United States Department of Labor
Employees' Compensation Appeals Board

D.B., Appellant	)	
and	)	**Docket No. 16-1214**
	)	**Issued: December 6, 2016**
DEPARTMENT OF THE ARMY, YAKIMA TRAINING CENTER, YAKIMA FIRING CENTER, WA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On May 18, 2016 appellant filed a timely appeal of a March 16, 2016 nonmerit decision of the Office of Workers' Compensation Programs (OWCP). As more than 180 days has elapsed from the last merit decision, dated February 26, 2015, and the filing of this appeal, pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3 the Board lacks jurisdiction over the merits of this claim.

ISSUE

The issue is whether OWCP properly denied appellant's request for reconsideration on the merits pursuant to 5 U.S.C. § 8128(a).

FACTUAL HISTORY

On June 6, 2012 appellant, then a 55-year-old heavy mobile equipment mechanic, filed a traumatic injury claim (Form CA-1) alleging on that date he experienced shortness of breath and a sharp pain in his chest while repairing a forklift.

[1] 5 U.S.C. § 8101 *et seq.*

In a letter dated June 20, 2012, OWCP informed appellant that when his claim was received, it had appeared to be a minor injury with minimal or no lost time from work such that a limited amount of medical expenses were administratively approved. It noted that the merits of appellant's claim had not been formally considered. As he remained off work, OWCP reopened appellant's claim for consideration of the merits. It requested that appellant provide additional factual and medical evidence in support of his claim.

Dr. David A. Angulo-Zereceda, a Board-certified pulmonologist, examined appellant on June 6, 2012 and noted that his medical history included chronic degenerative joint disease and chronic obstructive pulmonary disease (COPD) of moderate severity. He diagnosed a large left-sided 95 percent pneumothorax with mediastinum in the center. Dr. Angulo-Zereceda performed an immediate decompression with a pneumothorax catheter. He recommended a surgical consultation for a possible pleurodesis.

Dr. Julio Williams, a Board-certified cardiothoracic vascular surgeon, examined appellant and diagnosed spontaneous recurrent left tension pneumothorax, COPD exacerbation, bilateral apical blebs, bilateral panacinar emphysema, heavy smoking history, chronic arthritis, and recreational marijuana user. He noted that appellant had a complete collapse of his left lung which required insertion of a chest tube and drainage. Dr. Williams noted that appellant had incomplete expansion of the left lung and that a computerized tomography (CT) scan on June 7, 2012 revealed bilateral bullous emphysema with apical blebs. He performed a left video-assisted thoracic surgery with excision of apical blebs and argon beam laser photocoagulation of apical blebs and subpleural blebs as well as talc pleurodesis and an intercostal nerve block on June 8, 2012.

On June 27, 2012 appellant indicated that his injury occurred while he was repairing a forklift tire and after he had lifted the tire to load it onto a truck. He described the split ring tire and his difficulties in making the repair. Appellant felt that he pulled or strained a muscle in his back and that he kept trying to make the repair until he could no longer get a deep breath. He noted that he smoked for 35 years less than a pack a day. Appellant stopped smoking in 2007. In 2009 he was diagnosed with COPD by the employing establishment and was placed on the Asbestosis Surveillance Program by the Department of the Navy.

By decision dated July 24, 2012, OWCP denied appellant's claim finding that he had not established that his medical condition was causally related to his employment activities on June 6, 2012. Appellant requested a review of the written record from OWCP's Branch of Hearings and Review on August 14, 2012.

Dr. Williams completed a form report (Form CA-20) on August 13, 2012 and diagnosed emphysema, COPD, and pneumothorax on the left. He indicated that appellant had a history of concurrent injury including significant COPD and emphysema. Dr. Williams indicated by checking a box marked "yes" that appellant's condition was caused or aggravated by his employment as "pushing and straining increased chest pressure made his left lung collapse." He further noted that appellant's pushing and lifting contributed to the "bursting" of a bleb in his left lung.

