United States Department of Labor
Employees' Compensation Appeals Board

G.W., Appellant	)	
and	)	**Docket No. 08-319**
	)	**Issued: May 12, 2008**
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:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On November 13, 2007 appellant filed a timely appeal from the September 18, 2007 merit decision of the Office of Workers' Compensation Programs' hearing representative, which affirmed the denial of a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of the case.

ISSUE

The issue is whether appellant has a ratable lung impairment causally related to his accepted employment injury.

FACTUAL HISTORY

On December 26, 2002 appellant, then a 79-year-old auxiliary operator, filed a claim alleging that he developed pneumoconiosis as a result of his federal employment. His pulmonologist, Dr. William C. Houser, diagnosed pneumoconiosis, category 1/0, due to occupational mixed dust exposure. Dr. Houser reported a moderately reduced forced vital

capacity (FVC). Taking into account appellant's previous stroke, he reported that the restrictive impairment was due to pneumoconiosis. Appellant filed a claim for a schedule award.

Dr. Kenneth Anderson, a specialist in pulmonary disease and Office referral physician, reported that appellant had a chest x-ray abnormality of 1/0 profusion secondary to exposure in federal employment. He noted, however, that appellant was unable to complete pulmonary functions tests due to inactivity from a previous stroke. Dr. Anderson reported that appellant's pulmonary function test abnormalities did not correlate with his chest radiograph abnormalities.

The Office accepted appellant's claim for bilateral pneumoconiosis, which it later updated to coal workers' pneumoconiosis. The Office also found a conflict between Dr. Houser and Dr. Anderson regarding impairment associated with the condition. To resolve the conflict, the Office referred appellant, together with the record and a statement of accepted facts, to Dr. Robert W. Powell, a Board-certified specialist in pulmonary disease.

Dr. Powell examined appellant on December 21, 2005. He related appellant's history and complaints. Dr. Powell described his findings on examination and the results of pulmonary function studies:

> "Pulmonary function studies were obtained that show FVC #1: 2.5 liters, #2: 2.42 liters, #3: 2.33 liters, #4: 2.4 liters, #5: 2.31 liters with best percent of predicted being 90 percent. FEV_1 [forced expiratory volume in the first second] effort #1: 2.02 liters, #2: 2.03 liters, #3: 2.06 liters, #4: 1.99 liters, #5: 1.93 liters with best percent of predicted 95 percent. Lung volumes were also obtained. They showed a total lung capacity of 126 percent of predicted and a residual volume of 224 percent of predicted. DLCO [diffusing capacity for carbon dioxide] was obtained and uncorrected was 56 percent of predicted and corrected for volume was 71 percent of predicted."

Dr. Powell reported that x-rays showed no pleural abnormalities that would suggest pneumoconiosis. There were no active pneumonic infiltrates. There were several calcified granulomas from infection. Dr. Powell noted minimal nodularity "that has been accepted as being coal workers' pneumoconiosis category 1/0." He concluded that appellant had no impairment due to pneumoconiosis: "[Appellant] does not have a respiratory impairment related to his pneumoconiosis. His pulmonary functions specifically FVC and FEV_1 were normal on the pulmonary functions obtained in our office."

Appellant submitted a June 17, 2006 report from Dr. Glen Baker, a Board-certified specialist in pulmonary disease, who related appellant's history and reviewed the reports of Dr. Houser, Dr. Anderson and Dr. Powell. Dr. Baker stated that he was not clear why Dr. Powell reported appellant's FVC and FEV_1 to be normal: "I know Dr. Powell personally and know he is an excellent physician and I cannot think of anything critically to say about him except for whatever reason he stated these values were normal and, in fact, they were abnormal." Dr. Baker added: "I should state, however, that I do not have the weight and height that he obtained and this could, perhaps, make these values look better, but we would have to have the absolute test itself to make a statement in that regard."

The Office provided Dr. Powell with a copy of Dr. Baker's report and asked him to list appellant's predicted values and to provide an explanation of whether actual FVC and FEV_1 were normal. On October 18, 2006 Dr. Powell wrote:

> "[Appellant], an 82[-]year[-]old man who has had a stroke, was unable to stand and unable to have his height measured. Therefore his arm span of 72 inches was substituted for his standing height. [Appellant] weighed 129 pounds. He had a predicted FVC based on those parameters of 2.84 liters and actual of 2.56 liters which is 90 percent of predicted. [Appellant] had an FEV_1 predicted of 2.18 liters and actual of 2.06 liters which was 95 percent of predicted. These are indeed normal values."

Dr. Powell added: "If you would like for me to make some other assumptions about [appellant] or to use some different predicted values when I would be willing to do so. But, based on the information generated in my laboratory on the 21st of December 2005, my opinion in reasonable medical probability stands."

