U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of DAVID B. MOLLETTE and DEPARTMENT OF LABOR, MINE SAFETY & HEALTH ADMINISTRTION, Arlington, VA

Docket No. 98-1375; Submitted on the Record;
Issued July 6, 2000

DECISION and ORDER

Before DAVID S. GERSON, MICHAEL E. GROOM,
A. PETER KANJORSKI

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

Appellant timely filed a notice of occupational disease alleging that he developed coal workers' pneumoconiosis due to exposure to coal dust during his federal employment as a coal mine inspector. He stopped work February 1, 1985 and retired on disability October 1, 1985. The Office accepted appellant's claim for pneumoconiosis and thereafter processed appellant's claim for a schedule award.[1]

Appellant's treating physician, Dr. Ragu Sundaram, a pulmonary specialist, continued to opine that appellant had pneumoconiosis and was totally disabled for any type of employment.

By letter dated February 22, 1996, the Office referred appellant for an examination by Dr. Mitchell Wicker, Jr., a Board-certified pulmonary specialist and a "B" reader. He was requested to include the results of pulmonary function studies and was provided with a statement of accepted facts and the medical evidence of file. In a report dated March 8, 1996, Dr. Wicker stated that, based on his examination and medical evidence provided by both the Office and himself, it was his opinion that appellant did not have any evidence of pneumoconiosis as the March 6, 1996 chest x-ray was completely negative. In an attached pulmonary function study, he noted that appellant's arterial blood gas test results fell within the predicted normal range. Dr. Wicker rated appellant's cooperation with pulmonary testing as fair and indicated that, although this was not a true indicator of appellant's maximum voluntary ventilatory capacity, appellant fell within acceptable limits. On an electrocardiogram (EKG), he found a left axis deviation. In addressing the extent of pulmonary impairment, Dr. Wicker noted that appellant's

[1] The record indicates that, by letter dated December 15, 1989, appellant received an additional award of compensation for a 35 percent impairment of each lung. As the Office previously awarded a 15 percent impairment for each lung on October 1, 1985 appellant received a total impairment of 50 percent of each lung.

respiratory capacity was adequate to perform his previous occupation in the coal mining industry. He opined that appellant had an underlying constructive pulmonary disease which might represent reactive airway disease, secondary to his prolonged history of smoking as evidenced by the widely varying pulmonary function tests. Dr. Wicker also opined that much of appellant's reactive airway disease may be due to underlying congestive heart failure as based on his finding of cardiac enlargement.

The Office found a conflict in medical opinion between Drs. Sundaram 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 an examination to Dr. Bruce C. Broudy, a Board-certified pulmonary specialist and a "B" reader.[2]

In a May 3, 1996 report, Dr. Broudy reviewed appellant's employment history and reported the results of his examination which consisted of history, physical examination, spirometry, arterial blood gas study and chest x-rays. He stated that the cardiac examination revealed a regular rhythm without murmur rub or gallop. The spirometry was performed with less than optimal effort, but nonetheless the results showed only mild obstruction and did not qualify for the minimum federal criteria for disability in coal workers. The arterial blood gas study was normal for appellant's age. The chest x-rays were of good diagnostic quality with clear lung zones and no evidence of coal workers' pneumoconiosis. Dr. Broudy diagnosed chronic bronchitis and dyspnea. He concluded that appellant did not have pneumoconiosis and that he retained the respiratory capacity to perform his previous work or work requiring similar effort. Dr. Broudy stated that there was no evidence that there had been any significant pulmonary disease or respiratory impairment which had arisen from his occupation as a coal worker. He further stated that copies of the chest x-rays dated August 4, 1994 were reviewed, but graded them as a level 3 for diagnostic quality as they were of not of very good quality and were very underpenetrated laterally. Dr. Broudy stated that the areas of the August 4, 1994 film, which were readable, were negative for pneumoconiosis.

By letter dated May 16, 1996, the Office advised appellant of its proposed termination of compensation. He was provided 30 days within which to submit additional evidence or argument.

In letters of March 1 and May 20, 1996, Dr. Sundaram stated that appellant had been a patient since 1985. He also indicated that appellant is on multiple medications due to his severe lung impairment pneumoconiosis. Dr. Sundaram stated that appellant has history, physical examination, pulmonary function test data and radiological data supportive of ongoing workers pneumoconiosis and respiratory impairment. He stated that appellant has severe degree of small airway disease, restrictive airway disease and severe obstructive airway disease, chronic obstructive pulmonary disease, progressive pulmonary disease and impairment, coal workers' pneumoconiosis and significant functional limitations. Dr. Sundaram further stated that appellant had been out of the workforce for over 11 years and with the breathing impairment he

[2] 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).

now has, he is not medically, physically, mentally or emotionally able to be suited for any type of work.

