United States Department of Labor
Employees' Compensation Appeals Board

P.K., Appellant	)	
and	)	**Docket No. 25-0181**
	)	**Issued: February 25, 2025**
DEPARTMENT OF TRANSPORTATION, JOHN VOLPE NATIONAL TRANSPORTATION SYSTEM CENTER, Cambridge, MA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge

JURISDICTION

On December 14, 2024, appellant filed a timely appeal from a November 20, 2024 merit 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 this case.[2]

ISSUE

The issue is whether appellant has met his burden of proof to establish permanent impairment of a scheduled member or function of the body, warranting a schedule award.

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that following the November 20, 2024 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id*.

FACTUAL HISTORY

On July 1, 2021, appellant, then a 72-year-old general engineer, filed an occupational disease claim (Form CA-2) alleging that he developed a deep vein thrombosis in his left thigh, chest pain, difficulty breathing, and histoplasmosis causally related to factors of his federal employment, including exposure to microscopic airborne fungal spores, histoplasma capasulatum, during travel to Springfield-Beckley Municipal Airport, Ohio. He noted that he first became aware of his claimed condition on September 18, 2019 and realized its relationship to his federal employment on November 19, 2019. Appellant stopped work on September 18, 2019.

OWCP accepted the claim for disease of the mediastinum not otherwise classified.

In an August 25, 2022 report, Dr. Stefanos N. Kales, Board-certified in occupational medicine, reviewed appellant's medical record and provided his examination findings. He diagnosed disease of the mediastinum, or histoplasmosis, and performed a permanent impairment rating in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (A.M.A. *Guides*).[3] Dr. Kales reviewed a June 30, 2022 pulmonary function test (PFT) which demonstrated forced vital capacity (FVC) of 83 percent of predicted, forced expiratory volume in one second (FEV1) of 89 percent of predicted, and a ratio of FEV1 to FVC (FEV1/FVC) of 108 percent of predicted. He determined that appellant had reached maximum medical improvement (MMI) and found 23 percent whole person impairment based on impairments of the cardiovascular system. Dr. Kales further attributed appellant's recurrent atrial fibrillation and myocardial infarction to the occupationally-acquired histoplasmosis infection.

In a development letter dated September 16, 2022, OWCP requested that appellant submit a permanent impairment evaluation addressing whether he had reached MMI and providing an impairment rating using the sixth edition of the A.M.A., *Guides*. It informed him that there were no schedule awards for the whole person and afforded him 30 days to submit the necessary evidence.

On November 15, 2022, OWCP referred appellant's case to Dr. Michael Minev, a Board-certified internist serving as an OWCP district medical adviser (DMA), for determination of appellant's date of MMI and any permanent impairment of a scheduled member or function under the sixth edition of the A.M.A., *Guides*. It specifically requested that Dr. Minev review Dr. Kales' August 25, 2022 report. On December 8, 2022, Dr. Minev reviewed the medical evidence, found that appellant reached MMI on May 7, 2020, and determined that it was impossible to calculate a lung impairment in accordance with the A.M.A., *Guides* with the information provided.

On February 24, 2023, appellant filed a claim for compensation (Form CA-7) for a schedule award.

On July 5, 2023, OWCP again referred appellant's case to Dr. Minev for determination of appellant's date of MMI and any permanent impairment of a scheduled member or function under the sixth edition of the A.M.A., *Guides*. In his July 14, 2023 report, he repeated his finding that

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

Dr. Kales' August 25, 2022 impairment rating was insufficient to establish permanent impairment of a scheduled member in accordance with the A.M.A., *Guides*.

On July 28, 2023, OWCP referred appellant, along with an updated statement of accepted facts (SOAF), the medical record, and a series of questions, to Dr. Meena Mehta, a Board-certified internist specializing in pulmonary disease, for a second opinion evaluation. It requested that Dr. Mehta provide an opinion regarding appellant's permanent impairment under the A.M.A., *Guides* and date of MMI.

