# United States Department of Labor
# Employees' Compensation Appeals Board

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| **PERCY E. MARSHALL, Appellant** | ) | |
| **and** | ) | **Docket No. 06-795** |
| | ) | **Issued: June 22, 2006** |
| **TENNESSEE VALLEY AUTHORITY, NATIONAL FERTILIZER-DEVEOPMENT CENTER, Muscle Shoals, AL, Employer** | ) | |

*Appearances:*
*Percy E. Marshall, pro se*
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

### ***JURISDICTION***

On February 22, 2006 appellant filed a timely appeal of a merit decision of the Office of Workers' Compensation Programs dated February 9, 2006, rescinding the acceptance of his claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d), the Board has jurisdiction over the merits of the claim.

### ***ISSUE***

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

### ***FACTUAL HISTORY***

On October 25, 2001 appellant, a 63-year-old prototype foreman, filed an occupational disease claim alleging that he sustained asbestosis causally related to his federal employment.[1] On May 28, 2002 the Office received an undated statement from the employing establishment controverting the claim due to the lack of medical evidence and no information showed that he

[1] Appellant retired from the employing establishment effective October 17, 1994.

was exposed to asbestos during his employment. By letter dated July 15, 2002, the Office requested that appellant submit further information.

In a March 2, 2002 report, Dr. James Ballard, a Board-certified diagnostic radiologist and nuclear medicine physician, diagnosed asbestosis, based upon a December 10, 2001 x-ray interpretation. Dr. Ballard opined that based upon appellant's x-ray and work history that he had asbestosis due to occupational exposure.

In an April 30, 2003 treatment note, Dr. William M. Reid, a Board-certified internist, diagnosed hypertension, restrictive lung disease and coronary vascular disease. He reported that appellant "had an extensive evaluation at a screening in Columbus, Mississippi, dated August 3, 2002" with the x-ray interpretation showing "bilateral interstitial fibrosis consistent with pneumoconiosis." Dr. Reid reported pulmonary function studies performed at the time showed moderate to severe restrictions.

On May 20, 2003 the Office referred appellant to Dr. David G. Chase, Sr., a second opinion Board-certified internist and pulmonary specialist, for a medical examination. In a June 24, 2003 report, Dr. Chase diagnosed mild asbestosis, hypercholesterolemia, coronary artery disease and hypertensive cardiovascular disease (HCVD). In his summary, he noted:

> "Based on review of all the medical records, my history and physical exam[ination] and review of the chest x-ray, PFT's [pulmonary function tests], DLCO [diffusing capacity of the lungs for carbon monoxide], ABG's [arterial blood gas], CBC [complete blood count], urinalysis and EKG [electrocardiogram] I do agree that the patient has interstitial fibrosis that would be consistent with asbestosis. However, he does appear to be permanently disabled on that bases based on the guideline for a 74-inch person for disability for social security would be a FVC [forced expiratory vital capacity] less than 1.85 liters. A single breath diffusing capacity of less than 4 percent of predicted or less than 10.5 ml [milliliter]/min[ute]/m[illi]m[eter] of mercury."

In an addendum, Dr. Chase noted that appellant "was not giving good effort" on the pulmonary function study and was not sure how much disability appellant had from his mild asbestosis.

In a July 23, 2003 report, the Office medical adviser reviewed Dr. Chase's report and recommended that a repeat pulmonary function study be performed based on his observation that appellant did not provide a good effort.

In a September 29, 2003 treatment note, Dr. Reid noted that on April 30, 2003 he had diagnosed pulmonary fibrosis and that appellant's pulmonary function studies "revealed restricted spirometry with diminished diffusion capacity." An x-ray interpretation showed increased interstitial markings, mostly in the bases bilaterally, with cardiomegaly. Dr. Reid diagnosed pulmonary fibrosis, most likely related to asbestosis.

By letter dated August 6, 2003, the Office accepted appellant's claim for pulmonary asbestosis.

In a November 7, 2003 report, the Office medical adviser reviewed Dr. Reid's September 29, 2003 report and concluded that appellant had a 38 percent impairment of the whole person based upon the September 29, 2003 pulmonary function study.

On October 14, 2004 appellant was referred to Dr. Maria L. Johnson, a Board-certified internist with a subspecialty in critical care medicine. She was selected to resolve a conflict in the medical opinion evidence between appellant's treating physician, Dr. Reid, and the second opinion physician, Dr. Chase, as to whether appellant had any pulmonary impairment.

In a report dated November 5, 2004, Dr. Johnson reported that an x-ray performed that date showed appellant had cardiomegaly, but she did see any evidence of pleural plaques, interstitial lung disease, pleural effusions or any other pneumonic opacities or masses. With respect to the pulmonary function studies, she reported a forced expiratory volume ($FEV_1$) of 2.53 or 79 percent of predicted. She noted the $FEV_{1/}FVC$ ratio as 80, normal mid-lung volumes, total lung capacity was within normal range and diffusion capacity was decreased to 54 percent but corrects to normal when adjusted for alveolar volume. She also performed arterial blood gas tests which showed 42.67 for $PaCO_2$ (partial pressure of carbon dioxide) and 74.4 for $PaO_2$ (partial pressure of oxygen). A CBC showed white blood cell count as 9,100 cells, appellant's hematocrit was 35 percent, his platelet count was 282,000 and his hemoglobin was 12.4, which was described as low. Dr. Johnson noted that appellant had a history of asbestosis exposure, but opined that she did "not see any evidence of asbestosis-related disease, either by examination of his chest x-ray or by his pulmonary function tests."

