

On appeal, counsel asserts that OWCP erred by failing to accept the diagnosis of pneumoconiosis or that appellant sustained pneumoconiosis in the performance of duty. He also contends that OWCP wrongly accorded the weight of the medical evidence to a second opinion physician and not appellant's attending physicians.

FACTUAL HISTORY

On February 18, 2010 appellant, then a 60-year-old retired coal mine inspector, filed a notice of occupational disease (Form CA-2) claiming that he sustained a respiratory disease on or before June 22, 2005, the last date he was exposed to coal and rock dust at work. He retired from the employing establishment on June 30, 2005. In an associated statement, appellant explained that from 1978 to March 15, 2005, he was exposed to coal, rock and silica dust for four to six hours a day, four days a week. He noted that, after smoking one pack of cigarettes a day for many years, he quit in 2007.

In a March 8, 2010 letter, the employing establishment stated that from March 23, 1990 through March 15, 2005, appellant underwent mandatory periodic fitness-for-duty examinations performed by employing establishment physicians. March 23, 1990, May 4, 1992 and May 12, 1993 examinations showed moderate obstructive dysfunction. A March 15, 2005 x-ray showed I/O interstitial changes. On May 26, 2005 Dr. Barbara Connors, an employing establishment physician, diagnosed Stage I pneumoconiosis based on the March 15, 2005 x-ray and chronic obstructive pulmonary disease (COPD) consistent with appellant's cigarette smoking history.

January 13, 2010 x-rays showed small round opacities in the upper lung zones bilaterally suggestive of pneumoconiosis, category Q 0/1. A January 18, 2010 pulmonary function test showed airway resistance at 217 percent of predicted value, moderate restrictive infiltrate and reduced forced vital capacity (FVC).

In a February 5, 2010 report, Dr. Thomas D. Brinegar, an attending osteopathic physician Board-certified in family practice, diagnosed coal workers' pneumoconiosis and COPD. He opined that the pneumoconiosis was causally related to appellant's federal employment as a coal mine inspector.

In a March 25, 2010 letter, OWCP advised appellant of the additional evidence needed to establish his claim. Appellant was afforded 30 days to submit such evidence.

In a March 30, 2010 letter, the employing establishment confirmed that appellant was exposed to coal, rock and silica dusts for four to six hours a day, three to four days a week. Appellant explained in an April 1, 2010 letter that, although he was issued a respirator, he did not wear it frequently as it was too bulky to fit into the confined spaces he needed to inspect.

On August 17, 2010 OWCP obtained a second opinion from Dr. Charles E. Porterfield, a Board-certified pulmonologist, who reviewed the medical record and a statement of accepted facts provided by OWCP. Dr. Porterfield's performed pulmonary function testing showing a FVC of 60 percent of predicted value on room air, increased to 77 percent after using a bronchodilator. He stated that a B-reading of an unspecified x-ray was negative for coal workers' pneumoconiosis or silicosis. Dr. Porterfield opined that exposure to coal and silica

dusts could aggravate appellant's COPD. An August 17, 2010 x-ray interpreted by Dr. Manu Patel, a Board-certified diagnostic radiologist, demonstrated "classifiable pneumoconiosis."

By decision dated November 3, 2010, OWCP denied appellant's claim on the grounds that causal relationship was not established, based on Dr. Porterfield's opinion as the weight of the medical evidence.

In a November 22, 2010 letter, appellant requested an oral hearing, held by videoconference on March 16, 2011. Following the hearing, the employing establishment submitted a March 29, 2011 letter acknowledging that the respirator appellant used was bulky, but that a smaller half-mask respirator would not have provided adequate protection.

Appellant submitted January 25 and April 7, 2011 reports from Dr. Brinegar noting that appellant had a long history of COPD and coal workers' pneumoconiosis. He opined that appellant's chest x-rays showed findings consistent with pneumoconiosis, and that the low percentage of improvement on pulmonary function testing after using a bronchodilator demonstrated that appellant's shortness of breath was not due to COPD.

By decision dated and finalized May 3, 2011, an OWCP hearing representative set aside OWCP's November 3, 2010 decision and remanded the case to obtain a supplemental opinion from Dr. Porterfield, explaining why he opined that appellant's chest x-rays did not support a diagnosis of pneumoconiosis. Dr. Porterfield responded on June 13, 2011, stating that the findings noted on appellant's March 15, 2005 x-ray were insufficient to justify a diagnosis of pneumoconiosis.

By decision dated July 26, 2011, OWCP denied appellant's claim on the grounds that the medical evidence did not establish a causal relationship between the identified work factors and the claimed respiratory condition. It accorded the weight of the medical evidence to Dr. Porterfield.

In a March 30, 2012 letter, appellant requested reconsideration. He submitted a February 16, 2012 x-ray report from Dr. Thomas Miller, an attending Board-certified diagnostic radiologist and B-reader, opining that a February 16, 2012 chest x-ray showed primary and secondary opacities throughout all lobes of both lungs. Dr. Miller noted 1/1 profusion and International Labor Organization (ILO) profusion of I/0. He opined that the diffuse small opacities demonstrable on x-ray were compatible with a diagnosis of pneumoconiosis.

By decision dated June 14, 2012, OWCP denied reconsideration on the grounds that appellant did not submit new, relevant evidence. It found that Dr. Miller's reports were irrelevant to the critical issue of causal relationship.

