary disease (COPD), emphysema and chest pain of undefined origins. He first became aware of his condition and its relation to his federal employment on June 22, 2007. Appellant attributed his condition to exposure to cleaning solvents, paints, degreasers and asbestos.

Appellant submitted an exposure data record showing that for a one-month period, from January through February 2003, he had physical contact with asbestos while working in the fan tail and other areas of the USS John F. Kennedy. Additionally, during the period August 1991 through December 2006, while working at Building 875, at a hose cleaning facility, he was exposed to chemicals including bleach, detergents, degreasers, glues, cleaners, lubricants and cadmium.

Appellant submitted a June 25, 2007 report signed by Dr. Allison M. Smith, a Board-certified diagnostic radiologist, who reported on results from x-rays of his chest. Dr. Smith noted that there was diffuse prominence to the interstitial markings but no vascular redistribution was demonstrated. She reported that the size of appellant's heart was at the upper limits of normal and that there was no confluent consolidation or pleural effusion. Dr. Smith diagnosed interstitial disease but noted that whether this condition was chronic or otherwise could not be determined in the absence of prior films.

In a June 25, 2007 report, (Form CA-20) Dr. Christine Lomotan, Board-certified in family medicine, diagnosed appellant with COPD and shortness of breath. She noted that she was uncertain as to whether this condition was employment related.

Appellant submitted emergency room treatment reports signed by Dr. Katherine A. Pryde, Board-certified in emergency medicine, dated June 22, 2005. Dr. Pryde diagnosed acute COPD, emphysema and chest pain.

On April 17, 2007 Louis Fattrusso stated that in 1979 the employing establishment instituted controls on asbestos and that asbestos was securely wrapped at all times and only worked on in controlled areas. Employees assigned to work in these controlled areas were required to be medically qualified and be trained to handle asbestos. Mr. Fattrusso asserted that employees could not enter controlled asbestos areas unless they wore protective equipment to prevent exposure.

Appellant described his employment on the USS John F. Kennedy. He reported that, in January 2003, the employing establishment sent him to May Port, Jacksonville, Florida to work on the air craft carrier, the USS John F. Kennedy. Appellant and several other employees were assigned the task of tying services (hoses, air, water, etc.) to the overhead. While performing this task, he reported that he and his coworkers received a face full of dirt and dust. After reporting this incident to a supervisor, the area was condemned and tested by an environmental safety and health manager who found asbestos in the area.

[1] The record reflects that appellant filed for voluntary retirement on December 31, 2006.

Prior to working at employing establishment, appellant had been employed as a pipefitter where he was exposed to detergents and other chemicals. From 1988 through 2006 he worked at the employing establishment. When appellant first started, he was assigned to a test crew and his duties included hot acid flushing of machinery at the employing establishment. From 1991 through 2006 his federal employment duties required him to use a series of chemicals, including bleaches, degreasers and, in some cases, cadmium to test the type of metal he was working with. In the course of this employment experience, appellant alleged that he was exposed to chemical fumes and vapors. He asserted that, as a result of this exposure, he has lost his sense of smell, though he never filed a claim for this injury because he thought it was temporary. Furthermore, during part of appellant's employment at the employing establishment, in Building 875, he alleges that he was exposed to mercury fumes released from broken mercury switches.

Appellant also disclosed that from 1956 through 1967 he served in Viet-Nam and was exposed to Agent Orange herbicide.

On August 9, 2007 appellant reported that use of personal protective equipment did not become necessary after he was exposed because frequently it was days or weeks passed before he learned of the risks of toxic substances on the work site. He alleged that he was unaware of his lung condition until after his visit to the emergency room on June 22, 2007. Appellant stated that for the prior four or five years he experienced shortness of breath and fatigue, depending on the daily activities at work or home. He stated that, once he was diagnosed with lung disease, he knew his condition was the product of his many years of exposure to toxic chemicals at work.

Appellant submitted an environmental study concerning his asbestos exposure for the period August 1987 through December 2006, dated August 9, 2007. During this time period when he was employed as a pipefitter, Bernardo Perez of the Industrial Hygiene Branch, estimated his daily asbestos exposure was less than .1 fibers per cubic centimeter of air.

Appellant also submitted results from pulmonary function tests performed at intermittent periods between 1987 and 2001 and a series of medical reports from the EA Health Unit.

By report dated October 12, 1989, Dr. J.J. Morgan reported findings following a computerized tomography (CT) scan examination and diagnosed hilar congestion with minimal generalized pulmonary emphysema, suggesting allergic type bronchitis or bronchial asthma. He noted that clinical correlation was needed and that otherwise, appellant's chest was normal.

In a September 22, 1999 report, Dr. John Crowley, a Board-certified diagnostic radiologist, reported that comparison of the chest x-rays dated September 22, 1998 with those taken on March 27, 1987 revealed a mild bilateral apical pleural thickening. He noted that the examination was very stable and revealed no evidence of acute pleural cardiopulmonary disease.

