United States Department of Labor
Employees' Compensation Appeals Board

D.C., Appellant	)	
and	)	**Docket No. 14-1198**
	)	**Issued: December 1, 2015**
TENNESSEE VALLEY AUTHORITY, PARADISE FOSSIL 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:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On April 29, 2014 appellant, through counsel, filed a timely appeal of an April 2, 2014 Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of the case.

ISSUE

The issue is whether appellant has met his burden of proof to establish a pulmonary condition due to factors of his federal employment.

On appeal counsel argues that the reports of Dr. Glen Baker, a Board-certified pulmonologist and "B" reader is entitled to the weight of the medical evidence.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On July 12, 2012 appellant, then a 55-year-old laborer, filed an occupational disease claim (Form CA-2) alleging that he developed occupational pneumoconiosis with pulmonary asbestosis and chronic bronchitis due to exposures at the employing establishment. He stated that he first became aware of his condition on December 8, 2011 and first attributed his condition to his employment on that date. The employing establishment stated that appellant was last exposed to the conditions to which he attributed his disease on July 9, 2004.

In a letter dated August 3, 2012, OWCP requested additional factual and medical evidence in support of appellant's claim. Dr. Baker examined appellant's chest film on November 29, 2011 and diagnosed parenchymal abnormalities consistent with pneumoconiosis including small opacities, but no pleural abnormalities. He further found postoperative changes.

In a report dated January 17, 2012, Dr. Assedu A. Kalik, a Board-certified internist, examined appellant and diagnosed chronic obstructive pulmonary disease (COPD). He noted that appellant was a smoker. Appellant refused to stop smoking and reported an occasional cough, and wheezing as well as shortness of breath with moderate exertion. On physical examination he demonstrated diminished intensity of breath sounds bilaterally.

Dr. Baker completed a report on June 25, 2012 and listed appellant's intermittent employment with the employing establishment from 1978 to 2004 for a total of 18 years. He stated that appellant was exposed to both asbestos and coal dust through 2004. Dr. Baker also reported appellant's employment in a furniture factory for one year, a granary for four years and in the military for two years. He reported appellant's 39-year history of smoking at the rate of one to one and one half packs a day.

Dr. Baker indicated that appellant had experienced shortness of breath for 12 to 13 years with daily cough, sputum production and wheezing. Appellant utilized oxygen for sleeping and continued to experience shortness of breath at night even with the oxygen. His lungs were clear to auscultation and percussion. Dr. Baker found that appellant's chest x-ray of November 17, 2011 was consistent with occupational pneumoconiosis category 1/1 and exhibited irregular opacities suggesting pulmonary asbestosis. Appellant's pulmonary function studies were within normal limits. Dr. Baker diagnosed occupational pneumoconiosis with pulmonary asbestosis, chronic bronchitis, history of ischemic heart disease, hyperlipidemia, essential hypertension, hearing loss, and colon disease. He stated, "[Appellant] had exposure off and on for 18 years to asbestos fibers as well as coal dust. He has x-ray changes consistent with pulmonary asbestosis…. Appellant's bronchitis and occupational pneumoconiosis are caused by his exposure to asbestos and other dusts, odors, and fumes he was exposed to during his employment. His cigarette smoking history has contributed as well." Dr. Baker concluded that appellant had ratable impairment even though his pulmonary function studies were within normal limits as he had shortness of breath with continuous treatment and symptoms of chronic bronchitis. He found that appellant had class 1 E impairment of 10 percent as he continued to have symptoms despite maximum medication.

Appellant submitted a narrative statement noting that he began working at the employing establishment in 1978 as a laborer. He worked there intermittently from 1978 to 1982, from

1988 to 1992, and then became a regular employee from 2000 to 2004. Appellant stated that he was exposed to coal dust on a daily basis including coal dust in the air as well as settled coal dust on equipment and clothing. He reported that he was exposed to asbestos when steam lines blew and when he was required to tear asbestos off boilers and bag it. Appellant stated that he loaded trucks with a loader and that dust blew back into his face. He reported exposure to flue gas. Appellant worked five days a week eight hours a day and wore a paper mask for protection. He stated that he had experienced shortness of breath for 12 to 13 years with a productive cough and had smoked cigarettes for 39 years at the rate of one to one and one half packs a day.