In a September 6, 2023 report, Dr. Mehta discussed appellant's factual and medical history, and reviewed the SOAF and the medical record, including the results of March 23, 2023 physical examination and an August 15, 2023 PFT which included FVC results of 69 percent of predicted prebronchodilator and 73 percent of predicted post-bronchodilator, a prebronchodilator FEV1 of 79 percent of predicted and a post-bronchodilator of 86 percent of predicted, and a prebronchodilator FEV1/FVC of 75 percent of predicted and a post-bronchodilator FEV1/FVC of 77 percent of predicted. She interpreted this PFT as demonstrating evidence of mild restrictive lung disease, spirometry suggestive of mild restriction, with mildly decreased total lung volumes, and mildly decreased but within normal adjusted diffusion capacity. Dr. Mehta found that appellant had reached MMI on May 7, 2020 after completing treatment with antifungal medication for pulmonary histoplasmosis with no complaints of chest pain, shortness of breath, fever, chills, night sweats, or hemoptysis. She found 11 percent whole person impairment due to recurrent atrial fibrillation and bradycardia after pacemaker placement using Table 4-9 of the A.M.A., *Guides*, relevant to the cardiovascular system. Dr. Mehta further found 14 percent permanent impairment of the whole person due to coronary artery disease under Table 4-6, for a total combined impairment rating of 23 percent permanent impairment of the whole person. She found no impairment due to pulmonary dysfunction, noting that appellant had a normal spirometry with FVC of 83 percent of predicted and FEV1 of 89 percent of predicted. Dr. Mehta determined that the conditions of deep vein thrombosis and pulmonary embolism were likely caused from the prolonged disequilibrium of his hematologic system secondary to the chronic inflammatory response to the acquired histoplasmosis infection. She, however, also circled on a pulmonary dysfunction chart setting forth Table 5-4 of the A.M.A., *Guides* that appellant had Class 1 impairment due to pulmonary dysfunction due to an FVC between 70 and 79 percent of predicted and an FEV1 between 65 and 79 percent of predicted.

On September 11, 2023, OWCP referred appellant's case to Dr. Minev, serving as a DMA, to determine appellant's date of MMI and any permanent impairment of a scheduled member or function under the sixth edition of the A.M.A., *Guides*. In a September 18, 2023 report, Dr. Minev explained that the medical evidence failed to provide objective evidence linking appellant's histoplasmosis to the results of his pulmonary function test or to the development of recurrent atrial fibrillation, bradycardia, and coronary artery disease.

On September 22, 2023, OWCP requested that Dr. Mehta address the deficiencies referenced by the DMA in her March 23, 2023 report, including providing objective evidence linking histoplasmosis to the development of recurrent atrial fibrillation, bradycardia, and coronary artery disease.

In an October 24, 2023 development letter, OWCP requested that appellant provide additional information regarding the possible consequential conditions of histoplasmosis, atrial

fibrillation, bradycardia, and coronary artery disease in relation to his September 18, 2019 employment injury. It afforded him 30 days to submit the requested information.

On October 30, 2023, Dr. Mehta opined that appellant had reached MMI on May 7, 2020 and noted that "at that time, there was no complaint of chest pain, shortness of breath, fever, chills, night sweats, hemoptysis."

On November 6, 2023, OWCP requested that Dr. Mehta address whether appellant's accepted condition of histoplasmosis resulted in the additional conditions of recurrent atrial fibrillation, bradycardia, and coronary artery disease and provided objective evidence for her conclusions.

In a December 26, 2023 supplemental report, Dr. Mehta reviewed Dr. Minev's report and advised that she had her opinion and he had his, and that it was "up to the authorities to decide." She asserted that there was limited information in the medical literature regarding the relationship between histoplasmosis and the development of recurrent atrial fibrillation, bradycardia, and coronary artery disease. Dr. Mehta opined that a cardiologist could answer this question more specifically.

On December 27, 2023, OWCP referred appellant's case to Dr. Minev for a determination of appellant's date of MMI and any permanent impairment of a scheduled member or function under the sixth edition of the A.M.A., *Guides*.

