U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of NORRIS W. FURGERSON and DEPARTMENT OF LABOR, MINE SAFETY & HEALTH ADMINISTRATION, Barbourville, KY

Docket No. 99-1961; Submitted on the Record;
Issued September 19, 2000

DECISION and ORDER

Before DAVID S. GERSON, A. PETER KANJORSKI,
VALERIE D. EVANS-HARRELL

The issue is whether the Office of Workers' Compensation Programs met its burden of proof to rescind its acceptance of appellant's claim.

On December 2, 1996 appellant, then a 57-year-old supervisory coal mine safety and health inspector, filed an occupational disease claim alleging that he developed coal workers' pneumoconiosis due to exposure to coal dust during his federal employment. On the reverse side of the claim form, appellant's supervisor noted that appellant had been off work from October 12, 1990 to the present due to an employment-related injury.[1]

On May 23, 1997 the Office referred appellant, together with the case record and a statement of accepted facts, to Dr. Glen R. Baker, a Board-certified internist specializing in pulmonary diseases, for a second opinion evaluation. Dr. Baker, a certified "B" reader, interpreted an x-ray obtained on June 9, 1997 as revealing pneumoconiosis with a profusion of 1/0. In a report dated June 9, 1997, Dr. Baker diagnosed coal workers' pneumoconiosis due to coal dust exposure, chronic bronchitis due to coal dust exposure and cigarette smoking, and chronic obstructive pulmonary disease due to coal dust exposure and cigarette smoking.[2] He noted that a pulmonary function study revealed a mild obstructive defect and that an arterial blood gas study was normal. Dr. Baker concluded that appellant had a mild impairment as a result of the diagnosed lung conditions.

An Office medical adviser reviewed Dr. Baker's opinion and noted that his report did not contain physical findings on examination or appellant's medical history. At the request of the

[1] The Office accepted that appellant sustained lumbosacral strain due to an injury on October 12, 1990. The Office assigned the claim file number A11-105247.

[2] Appellant indicated to Dr. Baker that he smoked one pack per day from the 1970's to 1996.

Office, Dr. Baker submitted a supplemental report dated July 25, 1997, in which he discussed appellant's history of symptoms and listed findings on examination. Dr. Baker opined:

> "My interpretation is that [appellant] does have coal workers' pneumoconiosis, category 1/0, on the basis of the 1980 ILO [International Labour Organization] classification, chronic obstructive airway disease with a mild degree of reversibility and, on [the] basis of the response to bronchodilators on pulmonary function studies, chronic bronchitis with symptoms of cough, sputum production and wheezing with production of 2 tablespoons of sputum per 24 hours.
>
> "I feel that many of his symptoms are related to cigarette smoking history, but with [his] long history of dust exposure, this likewise probably contributed as well in that his history of cigarette smoking and dust exposure are probably synergistic in production of his obstructive airway disease and chronic bronchitis and that his coal workers' pneumoconiosis as regards to his x-ray findings.
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> "In summary, his federal employment could cause, aggravate and precipitate the lung condition that he currently has."

By letter dated September 3, 1997, the Office advised appellant that his claim had been accepted for chronic bronchitis, pneumoconiosis and obstructive airways disease.

On September 4, 1997 the Office requested that an Office medical adviser review the medical evidence and address whether appellant was entitled to a schedule award for a permanent impairment of his lungs.

In a report dated November 30, 1997, the Office medical adviser found that he could not base an impairment determination on the June 9, 1997 pulmonary function study by Dr. Baker due to appellant's questionable cooperation on the study. Consequently, on December 10, 1997, the Office referred appellant to Dr. Mitchell Wicker, a Board-certified internist and certified "B" reader, for a second opinion evaluation.

In a report dated January 5, 1998, Dr. Wicker interpreted an x-ray obtained on that date as showing findings of chronic bronchitis and "possible pleural interstitial thickening on the right, few small nodules. I feel that these are granulomas not TB [tuberculosis] and not pneumoconiosis." Dr. Wicker concluded that appellant did not have pneumoconiosis and that, based on the results of objective studies, he had the respiratory capacity to perform his regular employment.

The Office found a conflict between Dr. Baker and Dr. Wicker on the issue of whether appellant had an employment-related lung condition. The Office referred appellant to Dr. Frederick Seifer, a Board-certified internist who specializes in diagnostic radiology, for an examination.

In a report dated February 20, 1998, Dr. Seifer noted a stellate lesion on an x-ray obtained on that date. He related:

> "At this point in time, there is no doubt that [appellant] has had significant exposure to silica, which puts him at risk for silicosis and coal workers' pneumoconiosis. I do not, however, see definitive radiographic evidence to support the above diagnosis. [Appellant] most definitely has mild obstructive lung disease and should be aggressively medically managed for his obstructive lung disease."

Dr. Seifer further noted that appellant should be followed to determine whether the stellate lesion on x-ray represented a malignancy.

On March 5, 1998 the Office requested that Dr. Seifer provide an opinion regarding whether appellant had any lung condition caused or aggravated by his employment; however, Dr. Seifer declined the Office's request for additional findings. The Office, therefore, referred appellant to Dr. John M. Harrison, a Board-certified internist specializing in pulmonary diseases and certified "B" reader.

