United States Department of Labor
Employees' Compensation Appeals Board

B.H., Appellant	)	
and	)	**Docket No. 12-1960**
	)	**Issued: March 22, 2013**
DEPARTMENT OF LABOR, MINE SAFETY & HEALTH ADMINISTRATION, Norton, VA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 17, 2012 appellant filed a timely appeal from an August 20, 2012 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.

ISSUE

The issue is whether appellant is entitled to more than a 12 percent permanent impairment for loss of use of both lungs, for which he has received a schedule award.

FACTUAL HISTORY

On May 28, 2008 appellant, then a 51-year-old coal mine inspector, filed an occupational disease claim alleging that he suffered from pneumoconiosis as a result of exposure to coal dust when he inspected coal mines. He first became aware of his condition and realized it resulted

[1] 5 U.S.C. § 8101 *et seq.*

from his employment on August 23, 2007. Appellant did not stop work. The record reflects that the date of his last exposure was May 22, 2008. OWCP accepted appellant's claim for coal workers' pneumoconiosis.

In a February 11, 2010 report, Dr. Michael T. McCormack, a Board-certified pulmonary disease specialist, noted appellant's history of coal workers' pneumoconiosis and progressive dyspnea with increasing fatigue. He stated that noncontrast computerized tomography (CT) scan revealed bilateral upper lobe predominant nodularity and conglomerate mass formation compatible with complicated pneumoconiosis. Dr. McCormack diagnosed pneumoconiosis with massive pulmonary fibrosis and abnormal CT of the chest with increased right upper lobe conglomerate mass. He reported that, based on the CT scan, appellant had not necessarily reached a permanent state as his condition may worsen, but he certainly reached maximum medical improvement. Dr. McCormack concluded that, according to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001), Table 5-12, appellant had class 3 impairment or 26 to 50 percent whole person impairment.

On May 17, 2010 appellant filed a claim for a schedule award.

OWCP referred appellant's claim to a district medical adviser. In a July 11, 2010 report, an OWCP medical adviser, stated that the February 11, 2010 impairment rating from Dr. McCormack was not acceptable for schedule award purposes because it was not based on the sixth edition of the A.M.A., *Guides.*

OWCP referred appellant's claim, along with a statement of accepted facts, to Dr. Srinivasu Ammisetty, a Board-certified pulmonary disease specialist, for a second-opinion examination. In a September 9, 2010 report, Dr. Ammisetty noted appellant's work history of exposure to respirable coal, silica, rock dust and diesel fumes and that he sustained pneumoconiosis as a result of exposure to coal dust at work. He listed findings on examination and noted that pulmonary function studies (PFS) demonstrated moderate restrictive lung disease. Dr. Ammisetty reported that a September 2010 pulmonary function test (PFT) showed a forced expiratory volume 1 (FEV_1) of 69 percent of the predicted value and a forced expiratory capacity (FEC) of 68 percent of the predicted value. He opined that appellant's symptoms were worsening as evidenced by his deteriorating oxygenation and decrease in FEV_1. Dr. Ammisetty rated class 2E impairment or 23 percent whole person impairment.

In a November 28, 2010 report, the district medical adviser reviewed Dr. Ammisetty's September 9, 2010 impairment rating and noted that the report did not contain a PFT that was done contemporaneous with Dr. Ammisetty's impairment rating. He explained that without a contemporaneous PFT he could not provide an impairment rating for appellant. The district medical adviser reported that Dr. Ammisetty's September 9, 2010 second-opinion report was not acceptable as a basis to process a schedule award.

