United States Department of Labor
Employees' Compensation Appeals Board

J.G., Appellant	)	
and	)	**Docket No. 13-657**
	)	**Issued: July 22, 2013**
TENNESSEE VALLEY AUTHORITY, Drakesboro, KY, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On January 28, 2013 appellant filed a timely appeal from a November 28, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP) regarding a schedule award and a January 11, 2013 nonmerit decision denying his request for reconsideration. 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 appeal.

ISSUES

The issues are: (1) whether appellant has more than 26 percent impairment of the lungs; and (2) whether OWCP properly refused to reopen his case for further review of the merits under 5 U.S.C. § 8128(a).

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On June 21, 2002 appellant, then a retired 55-year-old machinist, filed an occupational disease claim alleging that factors of his employment caused or aggravated his pulmonary pneumoconiosis and asbestosis.[2] OWCP accepted pneumoconiosis as a work-related injury and paid benefits. By decision dated April 18, 2003, it granted appellant a schedule award for 26 percent permanent impairment of both lungs. By decision dated May 28, 2010, OWCP awarded him 24 percent impairment as related to his lungs.

On May 29, 2012 appellant requested an increased schedule award. In a May 24, 2012 report, Dr. Bernard J. Buchanan, a Board-certified internist, stated that appellant's black lung disease contributed to more than 60 percent of his disability. He noted that appellant continued to use two inhalers daily and nebulizer treatments three times daily and to expectorate mucous and experience shortness of breath, as expected with the diagnosis.

OWCP referred appellant to Dr. Harold Dale Harper, Jr., a Board-certified diagnostic radiologist, for a second opinion medical examination to determine any additional impairment. In a September 14, 2012 report, Dr. Harper reviewed history of injury and provided findings on examination. He diagnosed moderate chronic obstructive pulmonary disease, pneumoconiosis and dyspnea.

On November 15, 2012 OWCP received copies of appellant's September 14, 2012 spirometry and diffusing capacity studies. The spirometry showed a forced expiratory volume 1 (FEV_1) of 1.87 or 63 percent of the predicted value and reduced FEV_1/forced vital capacity (FVC) ratio and reduced forced expiratory flow at 25 and 75 percent indicative of airway obstruction. Dr. H. Dale Haller, a Board-certified pulmonologist, reviewed the September 14, 2012 spirometry and concluded that there was a moderately severe diffusion defect. He noted while there was moderate airway obstruction and a diffusion defect suggesting emphysema, the absence of over inflation indicated a concurrent restrictive process which may account for the diffusion defect.

On November 21, 2012 Dr. A.E. Anderson, Jr., an OWCP medical adviser, reviewed Dr. Harper's September 14, 2012 report. He found that appellant reached maximum medical improvement on September 14, 2012. Under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), Dr. Anderson rated 23 percent impairment due to pulmonary dysfunction. Under Table 5-4, he found the key impairment factor of FEV_1 of 1.87 was 63 percent of predicted was class 2, which allowed appellant to be ratable from 11 to 23 percent impairment, with default value being 17 percent. He noted that appellant had nonkey modifiers for history and physical examination. Dr. Anderson found appellant's history of severe dyspnea was class 4 and physical examination of decreased breath sounds was class 2. He subtracted the key factor from the nonkey modifiers (history modifier -- FEV_1)(4-2) + (physical modifier - FEV_1)(2-2) and found a net adjustment of 2. This moved the final impairment of FEV_1 to class 2, grade E or 23 percent impairment.

[2] Appellant stopped working in 1989. He has two other accepted work injuries: a lumbar strain from December 13, 1988, resolved; and a hearing loss claim, for which he received 54 percent permanent bilateral noise-induced hearing loss.

Dr. Anderson noted that appellant's condition may worsen or improve within this class, depending on nonkey modifiers, but would not move out of the class range. He further noted that while Dr. Haller diagnosed moderately severe diffusion defect or class 3, with range of 24 to 40 percent impairment, from the September 14, 2012 spirometry, he did not specify a specific key factor or a specific impairment rate.

By decision dated November 28, 2012, OWCP denied appellant's claim for an increased impairment finding 23 percent permanent impairment to both lungs.

In a December 10, 2012 letter, appellant requested reconsideration. He noted that his condition had worsened. Appellant used inhalers and breathing treatments.

Appellant submitted partial copies of Dr. Harper's September 14, 2012 report, the September 14, 2012 report from Dr. Haller, the May 24, 2012 medical report from Dr. Buchanan, and a May 11, 2002 report from Dr. Glen Baker, a Board-certified pulmonarist, and diagnostic testing from September 14, 2012. A copy of a newspaper article was submitted with an unsigned letter encaptioned "Replies to Form," from an unknown individual. It stated: "as a general internal medicine doctor, it is beyond my scope to determine whether his disabling respiratory impairment is totally related, unrelated to, or is materially related to his coal mine dust exposure."

