United States Department of Labor
Employees' Compensation Appeals Board

R.G., Appellant	)	
and	)	**Docket No. 15-209**
	)	**Issued: April 29, 2015**
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:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 29, 2014 appellant, through counsel, filed a timely appeal from a September 29, 2014 decision of the Office of Workers' Compensation Programs (OWCP). 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 case.

ISSUE

The issue is whether appellant met his burden of proof to establish that he has ratable lung impairment for his accepted pneumoconiosis.

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

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On March 8, 2012 appellant, then a 54-year-old former auxiliary operator, filed an occupational disease claim alleging that he had occupational pneumoconiosis. The employing establishment indicated that his date of last exposure was November 6, 2000, when he retired. Appellant indicated that he was not aware of his condition and its relationship to his employment until February 20, 2010. Following retirement, he worked in private employment.

In support of his claim, appellant submitted a February 27, 2012 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 worked at the employing establishment for approximately 17 years where he was exposed to coal dust, magnetite, and asbestos. A January 23, 2009 chest x-ray demonstrated occupational pneumoconiosis, category 1/1. Pulmonary function studies dated February 25, 2012 showed a prebronchodilator forced vital capacity (FVC) at 83 percent of predicted and forced expiratory volume in the first second (FEV_1) at 72 percent of predicted. Postbronchodilator studies showed an FVC at 95 percent of predicted and an FEV_1 at 75 percent of predicted. Dr. Baker indicated that both pre and poststudies demonstrated a mild-to-moderate obstructive defect. He diagnosed occupational pneumoconiosis, category 1/1, with pleural changes consistent with pleural and pulmonary asbestosis, chronic obstructive airway disease (COPD) with a mild obstructive defect, and bronchitis. Dr. Baker 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*),[2] appellant had a class 1, B, impairment based on a postbronchodilator FEV_1 value of 75 percent for 4 percent impairment, and his shortness of breath raised him to class 1, D, for 8 percent impairment.

In July 2012 OWCP referred appellant to Dr. Manoj Majmudar, Board-certified in internal medicine and pulmonary disease. In a September 17, 2012 report, Dr. Majmudar noted appellant's complaint of shortness of breath and a 17-year history of coal, asbestos, and silicon dust exposure. He provided physical examination findings. Dr. Majmudar reviewed x-ray and pulmonary function test findings which, he advised, were consistent with pneumoconiosis secondary to coal dust exposure. He stated that, based on Table 5-4 of the sixth edition, appellant had a class 1 rating, for an impairment of 2 to 10 percent.

On October 10, 2012 Dr. A.E. Anderson, an OWCP medical adviser, requested that Dr. Majmudar provide the complete battery of pulmonary function studies. Dr. Majmudar furnished studies dated August 8, 2012. These showed a prebronchodilator FVC of 4.15 at 87 percent of predicted and an FEV_1 of 1.61 at 61 percent of predicted. Postbronchodilator studies showed an FVC of 4.17 at 88 percent of predicted and an FEV_1 of 2.51 at 65 percent of predicted.

In an October 21, 2012 report, Dr. Anderson provided an impairment rating utilizing Table 5-4. He reviewed Dr. Majmudar's report and the August 8, 2012 pulmonary function tests. Dr. Anderson advised that appellant's key factor was the FVC value, measured at "4.16"

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

or 87 percent, with a default grade C, for 0 percent impairment. He additionally found no grade modifiers and advised that August 8, 2012 was the date of maximum medical improvement.

On November 14, 2012 OWCP accepted that appellant had coal workers' pneumoconiosis. Appellant filed a schedule award claim on November 21, 2012. By decision dated December 10, 2012, OWCP credited the opinion of OWCP medical adviser and found that appellant was not entitled to a schedule award.

Appellant, through counsel, timely requested an oral hearing, that was held on April 11, 2013. He did not appear at the hearing. Counsel noted that both Dr. Baker and Dr. Majmudar were Board-certified pulmonologists and each had indicated that, under Table 5-4, appellant had permanent lung impairment. He argued that their opinions should be credited, rather than that of OWCP medical adviser.

In an April 18, 2013 report, Dr. Baker maintained that the findings of his February 25, 2012 report were correct, concluding that appellant had eight percent impairment due to occupational pneumoconiosis, chronic obstructive pulmonary disease, and bronchitis.

By decision dated June 18, 2013, an OWCP hearing representative vacated the December 10, 2012 schedule award decision and remanded the case to OWCP to obtain a supplemental report from OWCP medical adviser, who was to discuss appellant's history of symptoms with use of a medication, physical examination findings, and FEV_1 test results.

Following OWCP's request, on June 21, 2013 Dr. Eric Puestow, Board-certified in internal medicine and endocrinology and an OWCP medical adviser, noted that Dr. Anderson had retired. Dr. Puestow reviewed the record, including the reports of Drs. Baker, Majmudar, and Anderson and the pulmonary function tests. He disagreed with Dr. Anderson that only the FVC should be used, noting that the A.M.A., *Guides* indicated that the key factor to be used was complete pulmonary function tests. Dr. Puestow compared the February 25 and August 8, 2012 studies, noting that, under the former, appellant would have had six percent impairment and under the latter, he had no impairment. He concluded that neither was valid because the former study did not indicate that a diffusing capacity of carbon monoxide (DLco) reading was done and that it was likely appellant made less than full effort on the latter. Dr. Puestow recommended that OWCP obtain a new pulmonary function test.

In a September 17, 2013 report, Dr. Baker noted his review of his February 25, 2012 report and the reports of Dr. Majmudar and Dr. Puestow. He disagreed with Dr. Puestow's conclusions and maintained that there was no reason the pulmonary function tests done earlier could not be used for evaluation of a schedule award.