OWCP referred appellant to Dr. Antoine Habre, a Board-certified pulmonary disease specialist, for another second-opinion examination. In a March 28, 2011 report, Dr. Habre reviewed appellant's history of occupational exposure and provided findings on examination. He noted that a PFT performed on March 31, 2009 also demonstrated a FEV_1 of 80 percent of the predicted value, a forced vital capacity (FVC) of 82 percent of the predicted value and a

diffusing capacity for carbon dioxide (DLCO) of 61 percent of the predicted value. Examination of the thorax and lungs was normal to inspection, palpation and percussion and clear to auscultation. Dr. Habre noted appellant's diagnoses of complicated coal worker' pneumoconiosis and progressive massive fibrosis based on his CT of the chest findings. He stated that determination of a disabling lung disease would not be possible since arterial blood gas tests, pulmonary ventilator study or other diagnostic testing were not obtained. Dr. Habre explained that, for an accurate determination of disability, appellant would need to have more recent diagnostic testing performed.

In a July 7, 2011 supplemental report, Dr. Habre noted that a January 26, 2011 PFT revealed a FVC of 3.24 or 74 percent of the predicted value and a FEV_1 of 2.46 or 69 percent of the predicted value. He stated that another study was obtained and showed similar findings, with a FVC of 3.21 or 73 percent of the predicted value and a FEV_1 of 2.42 or 68 percent of the predicted. Dr. Habre opined that this testing did not indicate a severe decline in spirometric parameters and did not meet disability standard guidelines.

In a report dated July 29, 2011, an OWCP medical adviser determined that, in accordance with the sixth edition of the A.M.A., *Guides*[2] appellant had 6 percent impairment for each lung for a total of 12 percent impairment for both lungs.[3] He stated that the PFT referenced in Dr. Habre's July 7, 2011 report showed FVC of 73 percent of the predicted value and FEV_1 of 68 percent of the predicted value. The medical adviser reported that "these percentages of the predicted values cause this individual to be ratable from 2 to 10 percent with the default value being 6 percent." He noted that although appellant complained of severe limitations, Dr. Habre's examination findings were not significant and revealed that his thorax and lungs were normal to inspection, palpation and percussion. The medical adviser opined that the "findings on the PFS put this claimant more or less in the middle range for the percentages that are required for the FEV and the FVC." Thus, he concluded that appellant had 6 percent impairment rating for each lung for a total of 12 percent bilateral lung impairment.

On August 5, 2011 OWCP granted a schedule award for 6 percent permanent impairment for each lung, for a total of 12 percent permanent impairment for both his lungs. The award covered a period of 18.72 weeks from January 26 through June 6, 2011.

On August 13, 2011 appellant requested an oral hearing, which was held on December 8, 2011. He alleged that he should be awarded a higher degree of permanent impairment and that OWCP failed to consider his physician's reports. Appellant stated that there was a big gap in the percentage of loss between his physicians and OWCP's physicians. He noted that he had a new report with an evaluation performed under the sixth edition of the A.M.A., *Guides* that he would submit.

In an October 14, 2011 report, Dr. McCormack stated that he treated appellant since September 24, 2008 and noted that he was diagnosed with pneumoconiosis with progressive massive pulmonary fibrosis. He reported that appellant had significant symptomatology with progressive dyspnea, wheezing and chest pain. Dr. McCormack opined that appellant

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

[3] *Id.* at 88, Table 5-4.

demonstrated class 3 impairment (24 to 40 percent whole body impairment) according to the sixth edition of the A.M.A., *Guides.* He concluded that appellant was currently at maximum medical improvement and that his degree of impairment was 40 percent.

By decision dated February 15, 2012, an OWCP hearing representative affirmed the August 5, 2012 schedule award decision finding that the medical evidence failed to establish that appellant had permanent impairment in excess of 12 percent for both lungs according to the sixth edition of the A.M.A., *Guides*.

In February 27 and May 21, 2012 statements, appellant disagreed with the February 15, 2012 decision. He alleged that he found discrepancies in the medical adviser's report and pointed out that Dr. McCormack awarded him 40 percent whole body impairment. OWCP treated these statements as requests for reconsideration.

In a February 27, 2012 cardiopulmonary exercise test, Dr. McCormack noted a diagnosis of dyspnea. Spirometry testing prebronchodilator showed FVC of 3.61 or 74 percent of the predicted value and FEV_1 of 2.55 or 66 percent of the predicted value. Post-bronchodilator testing showed FVC of 3.62 or 75 percent of the predicted value and FEV_1 of 2.57 or 67 percent of the predicted value.