In a decision dated October 10, 2012, OWCP's hearing representative remanded the case for further development of the medical evidence based on Dr. Williams' report. OWCP referred appellant to Dr. Robert E. Cox, a Board-certified pulmonologist. In a report dated December 6,

2012, Dr. Cox diagnosed spontaneous secondary pneumothorax with underlying bullous emphysema aggravated by work, specifically straining and bearing down while working to repair a forklift tire. He noted that appellant's past pulmonary function tests demonstrated forced expiratory volume in the first second (FEV_1) ranging from 32 percent of expected to 80 percent. Dr. Cox administered standard spirometry and found FEV_1 at 65 percent of predicted. He found that appellant's lung capacity was rated as moderate-to-moderately severe obstruction. Dr. Cox noted that there was an approximate five percent recurrence rate of pneumothorax following surgery which dropped off after the first year. He concluded that appellant's condition was temporary. Dr. Cox noted that appellant was at maximum medical improvement (MMI) for his pneumothorax and that his pulmonary function was better than that which was obtained one year prior to his injury. He further concluded that there was no permanent partial impairment as a result of appellant's injury.

OWCP accepted appellant's claim for temporary aggravation of bullous emphysema on December 31, 2012. Appellant returned to work with restrictions on July 16, 2013.[2]

Appellant filed a claim for compensation (Form CA-7) requesting a schedule award on April 25, 2014. In a letter dated April 29, 2014, OWCP requested additional medical evidence supporting appellant's claim for MMI and permanent impairment as a result of his accepted temporary aggravation of bullous emphysema. By decision dated June 17, 2014, it denied appellant's schedule award claim finding that the medical evidence of record failed to demonstrate a measurable impairment.

Appellant submitted a statement on June 16, 2014 and noted that he retired on May 1, 2014. He sought treatment on April 10, 2014 from Dr. Krithkia Ramachandran, a critical care physician. Dr. Ramachandran noted appellant's history of COPD, as well as a secondary spontaneous pneumothorax with pleurodesis. She reported that appellant performed his job duties and was able to walk up two or three flights of stairs without dyspnea. Dr. Ramachandran noted that appellant's prior pulmonary function tests from 2010 showed moderate obstructive defect with some air trapping.

Appellant requested a review of the written record on July 16, 2014. Dr. Williams examined appellant on February 4, 2014 and reported that appellant experienced ongoing paresthesia to the left scapular area since his surgery. He noted that appellant was concerned about his ongoing physical limitations due to a cervical spine injury and radiculopathy. Dr. Williams found that appellant's chronic COPD-related exertional dyspnea was unchanged. He found no dyspnea, no wheezing, rales, crackles, or rhonchi. Dr. Williams reported that appellant's breath sounds were normal with good air movement.

Dr. Scott Heflick, a Board-certified family practitioner, completed a report on July 11, 2014 and indicated that as he was unfamiliar with the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, he was unable to opine as to permanent impairment for schedule award purposes.

Dr. Ramachandran completed her report on July 15, 2014 and opined that appellant had permanent impairment to his lungs. She concluded that appellant was functioning at the

[2] Appellant filed a recurrence claim (Form CA-2a) on January 10, 2014 for a previous July 29, 1989 injury. That claim is not before the Board.

maximum of his lung capacity and that she expected no further impairment in lung function. In a note dated September 11, 2014, Dr. Ramachandran reported that appellant was coughing more and feeling short of breath. She prescribed medication.

Appellant completed an additional statement on December 30, 2014. He reported difficulty finding an appropriate physician to evaluate his lung condition. Appellant alleged that his lung was painful and that it hurt to lift even light awkward objects. He asserted that pushing and pulling strained his lung and pulled on the surgery scars.

By decision dated February 26, 2015, OWCP's hearing representative found that appellant had not submitted the necessary medical opinion evidence to establish a permanent impairment as a result of his accepted condition. She noted that there were no impairment rating or lung studies to support that appellant had less function of his lung than he had prior to his injury. OWCP's hearing representative further noted that Dr. Cox found that appellant had reached MMI, but with no permanent impairment. She affirmed OWCP's June 17, 2014 decision denying appellant's schedule award claim.

Following the February 26, 2015 decision, appellant submitted additional medical evidence. He resubmitted a report dated September 11, 2014 from Dr. Ramachandran. Appellant also submitted reports from Dr. Ramachandran dated May 11, 2015 which noted that appellant reported his symptoms were chronic with chest pain on the left where the surgical incisions were made. He alleged that the incision pain prevented him from taking deep breaths and lifting heavy loads as it felt like it was tearing through the front of his chest. Dr. Ramachandran found that appellant's pulmonary function tests demonstrated moderately severe obstruction on May 11, 2015 and severe obstruction without response to bronchodilator on August 13, 2015. She opined that appellant's secondary spontaneous pneumothorax and blebs had been surgically repaired and were no longer an issue.

