U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of BAILEY VARNADO, JR. and DEPARTMENT OF THE NAVY, MARE ISLAND NAVAL SHIPYARD, Vallejo, CA

Docket No. 02-863; Submitted on the Record;
Issued August 22, 2002

DECISION and ORDER

Before MICHAEL J. WALSH, ALEC J. KOROMILAS, MICHAEL E. GROOM

The issues are: (1) whether appellant has a respiratory disease causally related to his exposure to asbestos in his federal employment and, if so, (2) whether he has a permanent impairment of the lungs.

On October 22, 1996 appellant, then a 41-year-old pipefitter/maintenance worker, filed an occupational disease claim alleging that he sustained interstitial lung disease causally related to factors of his federal employment.[1] The Office of Workers' Compensation Programs accepted that appellant was exposed to asbestos in his federal employment and that he had restrictive lung disease causally related to factors of employment.[2]

By decision dated December 17, 1997, the Office denied appellant's claim for a schedule award on the grounds that the evidence did not establish that he had any impairment due to his accepted employment injury. In a decision dated February 26, 1998, the Office denied appellant's request for a hearing as untimely. He appealed to the Board. In a decision dated November 27, 1998, the Board granted the Director's motion to remand the case for a hearing.[3]

In a decision dated September 7, 1999, a hearing representative vacated the Office's December 17, 1997 decision and remanded the case for an Office medical adviser to obtain a current medical report regarding whether appellant has an asbestos-related lung disease and the degree of any permanent impairment of the lungs.

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[1] The record indicates that appellant stopped work in March 1996 in a reduction-in-force.

[2] The Office accepted appellant's claim for restrictive lung disease based on the opinion of Dr. Deepak Shrivastava, a Board-certified internist, who provided a second opinion evaluation on March 27, 1997.

[3] Docket No. 98-2260 (issued November 27, 1998).

By decision dated June 27, 2000, the Office denied appellant's claim on the grounds that the evidence established that he had no pulmonary condition or impairment caused by his exposure to asbestos. In a decision dated November 16, 2000, a hearing representative reversed the Office's June 27, 2000 decision. The hearing representative found that, in referring appellant for an impartial medical examination, the Office did not indicate in the statement of accepted facts that it had accepted restrictive lung disease as related to employment and did not properly rescind acceptance of the condition. The hearing representative instructed the Office to provide the impartial medical specialist, Dr. Thomas E. Addison, a Board-certified internist, with an amended statement of accepted facts and obtain a supplemental opinion on whether appellant had an employment-related pulmonary condition and whether he had any permanent pulmonary impairment.

After obtaining a supplemental report from Dr. Addison, in a decision dated July 16, 2001, the Office found that appellant had not established that he sustained a pulmonary disease due to asbestos exposure or that he had any permanent pulmonary impairment which would entitle him to a schedule award. The Office found that appellant was eligible for periodic medical examinations due to his employment-related restrictive lung disease. In a decision dated December 11, 2001, a hearing representative affirmed the Office's July 16, 2001 decision.

The Board finds that the case is not in posture for a decision, due to an unresolved conflict in medical opinion.

The Office found that a conflict existed between Dr. Carolyn S. Ray, a Board-certified internist and the Office medical adviser. In a report dated March 3, 1999, Dr. Ray discussed appellant's history of injury, reviewed the results of objective testing and listed findings on examination. She interpreted an x-ray obtained on January 19, 1999, as revealing "bilateral areas of pleural thickening with plaque formation consistent with asbestos-caused pleural disease." Dr. Ray stated:

> "The pulmonary function studies [(PFS)] show no obstructive disease, severe restrictive disease, small airways dysfunction, normal measurements of airway resistance and a severe reduction in diffusing capacity for carbon monoxide with a normal diffusing capacity to alveolar volume ratio."

She concluded:

> "[Appellant] has asbestosis and asbestos pleural disease. Although in the past pleural thickening and pleural plaques were thought to be only 'markers' of asbestos exposure that did not cause functional impairment, more than 20 articles over the last 10 years have conclusively demonstrated that pleural plaques, pleural thickening and diffuse pleural thickening all play a role in causing pulmonary impairment. Large studies of asbestos-exposed workers have shown asbestos-related pleural disease alone results in significant respiratory impairment. When pulmonary function is evaluated in individuals with asbestosis, they demonstrate a greater degree of impairment if pleural thickening is also present. Thus, given any grade of asbestosis, the presence of pleural disease increases the level of

impairment. Even isolated pleural thickening or plaques have been shown to be associated with dyspnea and a restrictive pattern of ventilatory impairment."

* * *

"[Appellant] has severe pulmonary impairment. His degree of pulmonary disability is severe. He is incapable of doing any but the most sedentary work. This opinion is based on the objective findings on chest x-ray, CT [computerized tomography] scan, physical examination and [PFS].[4] His [PFS] define a severe degree of impairment which is the result of his asbestosis and asbestos pleural disease."

An Office medical adviser reviewed the medical evidence of record and found, in an opinion provided October 10, 1999, that "a diagnosis of asbestos and asbestos-related pleural plaques is not established." The Office medical adviser indicated that it was more likely that appellant had a pulmonary condition not related to his asbestos exposure. He stated: "[Appellant] does appear to have restrictive lung disease and a possible active alveolitis by CT scan. Previous lung biopsies showed normal tissue, but this likely represented sampling error." The Office medical adviser recommended obtaining further information about the etiology of appellant's pulmonary condition from his attending physician, Dr. David Budson, a Board-certified internist.