In a January 16, 2024 report, Dr. Minev found that there was insufficient evidence to support that the diagnostic procedure required to diagnose appellant's histoplasmosis infection caused atrial fibrillation. He recommended that OWCP obtain the opinion of a cardiologist.

On March 18, 2024, OWCP referred appellant, along with an updated SOAF, the medical record, and a series of questions, to Dr. James Todd, Board-certified in thoracic cardiovascular surgery, for a second opinion evaluation. It requested that Dr. Todd provide an opinion regarding whether there was objective evidence linking histoplasmosis to the development of recurrent atrial fibrillation, bradycardia, and coronary artery disease.

In an April 2, 2024 report, Dr. Todd discussed appellant's factual and medical history, and his review of the SOAF and the medical record, finding that appellant had experienced six documented bouts of atrial fibrillation requiring hospitalization on October 24 and November 4, 2019, December 2, 2020, June 23, 2021, October 12, 2023, and January 16, 2024. He noted that appellant had not experienced atrial fibrillation since October 12, 2023. Dr. Todd discussed appellant's condition with his attending physician, Dr. Daniel Lombardi, a Board-certified internist specializing in cardiovascular disease, on April 8, 2024 and opined that the diagnosed atrial fibrillation was not due to histoplasmosis in the left upper lobe of the lung, but instead attributed this condition to sleep apnea, and coronary artery disease diagnosed on December 3, 2020. He related that there was no fibrotic tissue from mediastinitis or histoplasmosis and that imaging studies did not support the diagnosis of granulomatous mediastinitis due to histoplasmosis. Dr. Todd reviewed appellant's August 15, 2023 pulmonary function test and found mild restrictive lung disease with normal diffusion capacity demonstrating mild problems. He related that appellant's descriptions of severe limitation of stamina did not correlate with clinical record. Dr. Todd diagnosed mild restrictive lung disease, with no evidence of mediastinitis, and a fibrotic pulmonary nodule in the left upper lobe with pathology showing

histoplasmosis. He determined that the work-related condition had completely resolved, appellant's atrial fibrillation was well controlled, and the blockage in the left anterior descending coronary artery was cured with a stent. Dr. Todd concluded that there was no objective evidence that histoplasmosis played any role in appellant's atrial fibrillation, bradycardia, or coronary artery disease.

In a June 7, 2024 letter, OWCP requested that Dr. Lombardi address the findings in Dr. Todd's April 2, 2024 report. Dr. Lombardi completed a July 6, 2024 report agreeing with Dr. Todd's findings that sleep apnea and coronary artery disease were common risk factors associated with atrial fibrillation. He further related that neither the diagnosis of histoplasmosis nor the treatment of this condition caused or contributed to appellant's development of atrial fibrillation.

In an unsigned report dated July 15, 2024, Dr. Angus P. McIntyre, a Board-certified internist specializing in hematology and medical oncology, completed a report relating his treatment of appellant since 2009. He noted that the diagnosis of sleep apnea was well controlled with a continuous positive airway pressure (CPAP) machine. Dr. McIntyre related that on September 18, 2019 appellant was diagnosed with deep vein thrombosis and pulmonary emboli and presenting with symptoms of chest discomfort and shortness of breath. Within two days following mediastinoscopy on October 22, 2019, he experienced rapid irregular heart rhythm which was treated with medication. On November 4, 2019, appellant underwent left upper lobectomy, mediastinal, and hilar lymphadenectomy. He experienced an episode of atrial fibrillation on November 5, 2019, which converted to normal sinus rhythm, but he then experienced another episode of atrial fibrillation. Dr. McIntyre diagnosed histoplasmosis with inflammatory pulmonary lesions and regional lymphadenitis, paroxysmal atrial fibrillation, coronary artery disease, sleep apnea (well-controlled), secondary erythrocytosis, and exertional dyspnea attributed to decrease in lung volumes due to the left upper lobectomy. He explained that atrial fibrillation may be in part related to underlying coronary artery disease but was temporally related to the mediastinoscopy and the left upper lobectomy. Dr. McIntyre disagreed that atrial fibrillation was related to sleep apnea and found that appellant had lost some of his lung function due to the left upper lobectomy.

