

ISSUE

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

FACTUAL HISTORY

This case has previously been before the Board.³ The facts of the case as presented in the prior decisions are incorporated herein by reference. The relevant facts are as follows.

On November 7, 2006 appellant, then a 58-year-old retired gas and diesel mechanic and machinist, filed an occupational disease claim (Form CA-2) alleging that his chronic obstructive airway disease, chronic bronchitis, and pneumoconiosis were due to his exposure to coal dust and asbestosis in his federal employment from 1976 to 1996. He stated that he first became aware of these conditions and the connection to his federal employment on November 6, 2006.

On February 8, 2007 OWCP accepted that appellant was exposed to coal dust and asbestos on a daily basis for eight-plus hours, and that he wore no protective mask.

Appellant submitted an October 3, 2006 report from Dr. Glen R. Baker, Jr., Board-certified in pulmonary disease and a certified B-reader, who reported that appellant had occupational pneumoconiosis caused by his history of coal dust exposure and probable asbestos exposure. Dr. Baker opined that appellant's chronic obstructive airway disease and chronic bronchitis were caused by a combination of coal dust exposure and smoking, with smoking being a more substantial factor.

By report dated April 19, 2007, Dr. H. Dale Haller, Jr., Board-certified in pulmonary disease and a second opinion physician, related that appellant did have some pulmonary pathology with a degree of chronic obstructive pulmonary disease (COPD) and maybe some early emphysema, but the predominant process was chronic bronchitis. He reported that he was not at all convinced that appellant had evidence of pneumoconiosis or asbestos-related disease. In an addendum, Dr. Haller reviewed computerized tomography (CT) scans obtained on May 14, 2007 and concluded that it was unlikely that appellant had coal workers' pneumoconiosis or asbestos-related disease.

On June 4, 2007 OWCP denied appellant's claim finding that he failed to establish that his pulmonary condition was causally related to his federal employment.

Appellant requested a hearing before a representative of OWCP's Branch of Hearings and Review on June 24, 2007. On August 14, 2007 a hearing representative found a conflict in medical opinion and remanded the case for referral to an impartial medical specialist to resolve the conflict on the issue of causal relationship between appellant's exposures in federal employment and any diagnosed pulmonary condition.

³ Docket No. 13-1977 (issued March 18, 2014); Docket No. 10-1804 (issued April 15, 2011); Docket No. 08-1675 (issued May 4, 2009).

OWCP referred appellant, together with the case record and a statement of accepted facts (SOAF) to Dr. Manoj H. Majmudar, Board-certified in pulmonary disease, for an impartial medical evaluation. On September 27, 2007 Dr. Majmudar noted appellant's complaints and occupational history and concluded that, while appellant had worked with coal dust at the employing establishment for 23 years, his symptoms of shortness of breath and cough and sputum production were probably related to chronic obstructive airway impairment, mostly secondary to cigarette smoking and exposure to gasoline fumes. He concluded that there was no clinical evidence suggestive of pneumoconiosis or asbestosis.

In a decision dated November 5, 2007, OWCP denied appellant's claim. It found that Dr. Majmudar's opinion was afforded the special weight of medical evidence in resolution of the conflict in medical opinion on the issue of causal relationship.

On November 15, 2007 appellant requested a hearing before hearing with a representative of OWCP's Branch of Hearings and Review. In a decision dated April 1, 2008, the hearing representative affirmed the November 5, 2007 decision, finding that the special weight of the medical evidence, as represented by Dr. Majmudar's opinion, failed to establish that appellant had a pulmonary condition causally related to his exposure to coal dust and asbestos at work.

On May 27, 2008 appellant filed a timely appeal to the Board. In a decision dated May 4, 2009, the Board remanded the case for a supplemental report from Dr. Majmudar, the impartial medical examiner.⁴ The Board noted that the SOAF did not adequately address the level of appellant's exposure to coal dust or asbestos in the course of his federal employment. Given appellant's objection that Dr. Majmudar was not a certified B-reader, the Board noted that OWCP should consider whether it would be helpful to authorize Dr. Majmudar to consult a certified B-reader.

OWCP further developed the evidence on appellant's exposure. It prepared an addendum to the SOAF incorporating additional evidence of the extent of workplace exposures and asked Dr. Majmudar for a supplemental report.

