United States Department of Labor
Employees' Compensation Appeals Board

G.W., Appellant	)	
and	)	**Docket No. 10-2194**
	)	**Issued: August 23, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Waltham, MA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On August 24, 2010 appellant filed a timely appeal from the March 29, 2010 merit decision of the Office of Workers' Compensation Programs (OWCP) terminating his compensation benefits. Pursuant to the Federal Employees' Compensation Act (FECA)[1] and 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 OWCP properly terminated appellant's compensation benefits effective April 11, 2010 on the grounds his work-related injury ceased without residuals.

FACTUAL HISTORY

On March 22, 2005 appellant, then a 53-year-old supervisor customer services, filed an occupational disease claim for compensation (Form CA-2) alleging that he was exposed to asbestos around 1996 to 1997 during the demolition of a postal building in Waltham, MA. On

[1] 5 U.S.C. §§ 8101-8193.

December 6, 2006 OWCP accepted the claim for asbestosis. Appellant stopped work on June 14, 2006 and did not return. He received medical and wage-loss compensation benefits.

On June 30, 2008 Dr. Christopher H. Fanta, a Board-certified pulmonary disease specialist, stated that appellant had employment-related emphysema and asbestos pleural plaques and that he could not work due to breathlessness on light exertion. He stated that appellant had emphysema with severe airflow obstruction causing dyspnea on light exertion. Dr. Fanta noted that appellant had asbestos exposure with asbestos-related pleural plaques visible on chest computerized tomography (CT) scans. He submitted additional treatment records.

In a December 9, 2008 report, Dr. Thomas A. Morris, III, a Board-certified pulmonary disease specialist and OWCP referral physician, evaluated appellant's pulmonary condition. He reviewed the statement of accepted facts, appellant's medical record, performed a pulmonary function study and set forth findings on examination. Dr. Morris stated that appellant had two pulmonary conditions -- chronic obstructive pulmonary disease with emphysematous and mild asthmatic components and asbestos-related pleural thickening. He opined it was highly unlikely that appellant's employment precipitated his chronic obstructive pulmonary disease; rather, this was more likely caused by his heavy cigarette smoking history and was manifested symptomatically by his exertional shortness of breath. Dr. Morris opined that appellant's asbestos-related pleural disease may have been caused by his exposure to asbestos more than 20 years earlier, but indicated that this would not cause any disability. He stated that appellant's clinical symptoms and pulmonary function testing were secondary to his chronic obstructive pulmonary disease. Dr. Morris noted that appellant's employment-related asbestos pleural plaquing did not disable him from employment; rather, the chronic obstructive pulmonary disease, which was not employment related, disabled him. On the accompanying work capacity evaluation form, he opined that appellant was able to work four hours a day.

OWCP determined a conflict in medical opinion arose between Dr. Morris and Dr. Fanta on the issue of whether appellant continued to have disability or residuals of the employment injury and his work capacity. Appellant was referred, together with a statement of accepted facts, a list of questions and the medical record, to Dr. Ioana R. Preston, a Board-certified pulmonary disease specialist, for an impartial medical evaluation.

In an October 1, 2009 report, Dr. Preston noted the history of injury, reviewed appellant's medical records and set forth findings on examination. Appellant had current symptoms of dyspnea on exertion with everyday activity. Dr. Preston stated that a 2009 CT scan revealed moderate emphysematous changes mostly in the upper lung fields. Appellant had mild pleural thickening primarily in the posterior and lower lung fields with some calcification. There was a collapse of the lower part of the trachea and main bronchi suggestive of tracheobronchomalacia. Dr. Preston found obstructive airway disease and emphysema, with moderate obstruction and severe gas exchange abnormality, caused by long-standing tobacco use. She stated that, while appellant had pleural plaques, a marker of prior asbestos exposure, there was no evidence of asbestosis. Dr. Preston advised that his plural plaques were most likely secondary to exposure to asbestos at work but noted that, as it usually took 20 years from the time of asbestos exposure to the time plaques were diagnosed, she considered that the responsible exposure occurred in his early years of work. She stated that tracheobronchomalacia was usually of unknown cause or associated with gastroesophageal reflux disease and was not known to be associated with

asbestos exposure. Dr. Preston advised that pulmonary testing and x-ray results did not support a diagnosis of asbestosis, as there was no evidence of restrictive ventilator impairment or interstitial lung disease. Appellant's symptoms of dyspnea on exertion and his limitations in his daily activities were caused by the combination of obstructive lung disease and tracheobronchomalacia. Dr. Preston stated that the pleural plaques did not contribute to his respiratory limitation or render him disabled. Appellant's limitations and disability were due to his obstructive lung disease and tracheobronchomalacia. Dr. Preston noted that, while pleural plagues did not previously require treatment, he was at high risk for lung cancer, due to tobacco and asbestos exposure. She recommended regular CT scans of the chest. On the accompanying work capacity evaluation form, she stated that appellant could only work two hours with limitations due to his emphysema and tracheobronchomalacia.