The employing establishment's industrial hygienist provided a work history of exposure and stated that appellant was employed for a total of nine years as a laborer. He stated that exposures to asbestos and coal dust for laborers in general during appellant's employment periods were below the relevant permissible exposure limits of the time. The employing establishment's industrial hygienist stated that insulation could only be removed by trained personnel with proper personal protective equipment. He further noted that paper masks were not recognized as an acceptable form of respiratory protection and that there was a very strong respiratory protection program for workers exposed to airborne hazards including ongoing industrial hygiene assessments for work areas and engineering controls.

OWCP referred appellant for a second opinion examination, with Dr. Harold Dale Haller, Jr., a Board-certified pulmonologist, along with a prepared statement of accepted facts, and appellant's statement that he was exposed to coal dust, asbestos, and dust at the employing establishment as well as exposure to grain dust and a 39-year-smoking history. It also provided specific questions to Dr. Haller.

In a report dated December 17, 2012, Dr. Haller requested a computerized tomography (CT) scan, but appellant refused to undergo the testing. He noted appellant's employment exposures and continues positive airway pressure usage at night. Dr. Haller diagnosed mild COPD with bronchodilator responsiveness. He opined that cigarette smoking was responsible for most of the obstruction. Dr. Haller noted that significant dust exposure, when combined with cigarette smoke, could accelerate the rate of development of obstruction. He stated that he was not impressed with the chest radiograph regarding evidence for asbestosis as appellant's lung functions showed no evidence of restrictive process. Dr. Haller recommended a high resolution CT scan to resolve the issue of asbestosis.

In a letter dated December 17, 2012, OWCP notified appellant that his refusal to undergo the requested CT scan could result in a suspension of his eligibility for compensation benefits. Appellant underwent the CT scan on February 1, 2013 which demonstrated bi-apical fibrotic scarring and multiple sub pleural blebs and noncalcified nodular density in the left apex as well as sub pleural scarring in the right upper lobe. His right upper lobe demonstrated nodular appearing interstitial scarring and no calcified pleural plaques. Dr. Haller reviewed this report on February 8, 2013 and found that the bi-apical bullous disease was consistent with emphysema from appellant's smoking history. He stated that the fibrotic scarring was probably related to emphysema as well although there were some areas of scarring noted in other lung regions. Dr. Haller opined, "These changes certainly are not classic for asbestosis or pneumoconiosis. I think the chest CT [scan] supports the diagnosis of COPD and does not support a diagnosis of

pneumoconiosis." He noted that appellant exhibited noncalcified nodular densities that should be examined in six months to rule out malignancy.

OWCP's medical adviser reviewed the record on February 28, 2013 and found that appellant's diagnosed condition was COPD, mild, due primarily to cigarette smoking. He stated, "Although [appellant's] industrial exposure may have contributed to his COPD, his main contributing factor is his smoking." The medical adviser found that appellant had no permanent impairment under the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[2] (A.M.A., *Guides*).

On April 1, 2013 OWCP referred appellant, a statement of accepted facts and a list of specific questions to Dr. Manoj Majmudar, a Board-certified pulmonologist, for an impartial medical examination to resolve the conflict in medical opinion between Dr. Baker and Dr. Haller. In his May 9, 2013 report, Dr. Majmudar noted appellant's symptoms of shortness of breath with exertion and at rest as well as wheezing and productive cough. He reported appellant's 40-year smoking history of one to one half packs a day and his employment history including exposure to coal dust and asbestos. Dr. Majmudar found that appellant exhibited shortness of breath and bilateral diffuse end expiratory wheeze. He reviewed appellant's chest x-rays and found severely hyper inflated lungs with no evidence of pleural plaque or any nodular interstitial infiltrate. Dr. Majmudar found that appellant had mild obstructive airway impairment on pulmonary function tests and moderate reduction in diffusion capacity. He opined that appellant's pulmonary pathology was chronic obstructive airway impairment due to cigarette smoking. Dr. Majmudar found no evidence of any pneumoconiosis or asbestosis or any asbestos-related disease. He diagnosed COPD, chronic bronchitis and emphysema from cigarette smoking.