In a July 24, 2012 letter, appellant requested reconsideration. He submitted a July 13, 2012 report from Dr. Brinegar, opining that opacities visible on chest x-rays substantiated a diagnosis of pneumoconiosis. Dr. Brinegar noted that the lack of improvement in forced vital capacity after using a bronchodilator indicated that appellant's respiratory symptoms were not due to COPD.

By decision dated December 18, 2012, OWCP denied appellant's July 24, 2012 request for reconsideration on the grounds that his request did not raise substantive legal questions or include new, relevant evidence. It found that Dr. Brinegar's July 13, 2012 report was cumulative as it was highly similar to his January 25 and April 7, 2011 reports already of record.

LEGAL PRECEDENT

To require OWCP to reopen a case for merit review under section 8128(a) of FECA,² section 10.606(b)(2) of Title 20 of the Code of Federal Regulations provide that a claimant must: (1) show that OWCP erroneously applied or interpreted a specific point of law; (2) advance a relevant legal argument not previously considered by OWCP; or (3) constitute relevant and pertinent new evidence not previously considered by OWCP.³ Section 10.608(b) provides that when an application for review of the merits of a claim does not meet at least one of the three requirements enumerated under section 10.606(b)(2), OWCP will deny the application for reconsideration without reopening the case for a review on the merits.⁴

In support of a request for reconsideration, an appellant is not required to submit all evidence which may be necessary to discharge his or her burden of proof.⁵ Appellant need only submit relevant, pertinent evidence not previously considered by OWCP.⁶ When reviewing an OWCP decision denying a merit review, the function of the Board is to determine whether OWCP properly applied the standards set forth at section 10.606(b)(2) to the claimant's application for reconsideration and any evidence submitted in support thereof.⁷

ANALYSIS

The issue presented on appeal is whether appellant met any of the requirements of 20 C.F.R. § 10.606(b)(2), requiring OWCP to reopen the case for review of the merits of the claim. OWCP issued a July 26, 2011 decision finding that appellant did not establish that he sustained pneumoconiosis or silicosis in the performance of duty. Appellant requested reconsideration on March 30, 2012, asserting that a February 16, 2012 diagnosis of pneumoconiosis by Dr. Miller, an attending Board-certified diagnostic radiologist and B-reader, was sufficient to establish causal relationship. OWCP denied reconsideration by decision dated June 14, 2012, finding that as Dr. Miller did not provide medical rationale addressing the critical issue of causal relationship, his reports were irrelevant to the claim. Appellant requested reconsideration on July 24, 2012. He provided a July 13, 2012 report from Dr. Brinegar, an attending osteopathic physician Board-certified in family practice, opining that opacities visible on chest x-rays and a lack of improvement in FVC after using a bronchodilator were both indicative of pneumoconiosis.

² 5 U.S.C. § 8128(a).

³ 20 C.F.R. § 10.606(b)(2).

⁴ *Id.* at § 10.608(b). *See also D.E.*, 59 ECAB 438 (2008).

⁵ *Helen E. Tschantz*, 39 ECAB 1382 (1988).

⁶ *See* 20 C.F.R. § 10.606(b)(3). *See also Mark H. Dever*, 53 ECAB 710 (2002).

⁷ *Annette Louise*, 54 ECAB 783 (2003).

OWCP denied reconsideration by December 18, 2012 decision, finding that Dr. Brinegar's July 13, 2012 was cumulative of his opinions previously of record.

As noted above, the Board does not have jurisdiction over the July 26, 2011 OWCP merit decision. In his July 24, 2012 application for reconsideration, appellant did not show that OWCP erroneously applied or interpreted a specific point of law. He did not identify a specific point of law or show that it was erroneously applied or interpreted. Appellant did not advance a new and relevant legal argument. He submitted a July 13, 2012 report from Dr. Brinegar, reiterating opinions presented in his January 25 and April 7, 2011 reports already of record. However, evidence which is duplicative or cumulative in nature is insufficient to warrant reopening a claim for merit review.⁸ A claimant may be entitled to a merit review by submitting new and relevant evidence, but appellant did not submit any new and relevant medical evidence in this case.

The Board accordingly finds that appellant did not meet any of the requirements of 20 C.F.R. § 10.606(b)(2). He did not show that OWCP erroneously applied or interpreted a specific point of law, advance a relevant legal argument not previously considered by OWCP, or submit relevant and pertinent evidence not previously considered. Pursuant to 20 C.F.R. § 10.608, OWCP properly denied merit review.

On appeal, counsel asserts that OWCP erred by failing to accept the diagnosis of pneumoconiosis or that appellant sustained pneumoconiosis in the performance of duty. Counsel also contends that OWCP wrongly accorded the weight of the medical evidence to a second opinion physician and not appellant's attending physicians. These arguments concern the merits of the claim, regarding whether appellant established that he sustained pneumoconiosis or another respiratory condition in the performance of duty. As stated, the Board does not have jurisdiction over the merits of the claim on the present appeal. Therefore, the Board cannot address counsel's arguments.

⁸ *Denis M. Dupor*, 51 ECAB 482 (2000).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated December 18, 2012 is affirmed.

Issued: August 28, 2013
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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