On August 1, 2024, OWCP referred appellant's case to Dr. Minev for determination of appellant's date of MMI and any permanent impairment of a scheduled member or function under the sixth edition of the A.M.A., *Guides*. In a September 9, 2024 report, Dr. Minev found that it was possible that appellant's atrial fibrillation was caused by mediastinoscopy and left upper lobectomy, but that a direct causal relationship between histoplasmosis and atrial fibrillation, bradycardia, and coronary artery disease could not be determined by Dr. McIntyre's July 15, 2024 report.

On October 23, 2024, OWCP requested clarification from Dr. Minev addressing whether it was possible to provide an impairment rating based on the accepted condition of diseases of the mediastinum. In a November 18, 2024 addendum, Dr. Minev related that it was impossible to calculate an impairment rating for appellant due to mediastinal disease, as from a pulmonary perspective he did not have evidence of mediastinal disease. He reviewed appellant's June 30, 2022 PFT and found that FVC was 83 percent of predicted, FEV1 was 89 percent of predicted, and FEV1/FVC was 108 percent of predicted. He applied the sixth edition of the A.M.A., *Guides*, Table 5-4, page 88, finding that FVC and FEV1 with values greater than 80 percent were consistent with a whole person impairment rating of 0 percent. Dr. Minev found that, from a cardiac

standpoint, appellant's atrial fibrillation was no longer active and his coronary artery disease had been treated.

By decision dated November 20, 2024, OWCP denied appellant's schedule award claim. It found that the medical evidence of record was insufficient to establish permanent impairment of a scheduled member or function of the body.

LEGAL PRECEDENT

The schedule award provision of FECA,[4] and its implementing federal regulation,[5] 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.[6] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[7]

No schedule award is payable for a member, function, or organ of the body that is not specified in FECA or in the implementing regulations.[8] The list of schedule members includes the eye, arm, hand, fingers, leg, foot, and toes. Additionally, FECA specifically provides for compensation for loss of hearing and loss of vision.[9] By authority granted under FECA, the Secretary of Labor expanded the list of schedule members to include the breast, kidney, larynx, lung, penis, testicle, tongue, ovary, uterus/cervix and vulva/vagina, and skin.[10] Neither FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back or the body as a whole.[11] Compensation for total loss of use of a single lung is 156 weeks.[12]

Although FECA does not specifically provide for compensation for whole person impairment, the measurement of lung function warrants special consideration. Table 5-4, Pulmonary Dysfunction, A.M.A., *Guides* page 88, provides whole person impairment ratings based on a designated Class (0-4) of impairment. Depending on the assigned class, the range of whole person impairment due to pulmonary dysfunction is 0 to 65 percent. OWCP procedures provide that lung impairment should be evaluated in accordance with the A.M.A., *Guides* insofar

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id*. at § 10.404(a).

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[8] *J.S.*, Docket No. 23-0456 (issued October 2, 2023); *J.G.*, Docket No. 16-1533 (issued March 15, 2018); *W.C.*, 59 ECAB 372, 374-75 (2008); *Anna V. Burke*, 57 ECAB 521, 523-24 (2006).

[9] *Supra* note 5 at § 8107(c)(13) and (14).

[10] *Id*. at § 8107(c)(22); 20 C.F.R. § 10.404(b).

[11] *Id*. at § 8107(c); *id*. at § 10.404(a); *see Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

[12] *Id*. at § 10.404(b).

as possible. It further provides that schedule awards are based on the loss of use of both lungs and the percentage for the particular 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.[13]

The A.M.A., *Guides* provides that most pulmonary impairments should be rated using Table 5-4, Pulmonary Dysfunction. It further provides:

> "The examiner should note that throughout this chapter the objective test results are used as the primary or 'key' factor in the impairment rating for the condition, or range of conditions. Well-validated organ-specific functional test measures exist for the pulmonary system that correlate well with levels of impairment. It is therefore appropriate to choose "objective test results" as the primary determinant of impairment class rating in this chapter."[14]