In September 2013 OWCP referred appellant for an additional pulmonary function test. The study was done on October 18, 2013 at Muhlenberg Community Hospital. It demonstrated a prebronchodilator FVC of 5.03 or 104 percent of predicted and FEV_1 of 3.00 or 80 percent of predicted. Postbronchodilator studies showed an FVC at 95 percent of predicted and an FEV_1 at 75 percent of predicted. It showed a prebronchodilator FVC at 83 percent of predicted and FEV_1 at 72 percent of predicted. Postbronchodilator studies were not done. Dr. Puestow wrote on the test results that the study was normal.

In a November 7, 2013 report, Dr. Puestow noted his review of the medical record, including the October 18, 2013 study. He reported that prebronchodilator FVC was 104 percent, FEV_1 was 81 percent, the FEV_1/FVC ratio was 78 percent, and the DLco was 108 percent. Dr. Puestow indicated that "this key factor" clearly placed appellant in class 0 with zero percent impairment with the date of maximum medical improvement on October 18, 2013 when the pulmonary function tests were done.

By decision dated December 17, 2013, OWCP again found that appellant was not entitled to a schedule award. Counsel timely requested a hearing that was held on July 16, 2014. Appellant was not present at the hearing. Counsel again argued that the opinions of Dr. Baker and Dr. Majmudar should be credited.

In a September 29, 2014 decision, an OWCP hearing representative affirmed the December 17, 2013 decision. He found that the medical adviser, Dr. Puestow, 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[3] 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 the A.M.A., *Guides* as the uniform standard applicable to all claimants.[4] For decisions after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[5]

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).[6] Chapter 5 of the A.M.A., *Guides* addresses the framework to be used for addressing the pulmonary system.[7] 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.[8] The appropriate class of impairment is determined by the observed values for the FVC, FEV_1 or DLco, measured by their respective predicted values. If one of the three ventilatory function measures, FVC, FEV_1 or DLco or the ratio of FEV_1 to FVC, stated in terms of the observed values, is abnormal to the degree described in classes 1 to 4, then the

[3] 20 C.F.R. § 10.404 (2011). *See* 5 U.S.C. § 8107.

[4] *Id*.

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

[6] A.M.A., *Guides*, *supra* note 2 at 3, section 1.3, "The [ICF,] Disability and Health: A Contemporary Model of Disablement."

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

[8] *Id*. at 88.

individual is deemed to have an impairment which would fall into that particular class of impairments, either class 1, 2, 3 or 4, depending on the severity of the observed value.[9]

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.[10] 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.[11]

ANALYSIS

OWCP accepted appellant's occupational disease claim for coal workers' pneumoconiosis. 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.[12] The record includes three pulmonary function studies -- a February 25, 2012 study conducted by Dr. Baker, the attending pulmonologist, an August 8, 2012 study conducted by Dr. Majmudar, an OWCP referral pulmonologist, and an October 18, 2013 study done at Muhlenberg Community Hospital.

As noted above, Table 5-4, Pulmonary Dysfunction, describes four classes of pulmonary dysfunction.[13] The appropriate class of impairment is determined by the observed values for the FVC, FEV_1 or DLco, measured by their respective predicted values. If one of the three ventilatory function measures, FVC, FEV_1 or DLco or the ratio of FEV_1 to FVC, 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, either class 1, 2, 3 or 4, depending on the severity of the observed value.[14] In this case, Dr. Puestow, an OWCP medical adviser, indicated that Dr. Baker's December 25, 2012 study did not include a DLco value and was therefore invalid. Likewise, Dr. Majmudar's August 8, 2012 study was also invalid because appellant made less than full effort. OWCP then permissibly referred appellant for a new pulmonary function study.

[9] *Id*.

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

[11] *Id.* at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

[12] *Supra* note 2 at 88.

[13] *Id*.

[14] *Id*.

The October 13, 2013 study does not demonstrate ratable lung impairment under Table 5-4.[15] The reported FVC value was 5.03 or 104 percent of predicted. Table 5-4 indicates that an FVC greater than 80 percent of predicted equals class 0 impairment.[16] The reported FEV_1 value was 3.00 or 81 percent predicted. Since this was greater than 80 percent, it too equals class 0 impairment under Table 5-4.[17] The reported FEV_1/FVC ratio was 78 percent. Table 5-4 indicates that an FEV_1/FVC ration greater than 75 percent of predicted equals class 0 impairment.[18] The reported DLco was 34.47 or 108 percent of predicted. Since this was greater than 75 percent, it too equals class 0 impairment under Table 5-4.[19]

OWCP may rely on the opinion of an OWCP medical adviser to apply the A.M.A., *Guides*.[20] The Board finds that, as Dr. Puestow properly applied Table 5-4 of the A.M.A., *Guides* to determine that appellant did not have a ratable impairment, OWCP properly found that he had no ratable lung impairment that would entitle him to a schedule award,

On appeal counsel alleges that the reports of the attending pulmonologist and OWCP referral pulmonologist support impairment. The Board notes, however, that the pulmonary function study done at Muhlenberg Community Hospital on October 18, 2013 provided the only impairment rating that conformed to the A.M.A., *Guides* and reflected the most reliable pulmonary function study. Thus, Dr. Puestow's finding constitutes the weight of the medical evidence. Appellant has not provided any probative medical evidence to establish that he has ratable lung impairment.

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 did not establish that he has ratable lung impairment for the accepted pneumoconiosis.

[15] *Id*.

[16] *Id*.

[17] *Id*.

[18] *Id*.

[19] *Id*.

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

ORDER

IT IS HEREBY ORDERED THAT the September 29, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 29, 2015
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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

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