On January 26, 2010 OWCP advised appellant that it proposed to terminate his wage-loss compensation and medical benefits as the weight of the medical evidence established that he no longer had any disability or residuals due to the accepted work-related condition. Special weight was accorded to the opinion of Dr. Preston, the impartial medical specialist. Appellant was accorded 30 days to submit additional evidence and argument.

In a February 18, 2010 statement, appellant advised his disability from the employing establishment had been accepted in September 2009. In a February 19, 2010 statement, he described his injury and his current condition. Appellant contended that his symptoms continued to deteriorate and that he had filed a claim that his asbestos exposure had exacerbated his lung condition.

OWCP received chest CT scans and a July 2, 2009 report from Dr. Craig P. Hersh, a Board-certified pulmonologist, previously of record. Dr. Hersh noted the results of appellant's chest CT scan and pulmonary function testing. No opinion was offered on any of appellant's conditions except the pleural plaquing, which was noted to likely be related to prior asbestos exposure.

OWCP also received a December 1, 2009 progress report and a May 11, 2009 work capacity evaluation form from Dr. Fanta, who noted the status of appellant's chronic obstructive pulmonary disease and asbestos-related pleural plaques on CT scan imaging. Dr. Fanta opined that appellant's breathlessness on light exertion made regular work impossible.

On February 26, 2010 OWCP referred the case file to Dr. Preston to review the additional evidence and clarify her previous answers. In a March 22, 2010 supplemental report, Dr. Preston reviewed the December 1, 2010 CT scan and stated that it did not describe signs of asbestos. She noted there were signs of prior asbestos exposure, such as calcified pleural plaques and focal pleural thickening. Dr. Preston reiterated that appellant did not currently have asbestosis and she did not require further treatment at the time for the scattered pleural plaques or pleural thickening.

By decision dated March 29, 2010, OWCP terminated appellant's compensation benefits effective April 11, 2010. Special weight was accorded to Dr. Preston's impartial medical opinion.

LEGAL PRECEDENT

Once OWCP has accepted a claim and pays compensation, it bears the burden to justify modification or termination of benefits.[2] Having determined that an employee has a disability causally related to his or her federal employment, OWCP may not terminate compensation without establishing either that the disability has ceased or that it is no longer related to the employment.[3]

The right to medical benefits for an accepted condition is not limited to the period of entitlement for disability compensation.[4] To terminate authorization for medical treatment, OWCP must establish that appellant no longer has residuals of an employment-related condition, which require further medical treatment.[5]

Section 8123(a) of FECA provides in pertinent part: 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.[6] 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.[7]

ANALYSIS

The Board notes that a conflict in medical opinion evidence arose between appellant's treating physician, Dr. Fanta, and an OWCP referral physician, Dr. Morris, as to whether appellant had any disability or residuals causally related to his accepted asbestosis condition. Dr. Fanta noted that appellant had emphysema with severe flow obstruction and asbestos-related pleural plaques and that he could not work because of breathlessness on light exertion. Dr. Morris stated that appellant's clinical symptoms and pulmonary function testing were secondary to his chronic obstructive lung disease. He opined that appellant's asbestos-related pleural plaquing did not disable him from his employment, but rather, his nonemployment-related chronic obstructive pulmonary disease might be disabling. Dr. Morris further opined that appellant was able to work four hours a day. OWCP properly referred appellant to Dr. Preston for an impartial medical examination.[8]

---

[2] *Bernadine P. Taylor*, 54 ECAB 342 (2003).

[3] *Id.*

[4] *Roger G. Payne*, 55 ECAB 535 (2004).

[5] *Pamela K. Guesford*, 53 ECAB 726 (2002).

[6] 5 U.S.C. § 8123(a).

[7] *Jack R. Smith*, 41 ECAB 691, 701 (1990); *James P. Roberts*, 31 ECAB 1010, 1021 (1980).

[8] *See Geraldine Foster*, 54 ECAB 435 (2003).

