United States Department of Labor
Employees' Compensation Appeals Board

W.R., Appellant	)	
and	)	**Docket No. 12-1874**
	)	**Issued: March 22, 2013**
U.S. POSTAL SERVICE, POST OFFICE, St. Petersburg, FL, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA HOWARD FITZGERALD, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 13, 2012 appellant, through his attorney, filed a timely appeal from an August 22, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP) that denied his claim for a schedule award. 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 decision.

ISSUE

The issue is whether appellant met his burden of proof to establish that he sustained permanent impairment due to the accepted pulmonary embolism.

On appeal, appellant's attorney asserts that the August 22, 2012 decision is contrary to fact and law.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On April 25, 2007 appellant, then a 58-year-old maintenance mechanic, was in an employment-related motor vehicle accident. He stopped work that day. OWCP initially accepted lumbar, thoracic and cervical sprains and appellant was placed on the periodic compensation rolls. On November 7, 2007 it accepted displacement of cervical discs with myelopathy at C4-5, C5-6 and C6-7, displacement of lumbar intervertebral discs at L4-5 and L5-S1, bilateral post-traumatic shoulder sprain/strain, bilateral post-traumatic temporomandibular joint dysfunction, bilateral rotator cuff syndrome, bilateral carpal tunnel syndrome, adjustment disorder with mixed anxiety and depression and phobic disorder.

A November 4, 2008 computerized tomography (CT) scan of the chest demonstrated extensive bilateral pulmonary emboli.

On December 31, 2008 appellant returned to a full-time modified position. On July 2, 2009 he was granted a schedule award for two percent impairment of the right arm due to carpal tunnel syndrome and eight percent impairment of the left arm for his shoulder condition. In a December 17, 2009 decision, OWCP's hearing representative found that a conflict in medical opinion arose between Dr. John W. Ellis, an attending Board-certified family physician, and OWCP's medical adviser regarding the extent of permanent impairment. The case was remanded for impartial evaluation. Based on the opinion of Dr. William F. Bennett, a Board-certified orthopedic surgeon, selected as the referee physician, appellant was granted an additional three percent impairment of the right upper extremity on April 16, 2010.

On May 17, 2010 OWCP additionally accepted bilateral cubital tunnel syndrome, concussions with brain injury, complex integrated cerebral function disturbance and acute pulmonary embolism. Appellant filed a schedule award claim on June 20, 2010. In a November 7, 2010 report, Dr. Ellis advised that he had last seen appellant on September 15, 2009. The medical reports, including a CT scan and spirometry studies, from appellant's hospitalization in the fall of 2008 showed he developed a pulmonary embolism after having an epidural steroid injection.[2] Dr. Ellis advised that, at the time of appellant's examination, he was still short of breath. He diagnosed acute pulmonary embolism due to sedentary lifestyle caused by the multiple accepted injuries. Dr. Ellis concluded that, under Table 5-5 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 3 or 36 percent whole person impairment.

In a December 6, 2010 report, Dr. A.E. Anderson, Jr., OWCP's medical adviser, noted that Table 5-5 was used to rate asthma, not impairment due to a pulmonary embolism. Although Dr. Ellis mentioned a spirometry study, it was not of record. Dr. Anderson concluded that the appropriate table to rate appellant's pulmonary impairment was either Table 5-4 or Table 4-14. He recommended examination by a Board-certified pulmonologist.

[2] Dr. Ellis also reported that appellant retired on August 2, 2009.