In a March 5, 2001 report, Dr. Dianna Chooljian, a Board-certified diagnostic radiologist, reported findings following examination pertaining to cadmium surveillance. She noted that comparison of the x-rays taken February 27, 2001 with those taken September 22, 1998 revealed no evidence of acute cardiopulmonary disease.

The Office referred appellant, with a statement of accepted facts, for a second opinion examination by Dr. John Brottem, a Board-certified internist. Included in the statement of facts was a handwritten statement from appellant concerning his smoking history.

By report dated November 13, 2007, Dr. Brottem reported that appellant has an impairment, moderate in severity and obstructive in nature, with air trapping and concomitant reduction in diffuse capacity and specific diffuse capacity, consistent with smoking-related parenchymal loss and lung disease. He noted that appellant outlined his smoking history in the statement of accepted facts and opined that this was clinically significant. Dr. Brottem noted that he was a 40 to 50 pack smoker for years, though he alleged that he currently smoked less than half a pack a day. He opined that none of the changes in appellant's conditions were caused by exposure to asbestos or solvents. Dr. Brottem stated that this impairment was not associated with asbestos exposure because it was obstructive in nature and was not associated with clubbing of the lungs or significant crackles or nodularity commonly associated with pneumoconiosis. He noted that appellant could benefit from aggressive bronchodilator therapy. Dr. Brottem diagnosed obese, COPD and probable smoking-related interstitial lung disease best characterized as a bronchiolitis or smoker's lung bronchiolitis.

By decision dated December 14, 2007, the Office denied the claim because the evidence of record did not demonstrate that the claimed medical condition was related to established work-related events.

Appellant requested an oral hearing. The oral hearing was conducted on March 12, 2008 and appellant was present.

By report dated March 26, 2008, Dr. Michael McManus, Board-certified in occupational medicine, reviewed appellant's medical history. He noted that the chest x-rays dated June 25, 2007 revealed no diffuse prominence to the interstitial markings. Dr. McManus noted that these x-rays demonstrated no confluent consolidation or pleural effusion. Further, he noted that the CT scan of June 22, 2007 revealed peripheral diffuse increased reticular interstitial fine opacities were present with central lobular emphysema. Dr. McManus also noted that the June 22, 2007 CT scan did reveal several areas of enlarged lymph nodes. Based on his review of appellant's medical history and a physical examination, he diagnosed interstitial lung disease, possibly due to chronic hypersensitivity pneumonitis or humidifier lung by history (work related), centrilobular emphysema due to cigarette smoking and dermatitis of unknown etiology.

In an April 9, 2008 note, Dr. McManus asserted that appellant's diagnostic studies confirmed that he had tobacco-related centrilobular emphysema. He noted that the CT scans of appellant's chest revealed a significant component of restrictive disease. These findings, Dr. McManus opined, suggested an additional etiology for appellant's respiratory symptomatology. He opined that based on appellant's work history and workplace exposures, as well as evidence of interstitial lung disease, possibly granulomatous, he felt that there was a good probability that, in addition to his emphysema, appellant also had some work-related chronic hypersensitivity pneumonitis or humidifier lung.

By decision dated April 24, 2008, the hearing representative affirmed the Office's December 14, 2007 decision.

Appellant requested reconsideration and submitted a June 10, 2008 report from Dr. McManus who reported that a CT scan performed in May 2008 revealed centrilobular emphysema with air trapping. Dr. McManus noted that there was no evidence of asbestos-related disease. He observed a mild nonspecific septal thickening in the upper to mid lung fields and a scattered parenchymal density, which, he opined, likely reflected scarring. Dr. McManus diagnosed appellant with interstitial lung disease or humidifier lung work related and centrilobular emphysema nonwork related. In a subsequent medical report, dated July 11, 2008, he diagnosed appellant with interstitial lung disease and emphysema.

By decision dated July 29, 2008, the Office denied reconsideration of its December 14, 2007 decision.

Appellant disagreed and again requested reconsideration and submitted an August 13, 2008 note from Dr. McManus, who noted that he had been asked to clarify his opinion regarding his work-related pulmonary condition. Acknowledging that appellant had nonwork related severe centrilobular emphysema due to tobacco use, Dr. McManus asserted that his occupational exposure to sewage, sewage breakdown products, yeast and other chemical treatments applied to sewage and the steam cleaning of portable sewage tanks in the performance of duty produced a secondary occupational lung disease. He asserted that pulmonary function studies were consistent with a significant restrictive component of his lung disease and CT scans had confirmed an interstitial thickening and fibrosis. Dr. McManus opined that these findings supported the conclusion that appellant has chronic interstitial lung disease or humidifier lung due to his occupational exposures and work duties.

