United States Department of Labor
Employees' Compensation Appeals Board

C.F., Appellant	)	
and	)	**Docket No. 12-546**
	)	**Issued: February 5, 2013**
TENNESSEE VALLEY AUTHORITY, PARADISE FOSSIL PLANT, Drakesboro, KY, Employer	)	

Appearances:
Ronald K. Bruce, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On January 20, 2012 appellant, through his attorney, filed a timely appeal from a December 13, 2011 schedule award decision, in which a hearing representative of the Office of Workers' Compensation Programs (OWCP) affirmed a schedule award decision. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the schedule award decision.

ISSUE

The issue is whether appellant established that he has more than a six percent impairment of the lungs for which he received a schedule award.

On appeal, appellant's attorney asserts that the reports of the attending pulmonologist and OWCP referral pulmonologist support a greater impairment.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On March 16, 2010 appellant, then a 54-year-old coal tower foreman, filed an occupational disease claim alleging that he had an employment-related lung disease. The employing establishment indicated that his date of last exposure was October 16, 2009. In an undated statement, appellant described his work history. The employing establishment provided a table showing his federal employment.[2]

In support of his claim, appellant submitted a February 15, 2010 report, in which Dr. Glen Baker, Board-certified in internal medicine and pulmonary disease and a certified B-reader, provided examination findings. Dr. Baker advised that appellant had a 29-year history of dust and asbestos exposure at work. A January 15, 2010 chest x-ray demonstrated occupational pneumoconiosis, category 1/9. Pulmonary function studies dated February 12, 2010 showed a prebronchodilator forced vital capacity (FVC) at 78 percent of predicted and forced expiratory volume in the first second (FEV_1) at 57 percent of predicted, which Dr. Baker interpreted as demonstrating a moderate obstructive ventilatory defect. Postbronchodilator studies showed an FVC at 85 percent of predicted and an FEV_1 at 60 percent of predicted, which he indicated demonstrated a borderline mild to moderate obstructive defect, with a slight improvement of 6 percent following bronchodilators. Dr. Baker diagnosed occupational pneumoconiosis with pulmonary asbestosis, chronic obstructive airway disease (COPD) with a moderate obstructive ventilatory defect, which improved to a borderline mild-to-moderate obstructive defect following bronchodilators and chronic bronchitis. He indicated that, based on Table 5-4 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[3] appellant had a class 2, D, impairment based on an FEV_1 of 57 percent for a 20 percent impairment of the whole person.

In May 2010, OWCP referred appellant to Dr. Kenneth Anderson, Board-certified in internal medicine and pulmonary disease and a certified B-reader. In a July 15, 2010 report, Dr. Anderson noted his review of the statement of accepted facts, appellant's medical history and Dr. Baker's report. He provided physical examination findings and advised that a June 3, 2010 chest x-ray did not suggest coal workers' pneumoconiosis since the opacities were irregular and the upper lobes were not affected. Rather, Dr. Anderson indicated that the x-ray was consistent with asbestos-related pleural disease. He advised that pulmonary function tests performed on June 3, 2010 suggested mild obstruction with an FVC of 3.76 or 75.5 percent, an FEV_1 of 2.80 or 70.2 percent, with a ratio of 74.4. Dr. Anderson diagnosed moderate obstructive airways disease, a moderate diffusion defect, obstructive sleep apnea and hypersomnia. He advised that, based on Table 5-4 of the sixth edition, appellant had a class 2 rating, for an impairment of 11 to 23 percent.[4]

In a July 23, 2010 report, Dr. A.E. Anderson, OWCP's medical adviser, provided an impairment rating utilizing Table 5-4 of the sixth edition. He reviewed Dr. K. Anderson's report

[2] The employing establishment also submitted medical evidence not relevant to the instant schedule award claim.

[3] A.M.A., *Guides* (6th ed. 2008).