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

In December 2010, OWCP referred appellant to Dr. Leonard Y. Cosmo, Board-certified in internal medicine and pulmonary disease, for a second opinion. In a January 22, 2011 report, Dr. Cosmo reviewed the medical records and noted appellant's complaints of productive cough, wheezing, orthopnea and some shortness of breath. Respiratory examination demonstrated no intercostal retractions, no use of accessory muscles, no wheezes, no rhonchi and no rales. Dr. Cosmo advised that chest x-rays demonstrated clear, well-expanded lung fields and no evidence for consolidations, significant atelectasis or effusion. He reported that pulmonary function studies demonstrated forced vital capacity (FVC) of 2.92 liters or 53 percent of predicted; forced expiratory volume (FEV) of 2.56 liters or 61 percent of predicted; FEV_1/FVC ration of 115 percent, for a moderately severe airflow limitation. Dr. Cosmo found that appellant had reached maximum medical improvement on January 18, 2011 for acute pulmonary embolism. Appellant had no significant anatomical loss to either lung, no significant radiologic abnormalities and no subjective complaints to cause impairment. Dr. Cosmo stated that, while some objective findings of impairment were noted on pulmonary function testing, this was probably secondary to appellant's severe obesity of 350 pounds.

Dr. Anderson, OWCP's medical adviser, reviewed Dr. Cosmo's report. He agreed that maximum medical improvement was reached on January 18, 2011 and that, under Table 4-14 of the A.M.A., *Guides*, appellant did not have any impairment pulmonary.

By decision dated February 23, 2011, OWCP found that appellant was not entitled to a schedule award for the accepted pulmonary embolism.

On March 2, 2011 appellant, through his attorney, requested a hearing. He submitted a June 3, 2010 pulmonary function study by Dr. Eli Freilich, Board-certified in internal medicine and pulmonary disease. The study demonstrated a normal FEV_2/FVC ratio post bronchodilators. Vital capacity was 78 percent of predicted and total lung capacity was 82 percent of predicted. FEV_1 post bronchodilator was 3.03 liters or 69 percent of predicted and FVC was 3.91 or 71 percent of predicted. Diffusing capacity for carbon monoxide was 81 percent of predicted. Dr. Freilich advised that the study was suggestive of a mild-to-moderate obstructive ventilatory impairment with a significant response to inhaled bronchodilators.

Appellant also submitted records regarding his hospitalization from October 5 to 8, 2010 for complaints of shortness of breath. A CT scan demonstrated a pulmonary embolus in the right upper and lower lobes. Appellant was seen in consultation by Dr. Thyagarajan Ananthakrishnan, Board-certified in internal medicine and hematology, who diagnosed recurrent pulmonary embolism, obesity, hypertension, dyslipidemia, obstructive sleep apnea, chronic back pain. Dr. Salah Al-Andary, Board-certified in internal medicine and pulmonary disease, saw appellant in consultation. He had seen appellant in November 2008 when he was admitted secondary to an acute pulmonary embolism that resolved after treatment with Coumadin. Dr. Al-Andary reported that he also saw appellant two weeks prior with no evidence of embolism. He noted the CT findings and recommended weight loss, increased activity and indicated that appellant could require Coumadin for life.

By decision dated May 4, 2011, OWCP's hearing representative noted that Dr. Ellis had submitted an additional report. She vacated the February 23, 2011 decision and remanded the case for a supplementary report from Dr. Cosmo.

In a May 18, 2011 report, Dr. Cosmo reviewed the June 3, 2010 pulmonary function study and a test performed in his office on January 22, 2011. He concluded that appellant's work injuries, including pulmonary embolism, would not have any impact on either of the pulmonary studies. On June 3, 2011 Dr. Anderson, OWCP's medical adviser, noted that the criteria for rating pulmonary impairment due to pulmonary embolism were found at Table 4-14 of the A.M.A., *Guides* under the objective standard pulmonary artery pressure. He stated that Dr. Cosmo did not use Table 4-14 or list an objective standard, such as Doppler electrocardiography. Dr. Anderson recommended additional testing.

OWCP referred appellant for an echocardiogram. An August 23, 2011 echocardiogram demonstrated normal left ventricular size with preserved systolic function, mild concentric left ventricular hypertrophy with diastolic dysfunction, grossly normal right-sided structures, aortic valve sclerosis without stenosis, trace mitral and tricuspid insufficiency and normal pulmonary artery systolic pressure of approximately 30.[4]

In an October 8, 2011 report, Dr. Cosmo reviewed the August 23, 2011 echocardiogram. Due to the fact that appellant had normal pulmonary arterial pressure on the study, under Table 4-14, he was rated at class 0. Dr. Cosmo noted that based on appellant's echocardiogram findings, together with the medical evidence of record, appellant had no pulmonary impairment.