In his supplemental report, Dr. Majmudar described findings on physical examination, chest x-ray, and pulmonary function testing. He explained that appellant's pulmonary function test showed mild obstructive airway impairment, but no significant response to bronchodilator therapy. Diffusion capacity and lung volumes were normal. Chest x-ray showed hyper inflated lung, but no pleural plaque, pleural effusion, mass, or infiltrate. Dr. Majmudar further opined that appellant's shortness of breath was secondary to chronic obstructive lung disease and chronic bronchitis, secondary to cigarette smoking. While appellant had significant exposure to coal dust and there was some minimal asbestos exposure, there was no evidence of asbestosis, pleural plaques, or any pneumoconiosis on his physical examination or chest x-ray finding. Dr. Majmudar concluded that appellant's symptoms were related to chronic obstructive airway impairment, secondary to cigarette smoking. No evidence of asbestosis or pneumoconiosis was noted.

⁴ Docket No. 08-1675 (issued May 4, 2009).

In a decision dated October 30, 2009, OWCP denied appellant's claim for compensation. It found that Dr. Majmudar's opinion represented the special weight of the medical opinion evidence and failed to substantiate that appellant sustained a pulmonary condition causally related to his federal employment.

On November 5, 2009 appellant requested a hearing before a representative of OWCP's Branch of Hearings and Review.

In a February 5, 2010 report, Dr. William C. Houser, a Board-certified internist specializing in pulmonary disease and an A-reader, diagnosed pneumoconiosis category 1 due to mixed dust exposure including coal dust and asbestos, as well as mild COPD. He found that appellant had sufficient exposure and roentgenographic findings appropriate for the diagnosis of pneumoconiosis. Dr. Houser found that the restrictive changes on pulmonary function testing were probably secondary to obesity and pneumoconiosis. He added that the findings of airway obstruction were most likely secondary to inhaling respiratory irritants secondary to coal dust and asbestos as well as cigarette smoking.

In a decision dated April 23, 2010, an OWCP hearing representative affirmed the denial of appellant's claim for compensation. The hearing representative found that Dr. Majmudar's opinion represented the special weight of the medical evidence.

Appellant filed an appeal with the Board on June 29, 2010. In an April 15, 2011 decision, the Board set aside OWCP's April 23, 2010 decision and remanded the case for referral to a second impartial medical examiner to resolve the conflict in the medical opinion evidence.⁵

OWCP thereafter referred appellant, to Dr. Jack H. Hasson, a Board-certified specialist in pulmonary disease, a former certified B-reader, currently a certified A-reader and an assistant professor of medicine, for an impartial medical evaluation.

Dr. Hrudaya P. Nath, a Board-certified diagnostic radiologist and professor of medicine, interpreted a chest x-ray obtained for Dr. Hasson. Dr. Nath concluded that there was no acute disease. Dr. Jubal R. Watts, Jr., a Board-certified diagnostic radiologist and certified B-reader, interpreted the same chest x-ray. Dr. Watts' impression was small opacities with a perfusion compatible with pneumoconiosis.

Dr. Hasson evaluated appellant on July 21, 2011. He described his findings on examination, and reviewed previous imaging studies. Dr. Hasson noted that appellant's current chest x-rays showed lungs free of infiltrates. There were no rounded or irregular opacities and no conglomerate nodules. The pleural surfaces were free of plaque formation and pleural thickening. Dr. Hasson found no evidence of pneumoconiosis. He concluded that appellant's significant pulmonary impairment was related to a number of factors, including COPD with an asthmatic component. Dr. Hasson opined that appellant's dyspnea and impairment were due to his COPD related to tobacco exposure, but that pneumoconiosis played no role in his pulmonary impairment. He concluded that he found no evidence of pneumoconiosis

⁵ Docket No. 10-1804 (issue April 15, 2011).

In a decision dated September 2, 2011, OWCP denied appellant's claim. It found that the special weight of the medical evidence rested with the opinion of Dr. Hasson, supported by the medical findings of Dr. Watts, the certified B-reader, and failed to substantiate that appellant's pulmonary condition was causally related to his federal employment exposures.

On September 8, 2011 appellant requested a hearing before a representative of OWCP's Branch of Hearings and Review. On December 12, 2011 the hearing representative found that the case was not in posture for decision. He observed that Dr. Hasson did not mention Dr. Watts' interpretation of appellant's chest x-rays, which indicated that there was evidence of pneumoconiosis. Dr. Hasson also did not mention having reviewed the SOAF. Further, he provided no medical rationale to support his opinion that appellant sustained no impairment related to exposure to coal dust. The hearing representative remanded the case for a supplemental report from the impartial medical specialist to address specific questions.