Appellant requested reconsideration on February 19, 2016 and alleged that Dr. Ramachandran was submitting a report consistent with the A.M.A., *Guides*.[3]

By decision dated May 16, 2016, OWCP declined to reopen appellant's claim for consideration of the merits. It found that he failed to submit any relevant or pertinent new evidence or argument in support of his request for reconsideration.

LEGAL PRECEDENT

FECA provides in section 8128(a) that OWCP may review an award for or against payment of compensation at any time on its own motion or on application by the claimant.[4] Section 10.606(b)(3) of Title 20 of the Code of Federal Regulations provides that a claimant may obtain review of the merits of the claim by submitting, in writing, an application for reconsideration which sets forth arguments or evidence and shows that OWCP erroneously applied or interpreted a specific point of law, or advances a relevant legal argument not previously considered by OWCP, or includes relevant and pertinent new evidence not previously

[3] A.M.A., *Guides*, 6th ed. (2009).

[4] 5 U.S.C. §§ 8101-8193, 8128(a).

considered by OWCP.[5] Section 10.608 of OWCP's regulations provides that when a request for reconsideration is timely, but fails to meet at least one of these three requirements, OWCP will deny the application for review without reopening the case for a review on the merits.[6] Section 10.607(a) of OWCP's regulations provides that to be considered timely, an application for reconsideration must be received by OWCP within one year of the date of OWCP's merit decision for which review is sought.[7]

ANALYSIS

The Board finds that OWCP improperly declined to reopen appellant's claim for consideration of the merits on March 16, 2016.

On February 25, 2016 OWCP received appellant's timely request for reconsideration from the hearing representative's February 26, 2015 decision. By decision dated May 16, 2016, it found that he failed to submit relevant and pertinent new evidence or argument in support of his reconsideration request and declined to reopen his claim for merit review of the denial of his schedule award.

The most recent merit decision in this case is the February 26, 2015 decision of OWCP's hearing representative. The hearing representative denied appellant's claim for a schedule award noting that he had submitted no medical evidence supporting a permanent impairment of his left lung as a result of the accepted condition of temporary aggravation of bullous emphysema and no pulmonary function studies. He further noted that Dr. Cox opined that appellant had no permanent impairment as a result of his pneumothorax.

In support of his request for reconsideration, appellant submitted additional reports from Dr. Ramachandran dated May 11 and August 13, 2015. In these reports Dr. Ramachandran included pulmonary function tests.

It is well established that the requirement for reopening a claim for further merit review before OWCP does not require a claimant to submit all evidence necessary to discharge his burden of proof. Rather, the requirement for reopening a case specifies only that the evidence be relevant, pertinent, and not previously considered by OWCP. The presentation of such new evidence creates the necessity for review of the full case record in order to properly determine whether the newly submitted evidence warrants modification of an earlier decision.[8]

In this case, appellant responded to a specific deficit in his medical evidence described by the hearing representative and submitted additional pulmonary function studies from Dr. Ramachandran. These pulmonary function studies were new to the record and relevant to appellant's permanent impairment for schedule award purposes under the sixth edition of the

[5] 20 C.F.R. § 10.606(b)(3).

[6] *Id.* at § 10.608.

[7] *Id.* at § 10.607(a). Federal (FECA) Procedure Manual, Part 2 -- Claims, *Reconsiderations*, Chapter 2.1602.4 (October 2011).

[8] *F.D. (S.D.)*, 58 ECAB 413 (2007).

A.M.A., *Guides*.[9] The Board finds that these new reports are relevant and pertinent to the issue of whether appellant has permanent impairment of his left lung entitling him to a schedule award. Thus, a merit review is warranted.

CONCLUSION

The Board finds that OWCP improperly denied appellant's request for reconsideration under 5 U.S.C. § 8128 of FECA.

ORDER

IT IS HEREBY ORDERED THAT the March 16, 2016 decision of the Office of Workers' Compensation Programs is set aside. The case is remanded to OWCP for further actions consistent with this decision.

Issued: December 6, 2016
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[9] *D.P.*, Docket No. 11-36 (issued August 17, 2011).