[4] Both Dr. Baker and Dr. Anderson provided copies of x-ray and pulmonary function study reports.

and advised that appellant's key factor was the FVC value, measured at 3.61 or 77 percent, with a default grade C or class 1, for 6 percent impairment. In applying grade modifiers, Dr. A. Anderson found no net difference warranting an adjustment of the default impairment, noting that appellant had a history of intermittent dyspnea and, on physical examination, a rare crackle. He found July 15, 2010 was the date of maximum medical improvement. In a supplementary report dated September 13, 2010, Dr. K. Anderson advised that appellant had asbestosis-related pleural disease.

On October 5, 2010 OWCP accepted that appellant had a benign neoplasm of the pleura. Appellant filed a schedule award claim on October 12, 2010. On November 1, 2010 he was granted a schedule award for six percent lung impairment, for a total of 18.72 weeks, to run from July 15 to November 23, 2010. Appellant, through his attorney, timely requested a hearing, that was held on March 7, 2011. He did not appear at the hearing. Counsel asserted that the opinions of Dr. Baker and Dr. K. Anderson should be credited, as each found a class 2 impairment.

By decision dated May 10, 2011, OWCP's hearing representative vacated the November 1, 2010 schedule award decision and remanded the case to OWCP to obtain a supplemental report from Dr. A. Anderson, OWCP's medical adviser, who was to provide a rationalized opinion regarding his selection of the key factor and provide a rationalized opinion regarding appellant's class, grade and final pulmonary impairment percentage.

In a May 18, 2011 report, Dr. A. Anderson advised that the A.M.A., *Guides* provide that in selecting a key factor, only the valid pulmonary function test consistent with the validated pathology should be considered; thus it was entirely appropriate to use FVC as both appellant's diagnoses, pneumoconiosis and benign neoplasm of the pleura, were restrictive disorders. On May 26, 2011 he reiterated that, under the A.M.A., *Guides*, only the valid pulmonary function test consistent with the validated pathology should be considered in designating a key factor. Dr. A. Anderson advised that a review of Dr. K. Anderson's report indicated that appellant had a history of dyspnea and that his physical examination of the lungs demonstrated only a rare crackle. He concluded that, under Table 5-4, the FVC was the most sensitive indicator of restrictive disease.

By decision dated June 7, 2011 decision, OWCP again found that appellant had six percent lung impairment, for a total of 18.72 weeks of compensation. Counsel timely requested a hearing, which was held on October 12, 2011. Appellant was not present at the hearing. Counsel again argued that the opinions of Drs. Baker and K. Anderson should be credited.

In a December 13, 2011 decision, OWCP's hearing representative affirmed the June 7, 2011 decision. He found that Dr. A. Anderson, provided a rationalized opinion in accordance with the sixth edition of the A.M.A., *Guides*.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing federal regulations[5] set forth the number of weeks of compensation payable to employees sustaining permanent

[5] 20 C.F.R. § 10.404 (2011). *See* 5 U.S.C. § 8107.

impairment from loss or loss of use, of scheduled members or functions of the body. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[6] For decisions after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[7]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[8] Chapter 5 of the A.M.A., *Guides* addresses the framework to be used for addressing the pulmonary system.[9] Table 5-4, Pulmonary Dysfunction, describes four classes of pulmonary dysfunction based on an assessment of history, physical findings and objective tests, including a comparison of observed values for certain ventilatory function measures and their respective predicted values.[10] The appropriate class of impairment is determined by the observed values for either the FVC, FEV_1 or diffusing capacity of carbon monoxide (Dco), measured by their respective predicted values. If one of the three ventilatory function measures, FVC, FEV_1 or Dco or the ratio of FEV_1 to FVC, stated in terms of the observed values, is abnormal to the degree described in classes 2 to 4, then the individual is deemed to have an impairment which would fall into that particular class of impairments, either class 2, 3 or 4, depending on the severity of the observed value.[11]

OWCP's procedures provide that all claims involving impairment of the lungs will be evaluated by first establishing the class of respiratory impairment, following the A.M.A., *Guides* as far as possible. Awards are based on the loss of use of both lungs and the percentage for the applicable class of whole person respiratory impairment will be multiplied by 312 weeks (twice the award for loss of function of one lung) to obtain the number of weeks payable in the schedule award.[12] The procedures further provide that, after obtaining all necessary medical evidence, the file should be routed to the medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[13]

[6] *Id*.