Dr. Hasson provided a supplemental report dated January 4, 2012. He reported that he did not believe pneumoconiosis was present based on Dr. Watts' findings. Dr. Hasson explained that he saw no evidence of pneumoconiosis after his own evaluation of the chest x-ray or other evaluations of chest x-rays by other physicians, in spite of the fact that there were x-rays which were felt to show pneumoconiosis. Further, he explained that the best evidence for no evidence of pneumoconiosis on imaging studies was the CT scan, noted in his initial report, showing no description of round or irregular opacities or any diagnosis of pneumoconiosis. Dr. Hasson related that he considered CT scans to be the gold standard of imaging compared to a plain chest x-ray, and that it was well known that the CT scan of the chest was a better imaging modality as compared to a plain chest x-ray. He concluded that appellant's pulmonary condition was totally related to COPD from cigarette smoking. Although exposure to irritants and dust could aggravate COPD, there was no evidence of any injury from either of those substances as there was no evidence of pneumoconiosis on either his chest x-ray or his CT scan.

In a decision dated February 28, 2012, OWCP denied appellant's claim. It found that the special weight of the medical evidence rested with Dr. Hasson, the impartial medical examiner.

On March 15, 2012 appellant requested a hearing before a representative of OWCP's Branch of Hearings and Review. On August 14, 2012 an OWCP hearing representative remanded the case for another supplemental report from Dr. Hasson.

On November 1, 2012 OWCP received a response from Dr. Hasson in which he related that he had reviewed the record and his opinion had not changed.

By decision dated November 13, 2012, OWCP denied appellant's claim. It found that the special weight of the medical evidence rested with the opinion of Dr. Hasson.

On November 28, 2012 appellant requested a hearing before a representative of OWCP's Branch of Hearings and Review. By decision dated June 3, 2013, an OWCP hearing representative affirmed the denial of appellant's claim as there was no rationalized medical evidence in support of appellant's contention that the claimed pulmonary condition was causally

related to factors of his federal employment. She further found that Dr. Hasson's opinion represented the special weight of the medical evidence.

On August 28, 2013 appellant filed an appeal with the Board. The Board in a March 18, 2014 decision, set aside OWCP's June 3, 2013 decision.⁶ The Board found that the opinion of the impartial medical examiner, Dr. Hasson, was insufficient to resolve the conflict in the medical opinion evidence as he provided insufficient rationale for his opinion. The Board also found the opinion of Dr. Watts, a Board-certified diagnostic radiologist and certified B-reader, who interpreted an x-ray as showing pneumoconiosis, was entitled to more weight than Dr. Hasson's opinion. The Board found that despite attempts by OWCP to obtain clarification from Dr. Hasson, his opinion was insufficient to resolve the conflict of medical opinion in the case. Thus, the case was remanded to OWCP for further development of the evidence.

Following the Board's remand, in an April 3, 2014 memorandum of referral to specialist, OWCP indicated the need for the type of specialist as "Pulmonary Specialist -- MUST be a B-reader."

On July 16, 2015 OWCP referred appellant to Dr. Kumar Yogesh, a Board-certified pulmonologist, internist, and sleep medicine physician, to resolve the conflict in the medical opinion evidence regarding whether appellant's federal employment caused or aggravated any pulmonary condition. At the time of the referral, it noted that in the questions posed, that the impartial medical examiner should either refer appellant to a qualified B-reader to perform and review x-ray interpretations or provide a prescription for a B-reader evaluation.

In a September 17, 2014 report, Dr. Yogesh, based upon a review of appellant's medical and employment histories, as well as his physical examination, diagnosed COPD, obstructive sleep apnea, and multiple other health problems. He noted that appellant had a history of smoking a pack of cigarettes a day from the time he was a teenager until he quit five to six years ago. Dr. Yogesh reviewed a pulmonary function study performed in his office and found mildly decreased lung capacity, normal residual volume, and moderate decreased diffusion. A chest x-ray was also performed which he interpreted as showing a 1.17 centimeter calcified opacity in the right upper lung and several two to three millimeter opacities in both upper lungs. Based on his review of appellant's history of coal exposure, reports of pneumoconiosis by B-readers, and a May 14, 2007 CT scan interpreted as negative for pneumoconiosis, Dr. Yogesh concluded that a diagnosis of pneumoconiosis was less likely to be the cause of the chest x-ray abnormalities. He noted that due to appellant's large size, chest x-ray interpretations would be difficult to read. Dr. Yogesh recommended a CT scan for an accurate determination of appellant's respiratory condition.

In letters dated November 18, 2014 and January 5, 2015, OWCP requested Dr. Yogesh, as noted in June 17, 2014 questions provided to the doctor, to either refer appellant for a B-reader evaluation or provide a prescription for a B-reader evaluation.

In response to OWCP's request, Dr. Yogesh offered his opinion that referral to a B-reader was unnecessary as the record contained several B-reader reports.

