U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of NOAH OOTEN and DEPARTMENT OF LABOR,
MINE SAFETY & HEALTH ADMINISTRATION,
Mount Hope, W.Va.

Docket No. 96-1405; Submitted on the Record;
Issued March 12, 1999

DECISION and ORDER

Before GEORGE E. RIVERS, DAVID S. GERSON,
MICHAEL E. GROOM

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

On September 14, 1993 appellant, then a 59-year-old supervisory coal mine safety and health inspector, filed a claim alleging that he developed coal workers' pneumoconiosis due to exposure to coal dust during his federal employment. Appellant did not stop work.

On March 25, 1994 the Office referred appellant for examination by Dr. Charles Porterfield, an osteopathic physician specializing in pulmonary diseases. Dr. Porterfield was requested to include the results of pulmonary function studies and advised he could consult on x-rays with a certified "B" reader. In a report dated April 12, 1994, he stated that he had evaluated appellant and noted that chest x-rays had been read in the past as having interstitial changes compatible with pneumoconiosis and that appellant had a 37-year history of mine work. Dr. Porterfield listed his impressions as "coal workers' pneumoconiosis based on chest x-ray appearance" and "COPD [chronic obstructive pulmonary disease] secondary to Number 1 plus cigarette use."

By letters dated April 25 and May 25, 1994, the Office requested that Dr. Porterfield submit the results of a current chest x-ray, as interpreted by a certified "B" reader, together with pulmonary functions studies. In a report dated May 2, 1994, Dr. Porterfield noted that chest x-rays and an electrocardiogram (EKG) had not been obtained, and that his diagnosis of pneumoconiosis was based on a review of prior readings. The record indicates that Dr. Porterfield referred appellant to Dr. Maurice Bassali for radiographic evaluation. In a June 8, 1994 report, Dr. Bassali stated that x-ray examination on June 7, 1994 revealed diffuse chronic interstitial lung disease consistent with coal worker's pneumoconiosis, type q/t, profusion of 1/1 affecting all six lung zones.

By letter dated November 16, 1994, the Office advised appellant that his claim had been accepted for pneumoconiosis. Thereafter, the Office processed appellant's claim for a schedule award.

On August 21, 1995 the record was reviewed by Dr. Daniel D. Zimmerman, an Office medical adviser, who noted that Dr. Porterfield had not submitted the graphic results of any pulmonary function study. The medical adviser also noted that the record did not indicate whether appellant's x-rays were reviewed by a certified "B" reader. He recommended that confirmation be obtained that a certified "B" reader had interpreted appellant's x-rays and that pulmonary function studies be obtained for the record.

The April 12, 1994 pulmonary function studies of Dr. Porterfield were submitted to the record, together with a certification of Dr. Bassali's designation as a "B" reader under the Federal Mine Safety and Health Act. On August 25, 1995 Dr. Zimmerman reviewed the pulmonary function studies and noted that Dr. Porterfield had indicated that the studies were effort dependent and not representative of appellant's best capabilities. Dr. Zimmerman noted that the pulmonary studies demonstrated that appellant made an erratic effort and showed poor cooperation with the testing process.

On September 15, 1995 the Office referred appellant to Dr. Mitchell Wicker, a Board-certified pulmonary specialist and certified "B" reader, for a current evaluation. Appellant was examined on October 6, 1995, at which time Dr. Wicker obtained a chest x-ray which revealed no acute pulmonary disease, increased markings at both bases consistent with chronic bronchitis, no acute abnormalities and pleural interstitial thickening on the right. He opined that he saw no evidence of pneumoconiosis. In an attached pulmonary function study, Dr. Wicker noted that appellant's arterial blood gas test results fell within the predicted normal range. He rated appellant's cooperation with pulmonary testing as good and noted forced expiratory volume in the first second (FEV1) was 107 percent of the predicted normal value and FEV was 103 percent of the predicted normal value. On EKG, Dr. Wicker found a left axis deviation with nonspecific ST t-wave changes noted. In addressing the extent of pulmonary impairment, Dr. Wicker noted that appellant's respiratory capacity was adequate to perform his previous occupation in the coal mining industry.

The Office found a conflict in medical opinion between Drs. Porterfield and Wicker as to whether appellant had pneumoconiosis or any other pulmonary condition causally related to his employment as a coal mine inspector. Appellant was referred for examination to Dr. Dominic Gaziano, a Board-certified pulmonary specialist and certified "B" reader.