In an August 15, 2005 report, the Office medical adviser indicated that he had not calculated a schedule award because she found no evidence of asbestosis by pulmonary function tests or x-ray interpretation in her November 15, 2004 report.

On August 31, 2005 appellant filed a claim for a schedule award.

On October 6, 2005 the Office issued a notice of proposed rescission on the basis that the medical evidence established that appellant never had an asbestos-related condition. By letter dated November 5, 2005, appellant noted his disagreement with the proposed decision. He submitted a report of Dr. Laurence C. Carmichael, a treating Board-certified internist with subspecialty in critical care medicine and pulmonary disease, and the opinion of four other physicians established that he had asbestosis. By decision dated February 9, 2006, the Office finalized the decision to rescind acceptance of the claim.

## ***LEGAL PRECEDENT***

Section 8128 of the Federal Employees' Compensation Act provides that [t]he Secretary of Labor may review an award for or against payment of compensation at any time on his own motion or on application.[2] The Board has upheld the Office's authority to reopen a claim at any time on its own motion under section 8128 of the Act and, where supported by the evidence, set

[2] 5 U.S.C. §§ 8101-8193, 8128.

aside or modify a prior decision and issue a new decision.[3] The Board has noted, however, that the power to annul an award is not an arbitrary one and that an award for compensation can only be set aside in the manner provided by the compensation statute.[4]

Workers' compensation authorities generally recognize that compensation awards may be corrected, in the discretion of the compensation agency and in conformity with statutory provision, where there is good cause for so doing, such as mistake or fraud.[5] It is well established that, once the Office accepts a claim, it has the burden of justifying the termination or modification of compensation benefits. This holds true where, as here, the Office later decides that it erroneously accepted a claim. In establishing that its prior acceptance was erroneous, the Office is required to provide a clear explanation of the rationale for rescission.[6]

## ***ANALYSIS***

In the instant case, the Office accepted appellant's claim for pulmonary asbestosis on August 6, 2003. On October 6, 2005 the Office issued a notice proposing to rescind acceptance of appellant's claim. The Office finalized the proposed rescission by decision dated February 6, 2005.

On October 14, 2004 the Office referred appellant to Dr. Johnson to resolve the conflict in the medical opinion evidence regarding whether appellant had a ratable impairment due to his accepted pulmonary asbestosis. In her November 5, 2004 report, Dr. Johnson noted he had a history of asbestosis exposure, but opined that she did "not see any evidence of asbestosis-related disease, either by examination of his chest x-ray or by his pulmonary function tests." In support of this conclusion, Dr. Johnson noted that an x-ray performed on November 5, 2004 showed that appellant had cardiomegaly, but did not see any evidence of pleural plaques, interstitial lung disease, pleural effusions or "any other pneumonic opacities or masses." She addressed the pulmonary function studies noting, "an $FEV_1$ of 2.53 or 79 percent of predicted." She noted the $FEV_{1/}FVC$ ratio as 80, normal mid-lung volumes, total lung capacity was within normal range and "diffusion capacity is decreased to 54 percent but corrects to normal when adjusted for alveolar volume." She also performed arterial blood gas tests on air which showed 42.7 for $PaCO_2$ and 74.4 for $PaO_2$ and a CBC which showed "white blood cell count is 9,100 cells, his hematocrit is 35 percent, his platelet count is 282,000 and his hemoglobin is 12.4, which is low."

At the time of the Office referral to Dr. Johnson, there was no conflict in the medical opinion evidence regarding whether appellant had employment-related asbestosis, as the conflict in the medical evidence at the time of the referral was whether there was any pulmonary

[3] *Walter L. Jordan*, 57 ECAB ___ (Docket No. 05-1720, issued November 15, 2005); *John W. Graves*, 52 ECAB 160, 61 (2000).

[4] *See* 20 C.F.R. § 10.610; *Walter L. Jordan*, *supra* note 3.

[5] *See Kelly Y. Simpson*, 57 ECAB ___ (Docket No. 04-1809, issued October 26, 2005).

[6] *George A. Rodriguez*, 57 ECAB ___ (Docket No. 05-490, issued November 18, 2005); *John W. Graves*, *supra* note 3.

impairment.[7] Consequently, she served as an Office referral physician, rather than an impartial medical specialist, and there is a conflict in medical opinion with Dr. Ballard regarding whether appellant sustained pulmonary asbestosis.

As there is an unresolved conflict in the medical evidence, the Office failed to meet its burden of proof to rescind its acceptance of appellant's claim for asbestosis.

## ***CONCLUSION***

The Board finds that the Office has not met its burden of proof to rescind acceptance of appellant's asbestosis claim as there is an unresolved conflict in the medical opinion evidence on that issue.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the decision of the Office of Workers' Compensation Programs dated February 9, 2006 is reversed.

Issued: June 22, 2006
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

[7] *Joseph Roman*, 55 ECAB ___ (Docket No. 03-1883, issued January 8, 2004). (A physician was properly an impartial medical specialist with respect to the issue in conflict, the need for surgery, at the time appellant was referred to him. However, there was no medial conflict regarding appellant's disability for work at the time of the referral; therefore, the specialist was not an impartial medical specialist on other issues and his report was not entitled to special weight on these other issues.)