⁶ Docket No. 13-1977 (issued March 18, 2014).

An OWCP medical adviser reviewed Dr. Yogesh's reports and concluded the evidence was insufficient to determine whether appellant's respiratory problems were employment related. He recommended referral for a high resolution CT scan as recommended by Dr. Yogesh.

Dr. Yogesh referred appellant for a chest x-ray interpretation by a B-reader in a March 16, 2015 prescription and for a CT chest scan by a B-reader in a March 17, 2015 prescription.

On April 22 and May 27, 2015 OWCP referred appellant to Dr. Jeff W. Selby, a certified B-reader and physician Board-certified in internal medicine, pulmonology, and critical care, to provide a second opinion as a certified B-reader and to review x-ray interpretations and other diagnostic tests.

In a September 21, 2015 report, Dr. Selby summarized the x-ray interpretations, CT scans, and PFS tests, and reports that reviewed. He reviewed a June 9, 2015 CT scan performed by Dr. Anthony Perkins, a Board-certified diagnostic radiologist, and concurred with the determination of no pneumoconiosis. Dr. Selby reviewed a June 9, 2015 chest x-ray interpretation he performed. He found no evidence of any pleural or parenchymal abnormalities associated with pneumoconiosis, but reported some bilateral lung calcified and noncalcified granulomas. Based on his review of the objective tests and medical report, Dr. Selby opined that there was no evidence of any asbestosis, mesothelioma, or pneumoconiosis. In finding no evidence of pneumoconiosis, he relied on his review of a chest CT scan and the report from Dr. Perkins. With respect to the legal definition of pneumoconiosis, Dr. Selby opined that the preponderance of the evidence he reviewed clearly supported a diagnosis of asthma with waxing and waning mild obstruction. He opined that appellant's asthma was unrelated to workplace exposure to asbestos or coal dust. Dr. Selby did not examine appellant.

By decision dated October 20, 2015, OWCP denied appellant's claim. It found the weight of the evidence rested with the opinion of Dr. Selby, a B-reader and referral physician, who concluded that there was no evidence of pneumoconiosis or any lung impairment caused or aggravated by his federal employment.

In a letter dated November 5, 2015, counsel requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review. He, in a June 23, 2016 letter, changed the request for an oral hearing to a review of the written record. Counsel summarized the factual and medical histories. He alleged that OWCP erred in relying upon Dr. Selby's opinion as he never examined appellant and was not entitled to be accorded determinative weight.

By decision dated August 25, 2016, OWCP's hearing representative affirmed the denial of appellant's claim.

LEGAL PRECEDENT

An employee seeking benefits under FECA⁷ has the burden of proof to establish the essential elements of his or her claim, including the fact that the individual is an employee of the

⁷ 5 U.S.C. § 8101 *et seq.*

United States within the meaning of FECA, that the claim was filed within the applicable time limitation, that an injury was sustained while in the performance of duty as alleged, and that any disability and/or specific condition for which compensation is claimed are causally related to the employment injury.⁸ These are the essential elements of each and every compensation claim regardless of whether the claim is predicated on a traumatic injury or an occupational disease.⁹

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.¹⁰

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.¹¹ Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on whether there is causal relationship between the employee's diagnosed condition and the compensable employment factors.¹² 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.¹³

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.¹⁴ Where a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background must be given special weight.¹⁵

Board case precedent provides that, when OWCP obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, OWCP must secure a supplemental

⁸ *C.S.*, Docket No. 08-1585 (issued March 3, 2009); *Bonnie A. Contreras*, 57 ECAB 364 (2006).

⁹ *S.P.*, 59 ECAB 184 (2007); *Joe D. Cameron*, 41 ECAB 153 (1989).

¹⁰ *D.U.*, Docket No. 10-144 (issued July 27, 2010); *R.H.*, 59 ECAB 382 (2008); *Donald W. Wenzel*, 56 ECAB 390 (2005); *Roy L. Humphrey*, 57 ECAB 238 (2005).

¹¹ *Y.J.*, Docket No. 08-1167 (issued October 7, 2008); *D'Wayne Avila*, 57 ECAB 642 (2006); *A.D.*, 58 ECAB 149 (2006).

¹² *J.J.*, Docket No. 09-27 (issued February 10, 2009); *Michael S. Mina*, 57 ECAB 379 (2006).

¹³ *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

¹⁴ 5 U.S.C. § 8123(a); *Darlene R. Kennedy*, 57 ECAB 414 (2006); *R.C.*, 58 ECAB 238 (2006).