In a decision dated November 3, 2006, the Office denied appellant's claim for a schedule award. On September 18, 2007 an Office hearing representative affirmed, finding that Dr. Powell's opinion was entitled to special weight.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[1] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.[2]

Section 8123(a) of the Act provides in part: "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."[3] When 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.[4]

When the Office secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from the specialist requires

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404 (1999). Effective February 1, 2001 the Office began using the A.M.A., *Guides* (5th ed. 2001).

[3] 5 U.S.C. § 8123(a).

[4] *Carl Epstein*, 38 ECAB 539 (1987); *James P. Roberts*, 31 ECAB 1010 (1980).

clarification or elaboration, the Office has the responsibility to secure a supplemental report from the specialist for the purpose of correcting a defect in the original report. When the impartial medical specialist's statement of clarification or elaboration is not forthcoming or if the specialist is unable to clarify or elaborate on the original report or if the specialist's supplemental report is also vague, speculative or lacks rationale, the Office must submit the case record together with a detailed statement of accepted facts to a second impartial specialist for a rationalized medical opinion on the issue in question.[5] Unless this procedure is carried out by the Office, the intent of section 8123(a) of the Act will be circumvented when the impartial specialist's medical report is insufficient to resolve the conflict of medical evidence.[6]

ANALYSIS

A conflict in medical opinion arose between appellant's physician and the Office referral physician on whether appellant had a lung impairment causally related to his accepted employment injury. The Office properly referred appellant to Dr. Powell, a Board-certified specialist in pulmonary disease, to resolve the conflict under section 8123(a) of the Act.

Dr. Powell reported that the pulmonary function studies obtained in his laboratory showed normal FVC and FEV_1, so appellant had no lung impairment. At the Office's request, he reported the predicted values that he used and showed how appellant's actual values were 90 percent of predicted for FVC and 95 percent of predicted for FEV_1.

The problem is that the Board is unable to use the A.M.A., *Guides* to obtain the predicted values Dr. Powell reported. Table 5-2a, page 95 of the A.M.A., *Guides* gives predicted FVC values for men up to 74 years of age. The table provides a formula for calculating the predicted values, so it would appear that one may use this formula to calculate the predicted value for a patient of 82, appellant's age at the time of Dr. Powell's examination: FVC in liters = 0.06 (height in centimeters) -- 0.0214 (age) -- 4.65

Using a height of 182.88 centimeters and age of 82, the predicted value is 10.9728 -- 1.7548 -- 4.65, or 4.57 liters. The A.M.A., *Guides* explains that North American whites have larger spirometric values for a given age, height and gender than North American blacks, so the predicted lung function in blacks is adjusted on a population basis by multiplying the values for predicted normal FVC by 0.88.[7] This produces a predicted normal value for appellant of 4.02 liters, significantly higher than the 2.84 liters Dr. Powell reported.

[5] *Nathan L. Harrell*, 41 ECAB 402 (1990).

[6] *Harold Travis*, 30 ECAB 1071 (1979).

[7] A.M.A., *Guides* 94.

Using the same height and age with the formula in Table 5-4a produces a predicted FEV_1 value of 3.34 liters. Adjusted on a population basis, appellant's predicted FEV_1 is 2.94 liters,[8] significantly higher than the 2.18 liters Dr. Powell reported.[9]

The Board finds that clarification is warranted. Dr. Powell should explain how the predicted values he reported are consistent with the A.M.A., *Guides*, which does not appear to account for a patient's weight. If he cannot, he should apply the criteria of the A.M.A., *Guides* -- in particular, the formulas provided for determining predicted values, as adjusted on a population basis -- to evaluate any impairment demonstrated by the pulmonary function studies he obtained on December 21, 2005. He must then explain whether any such impairment is causally related to appellant's accepted employment injury. Should Dr. Powell's supplemental report fail to resolve the issue, the Office shall refer appellant to a second impartial medical specialist for an original evaluation. After such further development as may be necessary, the Office shall issue an appropriate final decision on appellant's claim for a schedule award.

CONCLUSION

The Board finds that this case is not in posture for decision. The opinion of the impartial medical specialist requires clarification.

[8] *Id*.

[9] Although Dr. Baker raised a general question whether appellant's actual values were normal, his opinion is not sufficiently probative to create a conflict with Dr. Powell. Dr. Baker did not have the weight and height that Dr. Powell obtained, which could make the actual values look better, and he admitted that "we would have to have the absolute test itself to make a statement in that regard."

ORDER

IT IS HEREBY ORDERED THAT the September 18, 2007 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this opinion.

Issued: May 12, 2008
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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