In a report dated August 11, 1998, Dr. Harrison opined that x-rays revealed some abnormalities which he attributed to "old granulomatous disease" rather than pneumoconiosis. Dr. Harrison found that appellant could perform his usual employment from a pulmonary standpoint.

In an addendum dated August 18, 1998, Dr. Harrison opined that he "found no evidence of pneumoconiosis and therefore feel [appellant] does not have any lung condition related to his employment."

Appellant submitted a report dated February 5, 1997, received by the Office on October 30, 1998, from Dr. Kenneth A. Perret, a Board-certified internist who specializes in pulmonary critical care medicine. Dr. Perret interpreted a February 5, 1997 x-ray as profusion 1/1 with "multiple scattered granulomas throughout both lung fields" and "a very mild prominence of interstitial markings throughout both lung fields." He diagnosed mild airflow obstruction as seen on pulmonary function study and chronic bronchitis based on appellant's symptoms. Dr. Perret attributed the diagnosed conditions to exposure to dust and abuse of tobacco and found that appellant "could not perform mining-type activities."

By decision dated April 14, 1999, the Office rescinded its acceptance of appellant's claim for pneumoconiosis, chronic bronchitis and obstructive lung disease and terminated compensation benefits.

The Board finds that the Office did not meet its burden of proof to rescind its acceptance of appellant's claim.

The Board has upheld the Office's authority to reopen a claim at any time on its own motion under section 8128(a) of the Federal Employees' Compensation Act and, where

supported by the evidence, set aside or modify a prior decision and issue a new decision.[3] However, the power to annul an award is not an arbitrary one and an award of compensation may only be set aside in the manner provided by the compensation statute.[4] It is well established that once the Office accepts a claim, it has the burden of justifying termination or modification of compensation. This holds true where, as here, the Office later decided that it erroneously accepted a claim.[5] To justify rescission of acceptance of a claim, the Office must show that it based its decision on new evidence, legal argument and/or rationale.[6]

In the present case, the Office accepted that appellant sustained chronic bronchitis, pneumoconiosis and obstructive airways disease due to exposure to dust in the course of his federal employment. The Office based its acceptance of appellant's claim on the report of Dr. Baker, a Board-certified internist who specializes in pulmonary diseases and is a certified "B" reader. Following acceptance of appellant's claim, an Office medical adviser reviewed Dr. Baker's pulmonary function studies for the purpose of rating appellant's pulmonary impairment for a schedule award; however, the Office medical adviser found that the test results were not reliable due to poor cooperation by appellant. The Office therefore referred appellant to Dr. Wicker, a Board-certified internist and certified "B" reader, who opined that appellant did not have evidence of pneumoconiosis or any respiratory impairment.

The Office found a conflict in medical opinion between Dr. Baker and Dr. Wicker and referred appellant to Dr. Harrison, a Board-certified internist specializing in pulmonary diseases, for resolution of the conflict. However, as both Dr. Baker and Dr. Wicker were Office referral physicians, their reports did not create a conflict of opinion pursuant to section 8123(a).[7] An Office referral physician cannot create a conflict on behalf of a claimant in a situation where the claimant did not use the referral physician as a treating physician.[8] Therefore, Dr. Harrison acted as an Office referral physician in this case rather than an impartial medical specialist.

Appellant submitted a report from Dr. Perret, a Board-certified internist who specializes in pulmonary critical care medicine, who found that he had a mild obstruction of airflow and chronic bronchitis due to employment-related dust exposure and cigarette smoking. Dr. Perret further noted on an x-ray interpretation that appellant had small opacities of profusion 1/1. The Board finds that the record contains a conflict of opinion between Dr. Perret and Dr. Harrison on the issue of whether appellant has chronic bronchitis or obstructive lung disease caused or aggravated by his federal employment. Dr. Perret's x-ray interpretation further suggests that

[3] *Eli Jacobs*, 32 ECAB 1147 (1981).

[4] *Shelby J. Rycroft*, 44 ECAB 795 (1993).

[5] *Noah Ooteen*, 50 ECAB ___ (Docket No. 96-1405, issued March 12, 1999).

[6] *Id*.

[7] 5 U.S.C. § 8123(a). This section provides that if 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 an examination.

[8] *See LeAnne E. Maynard*, 43 ECAB 482 (1992).

appellant may have pneumoconiosis. Consequently, the Board finds that the Office did not meet its burden of proof in rescinding its acceptance of appellant's claim for chronic bronchitis, pneumoconiosis and obstructive airways disease.

As there is a conflict of medical opinion under section 8123(a) of the Act, the Office has not met its burden of proof in rescinding its acceptance of appellant's claim for chronic bronchitis, pneumoconiosis and obstructive airways disease.[9]

The decision of the Office of Workers' Compensation Programs dated April 14, 1999 is reversed.

Dated, Washington, D.C.
September 19, 2000

David S. Gerson
Member

A. Peter Kanjorski
Alternate Member

Valerie D. Evans-Harrell
Alternate Member

[9] The Board notes that appellant submitted additional evidence with his appeal. The Board's jurisdiction is limited to reviewing evidence which was before the Office at the time of its final decision. 20 C.F.R. § 501.2(c).