By decision dated September 25, 2008, the Office denied reconsideration.[2]

LEGAL PRECEDENT -- ISSUE 1

An employee seeking benefits under the Federal Employees' Compensation Act[3] has the burden of proof to establish the essential elements of his claim by the weight of the evidence,[4] including that he sustained an injury in the performance of duty and that any specific condition or disability for work for which he claims compensation is causally related to that employment injury.[5] As part of his burden, the employee must submit rationalized medical opinion evidence

[2] On appeal, appellant submitted additional medical evidence. The Board may not consider evidence for the first time on appeal which was not before the Office at the time it issued the final decision in the case. 20 C.F.R. § 501.2(c). *See J.T.*, 59 ECAB ___ (Docket No. 07-1898, issued January 7, 2008) (holding the Board's jurisdiction is limited to reviewing the evidence that was before the Office at the time of its final decision). As appellant's September 8, 2008 medical report was not part of the record when the Office issued either of its prior decisions, the Board may not consider it for the first time as part of appellant's appeal.

[3] 5 U.S.C. §§ 8101-8193.

[4] *J.P.*, 59 ECAB ___ (Docket No. 07-1159, issued November 15, 2007); *Joseph M. Whelan*, 20 ECAB 55, 58 (1968).

[5] *G.T.*, 59 ECAB ___ (Docket No. 07-1345, issued April 11, 2008); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

based on a complete factual and medical background showing causal relationship.[6] The weight of medical evidence is determined by its reliability, its probative value, its convincing quality, the care of the analysis manifested and the medical rationale expressed in support of the physician's opinion.[7]

To establish that an injury was sustained in the performance of duty in a claim for occupational disease, an employee must submit: (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.[8]

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion 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.[9]

ANALYSIS -- ISSUE 1

Appellant asserts that his diagnosed medical conditions were caused by his employment-related exposure to asbestos and chemicals. It is his burden to produce competent, relevant, probative medical evidence establishing that his diagnosed medical conditions are causally related to factors of his employment. The Board finds that appellant has not met his burden of proof establishing that he sustained any of these diagnosed medical conditions in the performance of duty because the evidence of record is insufficient to establish the requisite causal relationship between the diagnosed condition and factors of his employment.

The Office referred appellant, with a statement of accepted facts, for a second opinion examination by Dr. Brottem, a Board-certified internist.

By medical report dated November 13, 2007, Dr. Brottem reported that appellant has an impairment, moderate in severity and obstructive in nature, with air trapping and concomitant reduction in diffuse capacity and specific diffuse capacity, consistent with smoking-related parenchymal loss and lung disease. He noted that appellant outlined his smoking history in the statement of accepted facts and opined that this was clinically significant. Dr. Brottem noted that

[6] *Nancy G. O'Meara*, 12 ECAB 67, 71 (1960).

[7] *Jennifer Atkerson,* 55 ECAB 317, 319 (2004); *Naomi A. Lilly*, 10 ECAB 560, 573 (1959).

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

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

he was a smoker for 40 to 50 years, though he alleged that he currently smoked less than half a pack a day.

Dr. Brottem opined that none of the changes in appellant's medical conditions were caused by exposure to asbestos or solvents. He stated that appellant's impairment was not associated with asbestos exposure because it was obstructive in nature and was not associated with other asbestos exposure stigmata such as clubbing of the lungs or significant crackles or nodularity commonly associated with pneumoconiosis. Dr. Brottem diagnosed obesity COPD and probable smoking-related interstitial lung disease best characterized as a bronchiolitis or smoker's lung bronchiolitis. His report clearly describes his condition and then continues to negate asbestos association, rather than asserting that it was caused by smoking by reasoning that it is obstructive in nature and not associated with clubbing of the lungs or significant crackles or nodularity commonly associated with pneumoconiosis. The Board finds that Dr. Brottem's report is well reasoned and therefore constitutes the weight of the medical evidence.

The medical evidence of record, consisting of medical reports from Drs. Smith, Lomotan, Pryde, Morgan, Bartow, Chooljian and Crowley, is not sufficient. While all seven physicians reported findings following examination and proffered diagnoses based on their findings, none of them proffered a medically reasoned opinion concerning the causal relationship between factors of appellant's federal employment and their respective diagnosed conditions. The Board has held that medical reports and notes lacking a medical rational on causal relationship are of little probative value.[10] As none of these physicians opined as to how appellant's federal employment caused or aggravated the conditions they diagnosed, their opinions are of diminished probative value and are insufficient to create a conflict with Dr. Brottem's opinion.