Appellant resubmitted Dr. McCormack's October 14, 2011 report with a different date of October 17, 2011.

OWCP referred appellant's claim to an OWCP medical adviser for review. In an August 15, 2012 report, the medical adviser reviewed his records, including Dr. McCormack's October 14, 2011 report, which found that appellant demonstrated a class 3 whole body impairment under to the sixth edition of the A.M.A., *Guides* for an impairment rating of 40 percent. He stated that "no documentation relevant to considering 'class 3' from presumably Table 5-4, page 88, of the sixth edition … accompanies this paragraph note." The medical adviser also noted that a rating from Table 5-4 would have to meet all of the requirements regarding PFS and no such information was provided. He concluded that appellant's right and left lung impairment rating should not be modified.

In a decision dated August 20, 2012, OWCP denied modification of the August 5, 2011 schedule award decision.

LEGAL PRECEDENT

The schedule award provision of FECA[4] and its implementing regulations 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. FECA, however, does not specify the manner in which the percentage of loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. The

[4] 5 U.S.C. §§ 8101-8193.

A.M.A., *Guides* (6th ed. 2009), has been adopted by OWCP for evaluating schedule losses and the Board has concurred in such adoption.[5]

OWCP evaluates respiratory or pulmonary impairments in accordance with the standards contained in Chapter 5 of the sixth edition of the A.M.A., *Guides.*[6] It provides a table which describes four classes of respiratory impairment based on a comparison of observed values for certain ventilator function measures and their respective predicted values. The appropriate class of impairment is determined by the observed values for either the FVC, FEV_1, the DLCO or the maximum oxygen consumption (VO2Max). If the FVC, FEV_1 or DLCO results, the ratio of FEV_1 to FVC or the specified range of oxygen volume, 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, depending on the severity of the observed value. A person will fall within class 0 and be deemed to have no impairment, if the FVC, FEV_1, ratio of FEV_1 to FVC and DLCO are greater than or equal to the lower limit of normal, or the VO2Max is greater than or equal to a specified oxygen volume.[7]

ANALYSIS

OWCP accepted appellant's occupational disease claim for the condition of coal workers' pneumoconiosis. On August 23, 2007 it granted a schedule award of 12 percent permanent impairment for both lungs. Appellant disagreed with this decision and alleged that he is entitled to a schedule award greater than 12 percent impairment for both lungs. The Board finds that the medical evidence does not support a permanent impairment greater than 12 percent bilateral lung impairment.

Appellant submitted reports by Dr. McCormack. In his February 11, 2010 report, Dr. McCormack noted appellant's history of coal workers' pneumoconiosis and progressive dyspnea. He reported that appellant had not reached a permanent state because his condition may worsen but he had reached maximum medical improvement. Dr. McCormack concluded that according to the fifth edition of the A.M.A., *Guides* appellant had class 3 impairment or 26 to 50 percent whole person impairment. As previously noted, however, OWCP no longer uses the fifth edition of the A.M.A., *Guides.*[8] Accordingly, Dr. McCormack's impairment rating does not conform to the A.M.A., *Guides.* Similarly, in his October 14, 2011 report, he noted appellant's significant symptomatology with dyspnea, wheezing and chest pain. Dr. McCormack stated that appellant reached maximum medical improvement. He opined that appellant demonstrated class 3 impairment according to the sixth edition of the A.M.A., *Guides* and concluded that his degree of impairment was 40 percent. Dr. McCormack did not, however, provide any diagnostic findings or pulmonary function test results to support his conclusion. Chapter 5 of the A.M.A., *Guides* provides respiratory impairment based on a comparison of observed values for certain ventilator function measures and their respective predicted values.[9]

[5] *R.D.*, 59 ECAB 127 (2007); *Bernard Babcock, Jr.*, 52 ECAB 143 (2000); *see also* 20 C.F.R. § 10.404.

[6] A.M.A., *Guides* 77-99.

