U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of TEDDY PHILLIPS and DEPARTMENT OF LABOR,
MINE SAFETY & HEALTH ADMINISTRATION, Norton, Va.

Docket No. 96-2340; Submitted on the Record;
Issued December 29, 1998

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
BRADLEY T. KNOTT

The issue is whether appellant has pneumoconiosis due to his exposure to coal dust.

The Office of Workers' Compensation Programs accepted that appellant was exposed to coal dust for about 17 years as a mine inspector for the employing establishment. The Office determined that there was a conflict of medical opinion between appellant's physicians -- Dr. Norman Rexrode, who is Board-certified in emergency medicine, Dr. Edward D. Aycoth, a diagnostic radiologist, Dr. Joseph F. Smiddy, a Board-certified internist, Dr. Maurice A. Bassali, a Board-certified radiologist, and Dr. Emory H. Robinette, who is Board-certified in pulmonary diseases -- and the Office's referral physician, Dr. S.K. Paranthaman, who is Board-certified in pulmonary diseases. Appellant's physicians[1] concluded, based on their readings of a chest x-ray taken on November 9, 1993 and on pulmonary function testing done in December 1993 that appellant had pneumoconiosis. Based on a chest x-ray and pulmonary function studies done on August 17, 1994, Dr. Paranthaman stated in an August 26, 1994 report that he was "unable to confirm the presence of coal workers' pneumoconiosis in a chest x-ray and unable to confirm any evidence of functional impairment in pulmonary function studies."

To resolve this conflict of medical opinion, the Office referred appellant, the case record and a statement of accepted facts to Dr. Ramanarao Mettu, who is Board-certified in pulmonary diseases. In his initial report, dated January 9, 1995, Dr. Mettu diagnosed chronic bronchitis. In conjunction with Dr. Mettu's report, Dr. Dennis H. Halbert, a Board-certified radiologist, noted that a chest x-ray done on January 9, 1995 showed "no evidence of pneumoconiosis." At the time of the initial evaluation, Dr. Mettu did not perform pulmonary function studies because appellant was experiencing chest pain. Dr. Mettu performed such studies on April 10, 1995, and in a supplemental report of that date stated that cooperation with the testing was good and that:

[1] After the Office determined there was a conflict of medical opinion and referred appellant to an impartial medical specialist, appellant submitted a March 29, 1995 report from Dr. Raghu Sundaram, a Board-certified internist, diagnosing pneumoconiosis.

"This gentleman has evidence of severe pulmonary impairment on pulmonary function studies; etiology factors pneumoconiosis and exposure to coal dust." In response to an Office request for clarification of his reports,[2] Dr. Mettu stated in a September 1, 1995 report: "Given his symptoms of chronic bronchitis and working in the coal mines, his pulmonary function studies, everything putting together it is my opinion this gentleman has pulmonary impairment. Etiology factors were mentioned earlier due to exposure to coal dust and pneumoconiosis."

The Office determined that Dr. Mettu's initial and supplemental reports did not resolve the conflict of medical opinion and consequently referred appellant, the case record and a statement of accepted facts to Dr. Mitchell Wicker, Jr., a Board-certified internist. In a report dated October 30, 1995 Dr. Wicker stated:

> "There is no evidence of any pulmonary disability in this individual. His pulmonary function studies are unreliable due to his poor effort evidenced on this. It is noted that his variability is small, however, this proves only that he was consistently not cooperating with the examination.
>
> "There is no evidence in this examination to substantiate the diagnosis of 'early pneumoconiosis.' X-ray, when compared to IL LO standards reveals no evidence of pneumoconiosis."

By decision dated November 30, 1995, the Office found that Dr. Wicker's report constituted the weight of the medical evidence and established that appellant had not sustained a disease as alleged. This decision was affirmed by an Office hearing representative in a June 11, 1996 decision.

The Board finds that the case is not in posture for a decision.