In reports dated June 5, 1996, Dr. Ballard D. Wright, a pulmonary specialist, provided rereadings of August 30, 1991, August 4, 1994 and November 9, 1995 chest x-ray films. All the films were found to have nonspecific interstitial opacities consistent with early category 1/0 pneumoconiosis, simple. All films were of acceptable quality with the exception of the August 4, 1994 film, which Dr. Wright rated as being under penetrated.

By decision dated June 19, 1996, the Office rescinded its acceptance of appellant's claim for pneumoconiosis and terminated compensation benefits. By decision dated March 11, 1998, an Office hearing representative affirmed the prior decision.

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.[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 pneumoconiosis due to exposure to coal dust in his federal employment. Acceptance of his claim was based on the pulmonary function studies and chest x-ray reports[7] submitted from Dr. Sundaram in which appellant was diagnosed as having a severe respiratory impairment resulting from pneumoconiosis and supportive of total disability. Following acceptance of appellant's claim, of which appellant had been on the periodic rolls since March 16, 1986, appellant was subsequently referred to Dr. Wicker, a Board-certified pulmonary specialist and certified "B" reader, who performed a thorough examination of appellant on March 8, 1996 and obtained diagnostic tests which he indicated fair cooperation. He concluded, however, that appellant's examination and testing revealed no evidence of pneumoconiosis and opined that appellant's respiratory capacity was adequate to perform his previous occupation in the coal mining industry. Based on this new

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

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

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

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

[7] The specific dates of the objective tests are set forth in Dr. Sundaram's May 20, 1996 letter.

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 Dr. Sundaram, appellant's treating physician and Dr. Wicker, an Office referral physician, as to the diagnosis of pneumoconiosis and resulting disability and, pursuant to section 8123(a) of the Act, properly referred appellant for examination and diagnostic testing to Dr. Broudy, a Board-certified pulmonary specialist and certified "B" reader, for an impartial medical examination and an opinion on the matter.[8]

In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[9] The Board finds that Dr. Broudy's May 3, 1996 report is sufficiently rationalized and responsive to the Office's inquiries to be entitled to special weight. He was provided with the entire case file and the statement of accepted facts. Dr. Broudy arranged for appellant to undergo current pulmonary function studies, chest x-ray as interpreted by a certified "B" reader (himself), arterial blood gas studies and diffusion capacity studies. He provided a detailed medical report based on his thorough examination and review of the entire case file in which he found that the evidence did not support a diagnosis of pneumoconiosis based upon a 0/0 profusion and that the diagnostic testing did not reveal any significant pulmonary condition or evidence of occupational pneumoconiosis. Dr. Broudy's conclusion is supported by medical rationale and is fully responsive to the inquiries of the Office. The Board finds that the report of Dr. Broudy is entitled to special weight and is sufficient to support the termination of appellant's wage-loss benefits.

Dr. Sundaram's reports of March 1 and May 20, 1996 merely summarize the results of appellant's previous testing and lack substantive medical rationale to support the opinion that appellant is disabled for any type of employment. He opines that appellant is disabled for any type of employment because he has not worked for 11 years and is not medically, physically, mentally or emotionally suitable for any type of work. However, no discussion was provided regarding the effect of appellant's long history of smoking or the effect of work environment exposure. Inasmuch as Dr. Sundaram failed to provide any medical rationale to support his conclusion, his opinion is of diminished probative value.[10]

Although Dr. Wright provided a diagnosis of pneumoconiosis based on rereadings of chest x-rays dated August 30, 1991, August 4, 1994 and November 9, 1995 in his reports of June 5, 1996, there is no certification in the case record pertaining to Dr. Wright's credentials to establish whether he is a "B" reader. Furthermore, he has not offered a medical opinion supported by medical rationale differentiating the effects of appellant's occupational exposure to coal dust and his long history of smoking and has not provided any pulmonary function tests to

[8] *See supra* note 2.

[9] *Jack R. Smith*, 41 ECAB 691, 701 (1990); *James P. Roberts*, 31 ECAB 1010, 1021 (1980).

[10] *See Jennifer Beville*, 33 ECAB 1970 (1982); *Leonard J. O'Keefe*, 14 ECAB 42 (1962).

access appellant's respiratory capacity. As such, Dr. Wright's positive rereadings of old x-ray films is of diminished probative value and is insufficient to overcome the opinion of Dr. Broudy, a certified "B" reader and a Board-certified specialist in the field, who opined that appellant did not have pneumoconiosis or any other pulmonary condition causally related to his employment as a coal mine inspector.

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 11, 1998 decision of the Office of Workers' Compensation Programs is affirmed.

Dated, Washington, D.C.
July 6, 2000

David S. Gerson
Member

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member