In a February 9, 1996 report, Dr. Gaziano reviewed appellant's employment history and reported the results of his February 1, 1996 examination. Dr. Gaziano stated that electrocardiogram revealed a sinus rhythm, rate 75, with moderate left axis deviation. Appellant was exercised on a bicycle ergometer and both resting and exercise arterial blood gas studies were found normal. Pulmonary function studies were obtained which revealed both prebroncodilator and postbronchodilator results to be above the predicted values for FEV and FEV1. Dr. Gaziano stated that normal ventilatory function was found with normal diffusing capacity for carbon monoxide. He reviewed the results of prior examination of appellant, noting that chest x-rays of March 18, 1980 and September 30, 1982 had been negative for evidence of pneumoconiosis, as were examinations of appellant in 1995 following Dr. Porterfield's diagnosis. Dr. Gaziano concluded that appellant did not have pneumoconiosis based upon a 0/0

profusion and that the results of his pulmonary studies and x-rays did not reveal a significant pulmonary condition or any evidence of occupational pneumoconiosis.

By decision dated March 6, 1996, the Office rescinded its acceptance of appellant's claim for pneumoconiosis and terminated compensation benefits.

The Board finds that the Office properly rescinded its acceptance of appellant's claim for pneumoconiosis.

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.[1] 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.[2] 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.[3] 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.[4]

In the present case, the Office accepted that appellant sustained pneumoconiosis due to exposure to coal dust in his federal employment. Acceptance of appellant's claim was based on medical evidence submitted from Dr. Porterfield, a pulmonary specialist who obtained pulmonary function studies and a chest x-ray report of Dr. Bassali, a certified "B" reader. Following acceptance of appellant's claim, the pulmonary function studies of Dr. Porterfield were reviewed by Dr. Zimmerman for the purpose of rating appellant's pulmonary impairment for a schedule award. Dr. Zimmerman noted, however, that the test results obtained by Dr. Porterfield showed an erratic effort and poor cooperation by appellant with the testing process. Appellant was subsequently referred to Dr. Wicker, a Board-certified pulmonary specialist and certified "B" reader, who performed a thorough examination of appellant and obtained diagnostic tests which he indicated showed good cooperation. He concluded, however, that appellant's examination and testing revealed no evidence of pneumoconiosis. Based on this new medical evidence, the Office properly proceeded to reopen the claim to determine whether appellant had pneumoconiosis.

In this case, the Office found a conflict in medical opinion between Drs. Porterfield and Wicker as to the diagnosis of pneumoconiosis, and referred appellant for examination and diagnostic testing by Dr. Gaziano, a Board-certified pulmonary specialist and certified "B" reader. However, the Board notes that as both Dr. Porterfield and Dr. Wicker were Office referral physicians, a conflict of medical opinion was not created under section 8123(a).[5] An

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

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

[3] *Alfonso Martinisi*, 33 ECAB 841 (1982); *Jack W. West*, 30 ECAB 909 (1979).

[4] *See Marvin L. Ralph*, 47 ECAB 626 (1996); *Shelby J. Rycroft*, *supra* note 2.

[5] 5 U.S.C. § 8123(a). This section 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; *see Shirley L. Steib*, 46 ECAB 309 (1994).

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.[6] For this reason, Dr. Gaziano acted as an Office referral physician in this case rather than an impartial medical specialist.

The Board finds that the weight of the medical opinion evidence is represented by the report of Dr. Gaziano, a Board-certified specialist in pulmonary diseases and certified "B" reader. He provided results of pulmonary function studies, chest x-rays and electrocardiograms in which he found that appellant's pulmonary function exceeded predicted normal values for his age, height and sex. Arterial gas studies on exercise testing were reported as revealing normal ventilatory function and normal diffusing capacity for carbon dioxide. The results obtained on diagnostic testing were noted to be reliable. In addition, Dr. Gaziano reviewed prior pulmonary function evaluations dating back to 1980 and noted that only Dr. Porterfield's examination had resulted in the diagnosis of pneumoconiosis. He concluded that appellant did not have pneumoconiosis based upon a 0/0 profusion and that diagnostic testing did not reveal any significant pulmonary condition or evidence of occupational pneumoconiosis.

The issue of whether appellant sustained pneumoconiosis causally related to his federal employment is primarily medical in nature. In this case, the Office submitted new medical evidence addressing the relevant medical issue. Based on the weight of the medical evidence, the Board finds that the Office properly reopened appellant's claim and rescinded acceptance of his claim for employment-related pneumoconiosis.

The March 6, 1996 decision of the Office of Workers' Compensation Programs is affirmed, as modified.

Dated, Washington, D.C.
March 12, 1999

George E. Rivers
Member

David S. Gerson
Member

Michael E. Groom
Alternate Member

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