The A.M.A., *Guides* specifies that in rating pulmonary impairment the examiner should assign an impairment class using the key impairment factor, objective test results, and that "only the key factor can be used to assign the impairment class." It further provides that "[w]hen non-key factors such as history and physical exam[ination] are relevant to the rating, they are each assigned a relative class value, which in turn is used to move the impairment rating up or down in the same class.... Regardless of the discrepancy of impairment classes between the key factor and non-key factors, the impairment rating should never move out of the class to which it was initially assigned, using only the key factor."[15]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[16]

ANALYSIS

The Board finds this case not in posture for decision.

In an August 25, 2022 report, Dr. Kales provided a permanent impairment rating in accordance with the sixth edition of the A.M.A., *Guides* based on a June 30, 2022 PFT which demonstrated FVC of 83 percent of predicted, FEV1 of 89 percent of predicted and FEV1/FVC, of 108 percent of predicted. Dr. Kales provided a 23 percent whole person impairment based on impairments of the cardiovascular system.

In an impairment evaluation dated March 23, 2023, Dr. Mehta, an OWCP referral physician, reviewed the results of an August 15, 2023 PFT prior to administration of

[13] *Supra* note 8 at Chapter 2.808.5c(1); *id*. at Chapter 3.700.4d(1)(c).

[14] A.M.A., *Guides*, 87.

[15] *Id*.

[16] *See supra* note 8 at Chapter 2.808.6(f) (March 2017); *see also J.S.*, Docket No. 23-0456 (issued October 2, 2023); *R.M.*, Docket No. 18-1313 (issued April 11, 2019); *C.K.*, Docket No. 09-2371 (issued August 18, 2010).

bronchodilators and determined that appellant had evidence of mild restrictive lung disease, spirometry suggestive of mild restriction, mildly decreased total lung volumes, but within normal adjusted diffusion capacity. She found that appellant reached MMI on May 7, 2020 and opined that appellant had 23 percent permanent impairment of the whole person due to his cardiac condition. Dr. Mehta provided conflicting findings regarding the extent of pulmonary dysfunction, noting both that he had a Class 1 impairment due to pulmonary dysfunction and finding that another spirometry was normal.

Dr. Minev, the DMA reviewed the medical evidence, including the impairment ratings of Drs. Kales and Mehta, and disagreed with their application of the A.M.A., *Guides*. In a November 18, 2024 addendum, he reviewed appellant's June 30, 2022 PFT and found that FVC was 83 percent of predicted, FEV1 was 89 percent of predicted, and FEV1/FVC was 108 percent of predicted. He applied the sixth edition of the A.M.A, *Guides*, Table 5-4, page 88, finding that FVC and FEV1 with values greater than 80 percent are consistent with a whole person impairment rating of 0 percent. Dr. Minev did not explain, however, why he selected the June 30, 2022 PFT rather than the findings from the findings of the August 15, 2023 PFT which demonstrated lower percentages of FVC and FEV1.

It is well established that proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter. While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares the responsibility in the development of the evidence to see that justice is done.[17] OWCP undertook development of the medical evidence by referring appellant to Dr. Minev for evaluation. It therefore has an obligation to secure a report from its physician that will resolve the relevant issues in the case.[18]

The case shall, therefore, be remanded for OWCP to refer the case record to a new DMA for an opinion regarding the extent of appellant's permanent impairment in accordance with the A.M.A., *Guides*. After this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for decision.

[17] *See N.W.*, Docket No. 24-0747 (issued August 28, 2024); *B.W.*, Docket No. 24-0223 (issued July 17, 2024); *L.F.*, Docket No. 20-0549 (issued January 27, 2021).

[18] *See B.W.*, *id.*; *Peter C. Belkind*, 56 ECAB 580 (2005).

ORDER

IT IS HEREBY ORDERED THAT the November 20, 2024 decision of the Office of Workers' Compensation Programs is set aside and remanded for further proceedings consistent with this decision of the Board.

Issued: February 25, 2025
Washington, DC

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

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board