By decision dated January 11, 2013, OWCP denied appellant's request for reconsideration without a review of the merits finding that it was insufficient to warrant review of its prior decision.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of FECA[3] and its implementing federal regulations[4] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members, functions and organs of the body. FECA, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[5] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[6] For decisions issued after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[7] For decisions issued after May 1, 2009, the sixth edition will be used.[8]

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] *Ausbon N. Johnson*, 50 ECAB 304 (1999).

[6] *Supra* note 3.

[7] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

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

A claim for an increased schedule award may be based on new exposure or, absent any new exposure to employment factors, medical evidence indicating that the progression of an employment-related condition has resulted in a greater permanent impairment than previously calculated.[9] In determining entitlement to a schedule award, preexisting impairment to the scheduled member should be included.[10] Any previous impairment to the member under consideration is included in calculating the percentage of loss except when the prior impairment is due to a previous work-related injury, in which case the percentage already paid is subtracted from the total percentage of impairment.[11]

OWCP evaluates respiratory or pulmonary impairments in accordance with the standards contained in Chapter 5 of the sixth edition of the A.M.A., *Guides*.[12] It provides a table which describes four classes of respiratory impairment based on a comparison of observed values for certain ventilator function measures and their respective predicted values. The appropriate class of impairment is determined by the observed values for either FVC, FEV_1, DLCO or maximum oxygen consumption (VO2Max). If the FVC, FEV_1 or DLCO results, the ratio of FEV_1 to FVC or the specified range of oxygen volume, stated in terms of the observed values, is abnormal to the degree described in classes 1 to 4, then the individual is deemed to have an impairment, which would fall into that particular class of impairments, depending on the severity of the observed value. A person will fall within class 0 and be deemed to have no impairment, if the FVC, FEV_1, ratio of FEV_1 to FVC and DLCO are greater than or equal to the lower limit of normal or the VO2Max is greater than or equal to a specified oxygen volume.[13]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to Dr. Anderson 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.[14]

ANALYSIS -- ISSUE 1

OWCP accepted appellant's occupational disease claim for the condition of coal workers pneumoconiosis. On April 18, 2003 appellant received a schedule award for 26 percent permanent impairment for both lungs. On May 28, 2010 OWCP awarded him 24 percent whole

[9] *See James R. Hentz*, 56 ECAB 573 (2005).

[10] *See Dale B. Larson*, 41 ECAB 481, 490 (1990); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.b. (June 1993). This portion of OWCP's procedure provides that the impairment rating of a given scheduled member should include any preexisting permanent impairment of the same member or function.

[11] *See Carol A. Smart*, 57 ECAB 340 (2006); *see also* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.7(a)(2) (March 2011).

[12] A.M.A., *Guides* 77-99.

[13] *Id.* at 88, Table 5-4; *see Boyd Haupt*, 52 ECAB 326 (2001).

[14] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

person impairment also for both lungs. Appellant filed a claim for an increased schedule award which OWCP denied on November 28, 2012. The Board finds that the medical evidence does not support permanent impairment greater than 26 percent bilateral lung impairment.

Appellant submitted a May 24, 2012 report from Dr. Buchanan, who opined that appellant's black lung disease or pneumoconiosis contributed to 60 percent of his disability. The medical evidence necessary to support a schedule award includes a physician's report that provides a detailed description of the impairment.[15] The Board has held that a medical report that does not describe the basis for the impairment rating or refer to specific tables in the A.M.A., *Guides* is of diminished probative value.[16] Dr. Buchanan's report is of diminished probative value as he did not provide a detailed description of appellant's pulmonary impairment or describe the basis for the impairment rating under the A.M.A., *Guides*.

OWCP referred appellant to Dr. Harper for a second-opinion examination. In a September 14, 2012 report, Dr. Harper reviewed appellant's history of occupational exposure, provided findings on examination and conducted diagnostic testing. He did not apply the A.M.A., *Guides* to the pulmonary function test findings to determine an impairment rating. Thus, Dr. Harper's report is of little probative value.

Dr. Haller reviewed the September 14, 2012 spirometry and concluded that there was a moderately severe diffusion defect. His report is of diminished probative value as he did not provide a detailed description of the impairment or describe the basis for an impairment rating under the A.M.A., *Guides*.[17]