The medical adviser reviewed this report on July 30, 2013 and found that, as appellant's COPD was due to cigarette smoking, it was not employment related and he was not entitled to a schedule award.

By decision dated August 1, 2013, OWCP denied appellant's claim for an employment-related occupational disease of the lungs finding that the weight of the medical evidence rested with Dr. Majmudar's report establishing that appellant's diagnosed conditions were due to his history of smoking cigarettes rather than to his employment exposures to coal dust and asbestos.

On August 8, 2013 appellant requested an oral hearing before an OWCP hearing representative, which was held on January 16, 2014. At the hearing he testified that he worked at a coal fired steam generating electrical plant. Appellant testified that his position as a laborer required him to shovel coal spills, clean hoppers, and work on the burner deck. He stated that the coal utilized in the plant was in the form of a fine dust. Appellant again described his exposure to asbestos and his usage of cigarettes. Counsel argued that Dr. Baker was entitled to the weight of the medical opinion evidence as he was a certified "B" reader. He further noted that Dr. Haller indicated that appellant's cigarette smoking was not entirely responsible for appellant's diagnosed conditions. Counsel also argued that appellant's CT scan was consistent

[2] A.M.A., *Guides*, 6th ed. (2009).

with pneumoconiosis. On March 20, 2014 he submitted publications regarding COPD, coal workers' lung and airway disease.

By decision dated April 2, 2014, the hearing representative found that Dr. Majmudar's report was sufficiently well reasoned to be entitled to special weight and established that appellant's pulmonary condition was chronic obstructive airway impairment due to cigarette smoking. She further noted that Dr. Majmudar found that there was no evidence of pneumoconiosis or asbestosis. The hearing representative noted that the excerpts from publications were not relevant in determining causal relationship between exposure and disease in appellant's specific claim.

LEGAL PRECEDENT

OWCP regulations define an occupational disease as "a condition produced by the work environment over a period longer than a single workday or shift."[3] 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) a 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 evidence required to establish causal relationship is rationalized medical opinion evidence, based upon a complete factual and medical background, showing a causal relationship between the claimed condition and identified factors. The belief of a claimant that a condition was caused or aggravated by the employment is not sufficient to establish causal relation.[4]

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) of FECA which 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 and resolve the conflict of medical evidence.[5] This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[6] In situations where there are 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 on a proper factual background, must be given special weight.[7]

[3] 20 C.F.R. § 10.5(q).

[4] *Lourdes Harris*, 45 ECAB 545, 547 (1994).

[5] 5 U.S.C. §§ 8101-8193, 8123; *M.S.*, 58 ECAB 328 (2007); *B.C.*, 58 ECAB 111 (2006).

[6] *R.C.*, 58 ECAB 238 (2006).

[7] *Nathan L. Harrell*, 41 ECAB 401, 407 (1990).

ANALYSIS

Appellant, a laborer at a coal burning power plant, alleged that he had been exposed to coal dust and asbestos resulting in occupational pneumoconiosis with pulmonary asbestosis and chronic bronchitis. Appellant's attending physician, Dr. Baker, examined x-rays dated November 17, 2011 and opined that appellant had sufficient employment exposures to result in occupational pneumoconiosis category 1/1 and irregular opacities suggesting pulmonary asbestosis. He diagnosed occupational pneumoconiosis with pulmonary asbestosis, chronic bronchitis history of ischemic heart disease, hyperlipidemia, essential hypertension, hearing loss, and colon disease and stated that appellant's bronchitis and occupational pneumoconiosis were caused by his exposure to asbestos and other dusts, odors, and fumes he was exposed to during his employment.