¹⁵ *V.G.*, 59 ECAB 635 (2008); *Sharyn D. Bannick*, 54 ECAB 537 (2003); *Gary R. Sieber*, 46 ECAB 215 (1994).

report from the specialist to correct the deficiency in his original report. Only when the impartial specialist is unable to clarify or elaborate on his original report or if his supplemental report is incomplete, vague, speculative or lacking in rationale, should OWCP refer the claimant to another impartial specialist.¹⁶

ANALYSIS

In the last appeal, the Board remanded the case for a third impartial medical evaluation to resolve the conflict in the medical opinion evidence as to whether appellant sustained a pulmonary condition causally related to his federal employment. OWCP referred appellant to Dr. Yogesh, a Board-certified pulmonologist, internist, and sleep medicine physician, to resolve the conflict. Based on a referral order from Dr. Yogesh, OWCP referred appellant to Dr. Selby, to provide review as a certified B-reader and second opinion physician of x-ray results and other diagnostic tests. In denying appellant's claim, OWCP relied upon Dr. Selby's opinion that there was no evidence of pneumoconiosis or any pulmonary condition attributable to appellant's employment.

The Board finds that this case is not in posture for decision as OWCP improperly relied upon the report of Dr. Selby, a certified B-reader and OWCP referral physician, instead of the impartial medical examiner, Dr. Yogesh to resolve the conflict in medical evidence.

In a September 17, 2014 report, Dr. Yogesh diagnosed COPD, obstructive sleep apnea and multiple other health problems. He provided examination findings, reviewed diagnostic tests, included x-ray interpretations and PFS studies, and concluded that the diagnosis of pneumoconiosis was less likely to be the cause of the chest x-ray abnormalities. Dr. Yogesh recommended a CT scan for an accurate determination of appellant's respiratory condition as appellant's size precluded an accurate reading by x-ray interpretation. He did not specifically address whether appellant's pulmonary conditions had been caused or aggravated by his employment.¹⁷ In addition, Dr. Yogesh recommended further testing in the form of a CT scan to differentiate and determine the origins of the capacities noted on the chest x-ray and provide an accurate determination regarding appellant's condition. Thus, his opinion was insufficient to resolve the medical conflict regarding whether appellant had an employment-related pulmonary condition.

OWCP referred appellant for a B-reader evaluation with Dr. Selby, who reviewed the medical evidence and had diagnostic testing performed. Dr. Selby reviewed an x-ray interpretation he performed and a CT scan and opined that there was no evidence of pneumoconiosis or any employment-related pulmonary condition. By decision dated October 20, 2015, OWCP found the weight of the medical opinion evidence rested with Dr. Selby's opinion, which was affirmed by an OWCP hearing representative in an August 25, 2016 decision. This was improper. To properly resolve the conflict of medical opinion, it is the impartial medical specialist who should provide a reasoned opinion regarding appellant's

¹⁶ See *Nancy Keenan*, 56 ECAB 687 (2005); *Margaret Ann Connor*, 40 ECAB 214 (1988).

¹⁷ *A.D.*, 58 ECAB 149 (2006); *Jaja K. Asaramo*, 55 ECAB 200 (2004) (medical evidence which does not offer any opinion regarding the cause of an employee's condition is of limited probative value).

condition and whether it had been caused or aggravated by the accepted employment factors. OWCP's procedures provide that if a referral physician needs to obtain information from another provider, the referral physician is authorized to make subsidiary referrals as necessary (for instance, a psychiatrist may refer a claimant to a clinical psychologist for testing). However, the referral physician should submit a summary report discussing any discrepancies among the physicians' viewpoints so that questions posed by OWCP are fully answered.¹⁸

OWCP procedures also provide that a report by someone other than the physician selected to resolve the conflict cannot be used to resolve a conflict in medical opinion and cannot be afforded special weight.¹⁹ As OWCP requested a B-reader to perform and review an x-ray interpretation, it should have forwarded Dr. Selby's report to Dr. Yogesh for review. According to OWCP procedures, Dr. Selby's opinion could not constitute the weight of the evidence to resolve the conflict was not the selected impartial medical examiner.²⁰ OWCP should have requested a supplemental report from Dr. Yogesh based upon review of Dr. Selby's report. On remand it should request a supplemental report from Dr. Yogesh. After such further development as OWCP deems necessary, it shall issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for a decision. Further development of the medical opinion evidence is required.

¹⁸ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.4(b)(7) (July 2011).

¹⁹ *Id.* at Chapter 3.500.4(g)(3)(a) (July 2011).

²⁰ *Id.*

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated August 25, 2016 is set aside and the case remanded for further development consistent with the above opinion.

Issued: September 7, 2017
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board