LEGAL PRECENDENT -- ISSUE 2

To require the Office to reopen a case for merit review under section 8128(a) of the Act,[11] the Office's regulations provide that the evidence or argument submitted by a claimant must: (1) show that the Office erroneously applied or interpreted a specific point of law; (2) advance a relevant legal argument not previously considered by the Office; or (3) constitute relevant and pertinent new evidence not previously considered by the Office.[12] To be entitled to a merit review of an Office decision, denying or terminating a benefit, a claimant also must file his or her application for review within one year of the date of that decision.[13] When a claimant

[10] *See Mary E. Marshall*, 56 ECAB 420 (2005) (medical reports that do not contain rationale on causal relationship have little probative value). *See also*, *Franklin D. Haislah*, 52 ECAB 457 (2001); *Jimmie H. Duckett*, 52 ECAB 332 (2001).

[11] 5 U.S.C. §§ 8101-8193. Under section 8128 of the Act, "[t]he Secretary of Labor may review an award for or against payment of compensation at any time on her own motion or on application." 5 U.S.C. § 8128(a).

[12] 20 C.F.R. § 10.606(b)(2).

[13] *Id*. at § 10.607(a).

fails to meet one of the above standards, the Office will deny the application for reconsideration without reopening the case for review on the merits.[14]

The Board has held that the submission of evidence or argument which repeats or duplicates evidence or argument already in the case record[15] and the submission of evidence or argument which does not address the particular issue involved does not constitute a basis for reopening a case.[16] While a reopening of a case may be predicated solely on a legal premise not previously considered, such reopening is not required where the legal contention does not have a reasonable color of validity.[17]

ANALYSIS -- ISSUE 2

The Office is required to reopen a case for merit review if an application for reconsideration or an appellant demonstrates that the Office erroneously applied a specific point of law, presents a new relevant legal argument or puts forth relevant and pertinent new evidence. Appellant did not argue that the Office erroneously applied a point of law, nor did he advance a new legal argument not previously considered by the Office. Therefore, he was not eligible or entitled to a merit review based upon the first two enumerated grounds noted above.

Concerning the third requirement, submission of relevant and pertinent new evidence not previously considered by the Office, appellant submitted medical reports, dated June 10 and July 11, 2008 and a copy of his July 15, 2008 personal statement. This evidence was already of record and, therefore, furnishes no grounds for the Office to reopen his claim for merit review. Evidence that duplicates evidence already in the case record has no evidentiary value and does not constitute a basis for reopening a case.[18]

Dr. McManus' August 13, 2008 medical report, however, is new evidence not previously considered by the Office. Acknowledging that appellant had nonwork-related severe centrilobular emphysema due to tobacco use, Dr. McManus noted that he had been asked to clarify his previous opinion regarding the cause of appellant's diagnosed conditions. Dr. McManus asserted that appellant's occupational exposure to sewage, sewage breakdown products, yeast and other chemical treatments applied to sewage and the steam cleaning of portable sewage tanks in the performance of duty produced a secondary occupational lung disease. Relying on the new diagnostic CT scan studies he had obtained since the Office's last merit review of the case, he asserted that pulmonary function studies were consistent with a significant restrictive component of his lung disease and CT scans had confirmed an interstitial

[14] *Id.* at § 10.608(b).

[15] *D.I.*, 59 ECAB ___ (Docket No. 07-1534, issued November 6, 2007); *Eugene F. Butler*, 36 ECAB 393, 398 (1984).

[16] *D.K.*, 59 ECAB ___ (Docket No. 07-1441, issued October 22, 2007); *Edward Matthew Diekemper*, 31 ECAB 224, 225 (1979).

[17] *M.E.*, 58 ECAB ___ (Docket No. 07-1189, issued September 20, 2007); *John F. Critz*, 44 ECAB 788, 794 (1993).

[18] *James W. Scott*, 55 ECAB 606 (2004).

thickening and fibrosis. Dr. McManus opined that these findings supported the conclusion that appellant had chronic interstitial lung disease or humidifier lung due to his occupational exposures and work duties.

The requirements for reopening a claim for merit review do not include the requirement that a claimant submit all evidence which may be necessary to discharge his burden of proof. The requirements pertaining to the submission of evidence in support of reconsideration only specify that the evidence be relevant and pertinent and not previously considered by the Office. If the Office should determine that new evidence lacks substantive probative value, it may deny modification of the prior decision, but only after the case has been reviewed on the merits.[19]

The Board finds that the Office improperly refused to reopen appellant's case for further review of the merits of his claim.

CONCLUSION

The Board finds that appellant has not met his burden to establish that he sustained an injury in the performance of duty causally related to his federal employment. The Board also finds that the Office improperly denied further merit review.

ORDER

IT IS HEREBY ORDERED THAT the April 24, 2008 and December 14, 2007 decisions of the Office of Workers' Compensation Programs are affirmed and the September 25, 2008 decision is set aside and the case remanded for further review consistent with this decision.

Issued: August 24, 2009
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

[19] *Donald T. Pippin*, 54 ECAB 631 (2003).