On October 17, 2011 Dr. Eric Puestow, OWCP's medical adviser Board-certified in internal medicine and endocrinology, reviewed the medical record. He agreed with Dr. Cosmos' conclusion that appellant had no (zero percent) impairment. The echocardiogram provided the key factor in this assessment and the date of maximum medical improvement would be September 12, 2011.

By decision dated October 25, 2011, OWCP denied appellant's claim for a schedule award, finding that the medical evidence failed to establish pulmonary impairment.

On November 2, 2011 counsel requested a hearing. In a December 8, 2011 report, Dr. Kevin Trangle, Board-certified in internal and occupational medicine, reviewed the medical record. He noted that appellant had gained over 60 pounds following the employment injury, and advised that it would be more appropriate to use Table 5-4, Pulmonary Dysfunction, in assessing appellant's pulmonary impairment. Dr. Trangle rated appellant at class 2, stating that he had a restrictive airway disease based on his FVC and FEV_1 findings. Appellant fell in the midrange or a C classification for a 17 percent impairment of the whole person, noting that there

[4] The report was dated September 12, 2011. In a treatment note dated August 24, 2011, Dr. Ali Saifi, Board-certified in internal medicine, noted that appellant was seen for rectal bleeding.

was no further data to modify the rating. Dr. Trangle stated that he utilized the fifth edition of the A.M.A., *Guides* and concluded:

> "The basis of this assumption of restrictive airway disease being due to his injury is the same basis for the pulmonary embolism being allowed within the context of this injury, namely that his sedentary lifestyle following his injury led him to become inactive and sedentary leading with subsequent pooling of blood and an eventual pulmonary embolism; also the same inactive and sedentary life style led to substantial weight gain causing his restrictive airway disease."

A hearing was held on February 16, 2012.[5] By decision dated May 7, 2012, OWCP's hearing representative affirmed the October 25, 2011 decision. She found that the weight of the medical evidence rested with the opinion of the medical adviser, noting that Dr. Trangle utilized the fifth edition of the A.M.A, *Guides*, rather than the sixth edition.

On June 21, 2012 appellant, through counsel, requested reconsideration. In a June 11, 2012 report, Dr. Trangle advised that his December 8, 2011 report contained a typographical error, as he did not use the fifth edition of the A.M.A, *Guides* to rate appellant's impairment, but used the sixth edition. He attached a copy of Table 5-4 with his annotated impairment analysis and indicated that maximum medical improvement was reached in 2010.

On July 12, 2012 Dr. Anderson, OWCP's medical adviser, reviewed the medical record. He found that maximum medical improvement was reached on September 12, 2011, the date of the echocardiogram. As the accepted condition was pulmonary embolism and infarction, the table to use for rating impairment was Table 4-14, as provided at pages 71 and 72 of the sixth edition of the A.M.A., *Guides*. Dr. Anderson found that appellant had normal pulmonary artery systolic pressure on the September 12, 2011 echocardiogram. Under Table 4-14, he would be rated at class 0, with an impairment rating of zero percent.

In a merit decision dated August 22, 2012, OWCP denied modification of the prior OWCP decisions, finding that the weight of the medical evidence rested with the opinion of Dr. Anderson, OWCP's medical adviser.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing federal regulations[6] set forth the number of weeks of compensation payable to employees sustaining permanent 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

[5] Although appellant was present at the hearing, he did not testify. OWCP's hearing representative and counsel discussed Dr. Trangle's report. Appellant thereafter submitted a February 10, 2012 treatment note from Dr. Saifi that did not include an impairment discussion.