OWCP then referred appellant for a second opinion evaluation with Dr. Haller who diagnosed mild COPD with bronchodilator responsiveness. Dr. Haller opined that cigarette smoking was responsible for most of the obstruction. He noted that significant dust exposure when combined with cigarette smoke could accelerate the rate of development of obstruction. Dr. Haller reviewed appellant's February 1, 2013 CT scan which demonstrated bi-apical fibrotic scarring and multiple sub pleural blebs and noncalcified nodular density in the left apex as well as sub pleural scarring in the right upper lobe. Appellant's right upper lobe demonstrated nodular appearing interstitial scarring and no calcified pleural plaques. Dr. Haller found that the bi-apical bullous disease and fibrotic scarring was consistent with emphysema from appellant's smoking history. He concluded that appellant's CT scan supported the diagnosis of COPD and not pneumoconiosis.

OWCP determined that there was a conflict of medical opinion evidence between Dr. Haller and Dr. Baker and referred appellant to Dr. Majmudar for an impartial medical examination, pursuant to 5 U.S.C. § 8123(a). Dr. Majmudar reviewed the statement of accepted facts and performed a physical examination as well as review of x-rays. He found that appellant exhibited shortness of breath and bilateral diffuse end expiratory wheeze. Dr. Majmudar noted that appellant's chest x-ray demonstrated no evidence of pleural plaque or any nodular interstitial infiltrate. He diagnosed chronic obstructive airway impairment, COPD, chronic bronchitis, and emphysema due to cigarette smoking. Dr. Majmudar found no evidence of any pneumoconiosis or asbestosis or any asbestos-related disease.

The Board finds that Dr. Majmudar's report was sufficiently detailed and well reasoned to resolve the conflict of medical opinion evidence and constitute the weight of the medical opinion. Dr. Majmudar's report was based on a proper factual background, included findings on physical examination as well as reviews of appellant's x-rays and offered a clear opinion that his current pulmonary conditions were due to his cigarette smoking rather than due to his employment exposures. He noted that appellant's x-rays did not demonstrate any pleural plaque or any nodular interstitial infiltrate suggestive of asbestosis or pneumoconiosis. As Dr. Majmudar provided his findings in support of his conclusion that appellant's conditions were not employment related Dr. Majmudar's report as the impartial medical examiner does not support appellant's claim.

The Board finds that appellant has not submitted the necessary medical opinion evidence to meet his burden of proof. While counsel argues that Dr. Baker as a "B" reader is entitled to special weight, OWCP procedures and regulations do not support this argument. Dr. Majmudar as a Board-certified pulmonologist was of the appropriate specialty to resolve the conflict of medical opinion and as noted above, his report is entitled to the special weight accorded an impartial medical examiner under FECA.

Following the oral hearing, counsel submitted publications regarding COPD, coal workers' lung, and airway disease. The Board finds that evidence, such as newspaper clippings, medical texts, and excerpts from publications, is of no evidentiary value to establish the necessary causal relationship, as it is of general application and is not determinative of whether the relevant employment exposure caused the specific condition claimed.[8]

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant has not submitted the necessary medical opinion evidence to establish that his pulmonary conditions are causally related to his accepted employment exposures.

[8] *P.J.*, Docket No. 14-498 (issued May 19, 2014); *Gloria J. McPherson*, 51 ECAB 441 (2000).

ORDER

IT IS HEREBY ORDERED THAT the April 2, 2014 decision of the Office of Workers' Compensation Programs is affirmed.[9]

Issued: December 1, 2015
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

[9] James A. Haynes, Alternate Judge, participated in the original decision but was no longer a member of the Board effective November 16, 2015.