In response to the Office's request for information, Dr. Budson provided a chart note dated April 15, 1998, in which he indicated that he had informed appellant that he did not have a definite diagnosis for him and that his studies did not reveal evidence of a progressive disease.

In a report dated November 24, 1999, the Office medical adviser reviewed the evidence, including Dr. Budson's April 15, 1998 chart note and stated:

"Although Drs. Ray and Breyer have made the specific diagnosis of asbestosis and asbestos-related pleural plaques, the data does not support this opinion and a conflict of interpretation is clearly present. Clearly, Dr. Budson, the treating pulmonologist with expertise in the diagnosis of asbestos[-]related diseases has determined that a specific diagnosis should not be made.

"As I have previously stated, a significant time interval has elapsed since [appellant's] previous evaluation. Given the fact that current treating medical records are not forthcoming, I would recommend that [appellant] be reevaluated for a second opinion. The evaluating physician should specifically be requested to obtain a high resolution CT scan of the chest and provide an opinion concerning the presence or absence of interstitial and pleural disease. A specific

[4] A CT scan of appellant's thorax dated February 9, 1999 was interpreted by Dr. Donald Breyer, a Board-certified radiologist, as revealing mild interstitial fibrosis "compatible with asbestos[-]related interstitial fibrosis" and pleural thickening suggesting "asbestos-related pleural disease." Dr. Gail S. Smith, a radiologist, interpreted a CT scan of appellant's thorax dated September 18, 1998 as showing "diffuse ground glass opacity in the lungs particularly in the lower lobes bilaterally which is nonspecific but does indicate an active process."

opinion should be requested as to whether the specific diagnosis of asbestosis and pleural plaques can be made. It would be useful for the examining physician to have these records for review. I would be pleased to review the file once again when that information has been obtained."

The Office referred appellant to Dr. Addison. In a report dated March 14, 2000, he discussed the history of appellant's employment injury, reviewed the evidence of record, including the results of objective testing and listed findings on physical examination. Dr. Addison interpreted a CT scan obtained on February 9, 1999 as failing "to confirm evidence of interstitial disease" or provide "any evidence of pleural changes suggestive of asbestos exposure." He stated:

"In conclusion, based on the objective findings of CT scanning and open lung biopsy, there does not appear to be any evidence of asbestos[-]related interstitial lung disease in [appellant]. Pulmonary fibrosis secondary to asbestos should not come and go. In reaching this conclusion, I have placed significant probative value on the current CT scanning in conjunction with [appellant's] treating physician who, in 1998, concluded that there was no difference between scans done in 1994 and 1998 and that there was no evidence of progressive pulmonary interstitial disease in this individual."

Dr. Addison attributed the results of appellant's pulmonary function studies to variations in effort. He concluded:

"In summary, based on the review of this case file and the current x-ray and pulmonary function studies generated during this examination, I conclude that there are no specific findings that allow a diagnosis of asbestosis or asbestos-related pleural disease. Instead, the findings of slight reduction in vital capacity, total lung capacity and absolute diffusing capacity probably represent normal findings in this individual. The minimal changes seen on CT scan from time to time represent scarring of uncertain cause but are not characteristic of the findings one would expect with asbestosis. Similarly, the pleural disease noted following the lung biopsy on some CT scans and not on others is minimal in nature and probably, in my opinion, represents postoperative scarring."

In a supplemental report dated May 21, 2001, Dr. Addison reviewed the amended statement of accepted facts and opined that there was no evidence that appellant's "restrictive pulmonary function studies were in fact caused by asbestos-related interstitial or pleural disease." He recommended monitoring appellant's condition by x-ray and physical examination.

The Board finds that the Office incorrectly characterized Dr. Addison as an impartial medical specialist. At the time of the Office's referral of appellant to him, the record did not contain a conflict in medical opinion between a physician for appellant and a physician for the United States. The Office found that a conflict existed between the opinion of the Office medical adviser and Dr. Ray, appellant's physician. However, the opinion of the Office medical adviser is insufficient to create a conflict in medical opinion as he did not specifically opine that appellant had no pulmonary condition causally related to his asbestos exposure but instead

reviewed the medical evidence and found that it was inconclusive. He recommended that appellant be referred for further objective tests and a second opinion evaluation prior to reaching a determination. Therefore, the Office incorrectly characterized Dr. Addison as an impartial medical specialist.

The Board finds, however, that there is a conflict in medical opinions between Dr. Ray, a Board-certified internist and appellant's physician and Dr. Addison, a Board-certified internist and an Office referral physician. Dr. Ray diagnosed asbestosis and asbestos-related pleural disease while Dr. Addison found that appellant did not have any condition causally related to his exposure to asbestos.

Section 8123(a) of the Federal Employees' Compensation Act,[5] provides in pertinent part: "[I]f there is a 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 the examination."

Consequently, the case is remanded for the Office to refer appellant to an appropriate Board-certified specialist for an impartial rationalized medical opinion regarding whether he has a pulmonary condition causally related to asbestos exposure during the course of his federal employment and, if so, the extent of any disability or permanent impairment. After such further development as the Office deems necessary, it shall issue a *de novo* decision.

The decisions of the Office of Workers' Compensation Programs dated December 11 and July 16, 2001 are set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Dated, Washington, DC
August 22, 2002

Michael J. Walsh
Chairman

Alec J. Koromilas
Member

Michael E. Groom
Alternate Member

[5] 5 U.S.C. § 8123(a).