[7] *Id.* at 88, Table 5-4; *see Boyd Haupt*, 52 ECAB 326 (2001).

[8] *Supra* note 5.

[9] *Supra* note 7.

Dr. McCormack did not provide any such pulmonary function test results and predicted values in his report to support his impairment rating. Because his reports failed to provide an estimate of impairment rating conforming to the A.M.A., *Guides,* Dr. McCormack's opinion is of diminished probative value in establishing the degree of permanent impairment.[10]

OWCP referred appellant's claim to Dr. Habre for a second-opinion examination. In the March 28, 2011 report, Dr. Habre reviewed appellant's history of occupational exposure and provided findings on examination. Examination of the thorax and lungs was normal to inspection, palpation and percussion and clear to auscultation. Dr. Habre stated that a determination of disability would not be possible without more recent diagnostic testing. In a July 7, 2011 supplemental report, he noted that a January 26, 2011 PFT had been conducted and revealed a FVC of 3.24 or 74 percent of the predicted value and a FEV_1 of 2.46 or 69 percent of the predicted value. Dr. Habre stated that another study was obtained and showed similar findings, with a FVC of 3.21 or 73 percent of the predicted value and a FEV_1 of 2.42 or 68 percent of the predicted value. He concluded that this testing did not meet disability guidelines.

While Dr. Habre did not properly apply the A.M.A., *Guides* to the PFT findings in determining impairment rating, OWCP may rely on the opinion of an OWCP medical adviser to apply the A.M.A., *Guides* to the findings reported by the attending physician.[11] In July 29 and August 15, 2012 reports, the medical adviser applied the A.M.A., *Guides* to the diagnostic testing provided in Dr. Habre's March 28, 2011 report. He referenced Table 5-4 of the sixth edition of the A.M.A., *Guides* and found that appellant had a 6 percent impairment for each lung for a total of 12 percent bilateral lung impairment. The medical adviser found that the results of the PFT placed appellant in class 1 impairment with a ratable impairment from 2 to 10 percent and a default value of 6 percent. He also noted that the diagnostic findings were in the middle range of percentages and that appellant's physical examination was normal. Table 5-4 of the A.M.A., *Guides* indicates that, in finding a class 1 impairment, the FVC value should be between 70 and 79 percent of the predicted value or the FEV_1 between 65 and 79 percent of the predicted value. Appellant's values for these tests as recorded by Dr. Habre were 73 percent and 68 percent of the predicted value, respectively.[12] The Board finds that the medical adviser properly applied the A.M.A., *Guides* to determine that appellant's impairment to his lungs placed him with class 1 impairment and that his examination findings were otherwise normal relative to inspection, palpation and percussion. Thus, OWCP properly found that appellant had 6 percent impairment for each lung for a total of 12 percent bilateral lung impairment.

On appeal, appellant alleges that an additional impairment should be awarded based on all the medical evidence. The Board notes, however, that the medical adviser provided the only impairment rating that conformed to the A.M.A., *Guides.* Thus, his finding constitutes the

[10] *Linda Beale*, 57 ECAB 429 (2006); *John L. McClenic*, 48 ECAB 552 (1997).

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

[12] The Board further notes that a February 27, 2012 cardiopulmonary exercise test showed FVC of 3.61 or 74 percent of the predicted value and FEV_1 of 2.55 or 66 percent of the predicted value. Post-bronchodilator testing showed FVC of 3.62 or 75 percent of the predicted value and FEV_1 of 2.57 or 67 percent of the predicted value. These predicted values also place appellant in class 1 impairment rating.

weight of the medical evidence.[13] Appellant has not provided any probative medical evidence to establish that he has more than 12 percent bilateral 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 has not established that he has more than 12 percent permanent bilateral lung impairment, for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the August 20, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 22, 2013
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[13] *See also H.B.*, Docket No. 09-2240 (issued June 18, 2010); *E.V.*, Docket No. 06-1989 (issued May 21, 2007); *Bobby L. Jackson*, 40 ECAB 593, 601 (1989).