In an October 1, 2009 report, Dr. Preston advised appellant had obstructive airway disease and emphysema, with moderate obstruction and severe gas exchange abnormality, which was caused by long-standing tobacco use. She noted that while he had pleural plaques, a marker of prior asbestos exposure, there was no evidence of asbestosis either on pulmonary testing or x-ray. Dr. Preston opined that appellant's limitations and disability were caused by his obstructive lung disease and tracheobronchomalacia. She noted that tracheobronchomalacia was not associated with asbestos exposure. Dr. Preston stated that the pleural plaques did not contribute to appellant's respiratory limitation or make him disabled. In her March 22, 2010 supplemental report, Dr. Preston opined that appellant did not currently have asbestosis but noted the signs of prior asbestos exposure in the calcified pleural plaques and focal pleural thickening.

Dr. Preston's reports are based on a thorough history of appellant's condition, a statement of accepted facts, a review of the medical evidence and diagnostic studies. She opined that while there were signs of prior asbestos exposure, such as calcified pleural plaques and focal pleural thickening, appellant did not currently suffer from asbestosis. Dr. Preston opined that his limitations and disability were caused by his obstructive lung disease and tracheobronchomalacia. Her opinion is probative, rationalized and based upon a proper factual background. Therefore, OWCP properly accorded Dr. Preston's opinion the special weight of an impartial medical examiner in finding that appellant had no work-related disability.[9]

The Board finds that OWCP properly relied upon Dr. Preston's impartial opinion in terminating appellant's right to wage-loss compensation benefits. Furthermore, none of the medical evidence contemporaneous with OWCP's termination found disability due to the accepted condition. Several reports were received from Dr. Fanta, most previously of record. As noted, Dr. Fanta's opinion gave rise to the conflict in medical opinion. His subsequent reports provide an impression of chronic obstructive pulmonary disease and note chest x-rays show pleural plaques. They also indicated that appellant was unable to work because of breathlessness on light exertion. These reports, however, are insufficient because Dr. Fanta provided no further opinion on causation. This reduces the probative value of Dr. Fanta's report.[10] Additionally, as he was on one side of the conflict resolved by Dr. Preston and he did not present new findings or rationale to support his opinion, his latter reports do not overcome or create a new conflict with Dr. Preston's impartial medical opinion that the work-related conditions had resolved and no further treatment was necessary.[11]

While Dr. Hersh noted in his July 2, 2009 medical report that appellant's pleural plaques were likely related to prior asbestos exposure, he did not specifically relate any disability to appellant's employment. Thus, his opinion is of limited probative value. Furthermore, reports of

[9] *Gary R. Seiber*, 46 ECAB 215 (1994).

[10] *See J.F.*, Docket No. 09-1061 (issued November 17, 2009) (medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship).

[11] *See Kathryn E. Demarsh*, 56 ECAB 677 (2005); *Jaja K. Asaramo*, 55 ECAB 200 (2004) (submitting a report from a physician who was on one side of a medical conflict that an impartial specialist resolved is generally insufficient to overcome the weight accorded to the report of the impartial medical examiner or to create a new conflict).

diagnostic testing are insufficient to support work-related disability as these reports provide no physician's opinion on the cause of appellant's disability.

The Board finds that OWCP has not met its burden to terminate appellant's medical benefits as it relates to his calcified pleural plaques and pleural thickening. Exposure to asbestos dust generally results in permanent and irreversible changes in the pulmonary system, which may or may not result in a disabling employment-related condition.[12] In this case, the opinion of Dr. Preston establishes that appellant does not have a disabling employment-related condition, but she found the calcified pleural plaques and focal pleural thickening was evidence of asbestos-related residuals. In an October 1, 2009 report, she recommended regular chest CT scans. Although, in Dr. Preston's March 22, 2009 supplemental report, she noted that appellant's work-related condition did not require treatment at that time, she did not state that there would never be a need for treatment of work-related residuals. The Board notes that OWCP procedures state that when appellant has x-ray evidence of asbestos-related disease, but no disability for work, a claimant is entitled to yearly medical examinations.[13] As the medical evidence shows that appellant has a continuing employment-related condition, he will remain entitled to appropriate medical benefits. Thus, the Board will reverse the termination of appellant's medical benefits as it pertains to the asbestos-related residuals.

CONCLUSION

The Board finds that OWCP met its burden of proof to terminate appellant's wage-loss benefits effective April 11, 2010. However, the decision is reversed with regards to OWCP's termination of medical benefits for his accepted asbestos-related conditions.

[12] *James L. Hearn*, 29 ECAB 278 (1977); *see Dennis L. O'Neill*, 29 ECAB 151 (1977).

[13] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Automated System Support for Case Actions*, Chapter 2.401.8.8(c)(2)(a) (September 2009).

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs decision dated March 29, 2010 is affirmed in part and reversed in part.

Issued: August 23, 2011
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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