The Board has held that when a case is referred to an impartial medical specialist for the purpose of resolving a conflict in medical opinion evidence, the opinion of such specialist, if sufficiently well rationalized and based on a proper medical background, must be given special weight.[3] The Board has also held that in a situation where the Office secures an opinion from an impartial medical specialist and the opinion from such specialist requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the specialist for the purpose of correcting the defect in the original report. However, when the impartial specialist does not clarify the original report, the Office must refer the case to another impartial specialist for a rationalized medical opinion on the issue in question. Unless this procedure is carried out by the Office, the intent of section 8123(a) of the Federal Employees' Compensation Act[4] will be circumvented when the impartial specialist's reports are not sufficient to resolve the conflict of medical opinion.[5]

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[2] This request for clarification is not contained in the case record submitted by the Office to the Board on appeal.

[3] *James P. Roberts*, 31 ECAB 1010 (1980).

[4] 5 U.S.C. § 8123(a) states 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

In the present case, the Office properly identified a conflict of medical opinion on the question of whether appellant has pneumoconiosis due to his exposure to coal dust. To resolve this conflict, the Office referred appellant to Dr. Mettu. In an April 10, 1995 report, Dr. Mettu stated that appellant had evidence of severe pulmonary impairment and that the etiology was pneumoconiosis and exposure to coal dust. Dr. Mettu, however, did not reconcile the opinion that appellant had pneumoconiosis with results of the chest x-ray done on January 9, 1995, which was interpreted as showing "no evidence of pneumoconiosis." Dr. Mettu's supplemental report, which was dated September 1, 1995, also did not reconcile these contradictory findings.

As Dr. Mettu's original and supplemental reports were not sufficient to resolve the conflict of medical opinion by presenting a rationalized medical opinion on the issue in conflict, the Office was required to refer the case to another impartial medical specialist. The referral should have been to a Board-certified specialist in pulmonary diseases. Although Dr. Wicker, the physician selected by the Office as the second impartial specialist, is Board-certified in internal medicine, he is not listed in the applicable medical directory[6] as a Board-certified specialist in pulmonary diseases. Pulmonary diseases clearly is the appropriate specialty in this case. It is one of the subspecialties under internal medicine in the applicable medical directory, which lists the following additional subspecialties under internal medicine: allergy and immunology, adolescent medicine, cardiac electrophysiology, clinical cardiac electrophysiology, critical care medicine, clinical and laboratory immunology, cardiovascular disease, diagnostic laboratory immunology, endocrinology, diabetes and metabolism, endocrinology, gastroenterology, geriatric medicine, hematology, interventional cardiology, infectious disease, nephrology, medical oncology, rheumatology, and sports medicine. As a specialist in most of these subspecialties would not be the appropriate physician to resolve a conflict regarding the presence or absence of pulmonary disease, a physician Board-certified in internal medicine cannot serve as an impartial specialist in the present case, absent documentation of special qualifications.[7]

As there is no documentation of special qualifications for Dr. Wicker,[8] the Office should refer appellant, the case record and a statement of accepted facts to an appropriate physician who is Board-certified in pulmonary diseases for a reasoned medical opinion of whether appellant has

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who shall make an examination."

[5] *Harold Travis*, 30 ECAB 1071 (1979).

[6] The Official ABMS Directory of Board Certified Medical Specialists, (30th edition 1998).

[7] "A physician who is not Board-certified may be used if he or she has special qualifications for performing the examination, but the MMA [medical management assistant] must document the reasons for the selection in the case record." Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.4b(1) (March 1994).

[8] The Board notes that Dr. Wicker concluded that appellant had no pulmonary impairment based on what the doctor acknowledged was an unreliable pulmonary function study.

pneumoconiosis due to his exposure to coal dust. This specialist should review all the chest x-rays and pulmonary function studies in the case record in reaching this opinion.[9]

The decisions of the Office of Workers' Compensation Programs dated June 11, 1996 and November 30, 1995 are set aside and the case remanded to the Office for further action consistent with this decision of the Board.

Dated, Washington, D.C.
December 29, 1998

David S. Gerson
Member

Willie T.C. Thomas
Alternate Member

Bradley T. Knott
Alternate Member

[9] *See Herman L. Henson*, 40 ECAB 341 (1988) (In this hearing loss case, the Board required that the medical specialist review all the audiograms done to test appellant's hearing).