When an examining physician does not apply the A.M.A., *Guides* to determine an impairment rating, OWCP may rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the findings reported by the attending physician.[18] In a November 21, 2012 report, Dr. Anderson applied the A.M.A., *Guides* to the diagnostic testing provided in Dr. Harper's September 14, 2012 report. He referenced Table 5-4 of the sixth edition of the A.M.A., *Guides* and found that appellant had 23 percent impairment for both lungs. Dr. Anderson found that the results of the pulmonary function tests placed appellant in class 2 impairment with a ratable impairment from 11 to 23 percent and a default value of 17 percent. He also noted that appellant's history of severe dyspnea placed him in class 4 and his physical examination findings placed him in class 2. Table 5-4 of the A.M.A., *Guides* indicates that, in finding class 2 impairment, the FVC value should be between 60 percent and 69 percent of the predicted value or the FEV_1 between 64 percent and 55 percent of the predicted value. Appellant's values for these tests as recorded by Dr. Haller were 87 percent and 63 percent of the predicted value, respectively. The Board finds that Dr. Anderson properly applied the A.M.A., *Guides* to determine that appellant's impairment to his lungs placed him with class 2 impairment and that

[15] *See James E. Jenkins*, 39 ECAB 860 (1988); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(c) (August 2002).

[16] *See Mary L. Henninger*, 52 ECAB 408 (2001).

[17] *Id.*

[18] *See J.G.*, Docket No. 09-1714 (issued April 7, 2010).

nonkey modifiers of history and physical examination findings related to class 4 and class 2, respectively, which were properly used to move the impairment up to grade E or 23 percent in the key factor class.[19] OWCP properly found that appellant had 23 percent bilateral lung impairment.

On appeal, appellant contends that he has additional impairment based on all the medical evidence. The Board notes, however, that Dr. Anderson provided the only impairment rating that conformed to the A.M.A., *Guides.* Dr. Anderson's opinion constitutes the weight of the medical evidence.[20] Appellant has not provided any probative medical evidence to establish that he has more than 23 percent bilateral lung impairment. As noted, he previously received awards for 26 percent and 24 percent impairment of both lungs.

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

LEGAL PRECEDENT -- ISSUE 2

Under section 8128(a) of FECA,[21] OWCP may reopen a case for review on the merits in accordance with the guidelines set forth in section 10.606(b)(2) of the implementing federal regulations, which provide that a claimant may obtain review of the merits if the written application for reconsideration, including all supporting documents, sets forth arguments and contains evidence that:

> (1) Shows that OWCP erroneously applied or interpreted a specific point of law; or
>
> (2) Advances a relevant legal argument not previously considered by OWCP; or
>
> (3) Constitutes relevant and pertinent new evidence not previously considered by OWCP.[22]

[19] *See* A.M.A., *Guides* 87.

[20] *See also H.B.*, Docket No. 09-2240 (issued June 18, 2010); *E.V.*, Docket No. 06-1989 (issued May 21, 2007); *Bobby L. Jackson,* 40 ECAB 593, 601 (1989).

[21] 5 U.S.C. § 8128(a).

[22] 20 C.F.R. § 10.606(b).

Section 10.608(b) provides that any application for review of the merits of the claim which does not meet at least one of the requirements listed in section 10.606(b) will be denied by OWCP without review of the merits of the claim.[23]

ANALYSIS -- ISSUE 2

Appellant disagreed with the denial of his claim for an increased schedule award and requested reconsideration on December 10, 2012.

Appellant does not make any argument that OWCP erroneously applied or interpreted a specific point of law or advanced a relevant legal argument not previously considered by OWCP. He argued that his accepted condition was worse. However, appellant did not submit any new medical evidence to support that he sustained a ratable impairment greater than that previously received. He submitted a portion of Dr. Harper's September 14, 2012 report, Dr. Haller's September 14, 2012 report, Dr. Buchanan's May 24, 2012 report, Dr. Baker's May 11, 2002 report and the September 14, 2012 diagnostic studies. However, the Board notes that neither the physician's reports nor the diagnostic studies are new and relevant as they were previously of record and considered by OWCP.[24] While appellant submitted a newspaper article along with an unsigned letter encaptioned "Replies to Form," from an unknown individual, this evidence is of general nature and not relevant to the issue of increased impairment as it does not contain a medical opinion from a qualified physician to support an impairment rating greater than 26 percent of his lungs.

The Board accordingly finds that appellant did not meet any of the requirements of 20 C.F.R. § 10.606(b)(2). Appellant did not show that OWCP erroneously applied or interpreted a specific point of law, advance a relevant legal argument not previously considered by OWCP or submit relevant and pertinent evidence not previously considered by OWCP. The Board finds that OWCP properly determined the application for reconsideration was insufficient to warrant merit review of the claim.

CONCLUSION

The Board finds that appellant has not established that he has more than 26 percent impairment of his lungs. The Board also finds that OWCP properly refused to reopen appellant's case for further review of the merits of his claim under 5 U.S.C. § 8128(a).

[23] *Id.* at § 10.608(b).

[24] *See James W. Scott*, 55 ECAB 606 (2004) (evidence that repeats or duplicates evidence already in the case record has no evidentiary value and does not constitute a basis for reopening a case).

ORDER

IT IS HEREBY ORDERED THAT the January 11, 2013 and November 28, 2012 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: July 22, 2013
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

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

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board