[7] FECA Bulletin No. 09-03 (issued March 15, 2009).

[8] *Supra* note 3 at 3, section 1.3, "The [ICF,] Disability and Health: A Contemporary Model of Disablement."

[9] *Id*. at 77-99.

[10] *Id*. at 88.

[11] *Id*.

[12] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.4(d)(1) (January 2010).

[13] *Id.* at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

ANALYSIS

The Board finds that this case is not in posture for decision because further development of the medical evidence is warranted.

Section 5.5 of the A.M.A., *Guides* explains that only the valid pulmonary dysfunction consistent and concordant with the validated pathology should be considered in evaluating impairment under Table 5-4.[14] The record includes two pulmonary function studies, a February 12, 2010 study conducted by Dr. Baker, the attending pulmonologist and a June 3, 2010 study conducted by Dr. K. Anderson, a pulmonologist and OWCP referral physician. The medical adviser, Dr. A. Anderson, advised that, because appellant's diagnoses of pneumoconiosis and benign neoplasm of the pleura were listed as restrictive disorders in Table 5-12,[15] it was more appropriate to identify the FVC reading as the key factor in assessing appellant's lung impairment. However, Dr. Baker and Dr. K. Anderson, diagnosed COPD with a moderate ventilatory defect.

As noted above, Table 5-4 is to be used in evaluating pulmonary impairment.[16] While appellant's FVC readings of 78 (found by Dr. Baker) and 77 percent (found by Dr. K. Anderson) place appellant in class 1, with a class C default impairment value of 6 percent, appellant's FEV_1 readings of 58 and 62 percent of predicted place him in class 2, with a class C default impairment value of 17 percent.[17]

The accepted condition in this case is benign neoplasm of the pleura. The Board, however, has long held that in determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included.[18] The record is unclear whether appellant's COPD preexisted his accepted condition.[19] The Board also notes that, when OWCP referred appellant to Dr. K. Anderson, the physician was provided with a set of questions. OWCP did not ask Dr. K. Anderson to provide an impairment rating and he merely advised that, under Table 5-4, appellant had a class 2 rating with an impairment of 11 to 23 percent and provided no further explanation.

An employee should have the benefit of the impairment rating that is more favorable.[20] The Board will set aside the December 13, 2011 schedule award decision and remand the case

[14] *Supra* note 3 at 87.

[15] *Id*. at 96.

[16] *Id*. at 88.

[17] *Id*.

[18] *Peter C. Belkind*, 56 ECAB 580 (2005).

[19] An employing establishment pulmonary function test dated October 20, 2008 demonstrated an FEV_1 of 55 percent of predicted and appellant was informed by an employing establishment physician's assistant that this was outside the reference range.

[20] *See Jeffrey J. Stickney*, 51 ECAB 616 (2000).

for OWCP to obtain a supplementary report from Dr. K. Anderson regarding whether appellant's COPD preexisted his accepted condition. Dr. K. Anderson should also provide an impairment analysis in accordance with the A.M.A., *Guides*.[21] After such further development as it deems necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds the case is not in posture for decision as further development of the medical evidence is warranted.

ORDER

IT IS HEREBY ORDERED THAT the December 13, 2011 decision of the Office of Workers' Compensation Programs is vacated and the case remanded to OWCP for proceedings consistent with this opinion of the Board.

Issued: February 5, 2013
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

[21] Dr. K. Anderson should be informed that, if appellant's COPD preexisted his accepted condition, the COPD should be included in his impairment evaluation. If not preexisting, then only the accepted condition, benign neoplasm of the pleura, should be included in the impairment analysis.