[6] 20 C.F.R. § 10.404. *See* 5 U.S.C. § 8107.

the A.M.A., *Guides* as the uniform standard applicable to all claimants.[7] For decisions after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[8]

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).[9] OWCP procedures 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.[10]

ANALYSIS

Appellant was in an employment-related motor vehicle accident on April 25, 2007 and OWCP accepted various employment-related conditions. He first had a pulmonary embolism after an epidural injection in October 2008. On May 17, 2010 OWCP accepted acute pulmonary embolism. The Board finds that appellant has not established permanent impairment based on the accepted pulmonary embolism.

Dr. Cosmo, a Board-certified pulmonologist, provided a second-opinion evaluation. In a January 22, 2011 report, he advised that appellant reached maximum medical improvement on January 18, 2011 for acute pulmonary embolism. Dr. Cosmo noted that appellant had no significant anatomical loss to either lung, no significant radiologic abnormalities and no subjective complaints to cause impairment. While appellant had objective findings of impairment on pulmonary function testing, this was secondary to his severe obesity of 350 pounds. On May 18, 2011 Dr. Cosmo reviewed both the January 3, 2010 and January 22, 2011 pulmonary function studies. He concluded that appellant's work injuries, including pulmonary embolism, would not have an impact on pulmonary function. In an October 8, 2011 report, Dr. Cosmo reviewed an August 23, 2011 echocardiogram. He advised that, because appellant had normal pulmonary arterial pressure on the study, under Table 4-14, he would be at class 0 and had no pulmonary impairment.

Dr. Anderson and Dr. Puestow, OWCP's medical advisers found that appellant's accepted pulmonary embolism should be rated under Table 4-14, Pulmonary Artery Diseases.[11] Pulmonary embolism is defined as the closure of the pulmonary artery or one of its branches by an embolus, sometimes associated with pulmonary infarction.[12]

---

[7] *Id*.

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

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

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

[11] A.M.A., *Guides* 72.

[12] *Dorland's Illustrated Medical Dictionary*, 29th ed. (2000).

Section 4.9 of the A.M.A., *Guides* provides guidance for rating impairment due to diseases of the pulmonary artery.[13] It states that pulmonary emboli and obesity can affect the presence of pulmonary artery hypertension and must be considered in evaluating impairment. Section 4.9 further states that pulmonary hypertension is typically diagnosed on echocardiogram, and the criteria for evaluating diseases of the pulmonary artery are found in Table 4-14.[14] Table 4-14 indicates that normal pulmonary artery pressure is less than 40.[15] The August 23, 2011 echocardiogram found that appellant's pulmonary artery systolic pressure was approximately 30. On July 16, 2012 Dr. Anderson, an OWCP medical adviser, reviewed the medical record. Based on appellant's normal pulmonary artery systolic pressure, as found on the echocardiogram, he had no impairment under Table 4-14. The Board finds that Dr. Cosmo and the medical advisers properly utilized Table 4-14 to rate appellant's pulmonary impairment. OWCP properly found that appellant had no ratable impairment due to the accepted pulmonary embolism.

While the record contains pulmonary function tests with abnormal readings, these studies do not indicate the cause for the abnormality. In a November 7, 2010 report, Dr. Ellis noted that the pulmonary embolism was due to appellant's sedentary lifestyle. He utilized Table 5-5, Asthma, in findings that appellant had a 36 percent whole person impairment. On December 8, 2011 Dr. Trangle noted that appellant had gained over 60 pounds following the employment injury. He indicated that appellant's inactive and sedentary life style led to this weight gain which caused restrictive airway disease. Dr. Trangle maintained that Table 5-4, Pulmonary Dysfunction, should be used in rating appellant's pulmonary condition. As noted, the Board finds the weight of medical opinion represented by Dr. Cosmo and Dr. Anderson, who utilized Table 4-14, to rate impairment based on the accepted pulmonary embolism.

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.

CONCLUSION

The Board finds that appellant has not established entitlement to a schedule award for the accepted pulmonary embolism.

[13] A.M.A., *Guides* 71.

[14] *Id*.

[15] *Id.* at 72.

ORDER

IT IS HEREBY ORDERED THAT August 22, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 22, 2013
Washington, DC

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

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