United States Department of Labor
Employees' Compensation Appeals Board

L.B., Appellant	)	
	)	
and	)	**Docket No. 12-134**
	)	**Issued: December 19, 2012**
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:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 19, 2011 appellant, through his attorney, filed a timely appeal from a July 25, 2011 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 the claim.

ISSUES

The issues are: (1) whether appellant established that he sustained pneumoconiosis in his federal employment; and (2) whether he sustained permanent impairment of his lungs due to his accepted chronic bronchitis condition.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On June 9, 2005 appellant, then a 61-year-old electrician, filed an occupational disease claim pneumoconiosis and chronic obstructive lung disease as a result of his federal employment. He first realized the relationship of his pulmonary condition to his employment on April 21, 2005. Appellant also filed a claim for a schedule award. The record reflects that he retired on January 22, 1999.

In a May 7, 2005 report, Dr. Glen Baker, a Board-certified pulmonary disease specialist and certified B-reader, examined appellant on April 30, 2005. He noted appellant's work history of exposure to coal dust, asbestos and other irritants and a 10-year history of smoking for 5 to 6 years of one pack a day and then of smoking four to five pipes a day. Appellant quit smoking approximately 20 years prior. Dr. Baker listed findings on physical examination and noted that pulmonary function studies were interpreted to reflect a mild obstructive ventilatory defect. He listed an impression of occupational pneumoconiosis, category 1/0, with changes secondary to coal dust and possible asbestos; chronic bronchitis based on cough, sputum production and wheezing; chronic obstructive pulmonary disease with mild obstructive defect with mild improvement following bronchodilators. Under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), he rated a class 2 impairment or 10 to 25 percent whole person impairment.

Appellant was referred to Dr. Kenneth Anderson, a Board-certified pulmonary disease specialist, for a second opinion evaluation. On December 5, 2006 Dr. Anderson reviewed the statement of accepted facts, appellant's history of occupational exposure and smoking history. He listed findings on examination and pulmonary function studies, noting that appellant exhibited symptoms of dyspnea and a cough with symptoms consistent with chronic bronchitis. Dr. Anderson found that appellant had no radiographic evidence of pneumoconiosis, rated 0/1, with small opacities noted but no pleural abnormalities. The pulmonary function studies demonstrated early/mild obstructive disease with no hyperinflation or evidence of restrictive lung disease. Appellant had a normal diffusion capacity of carbon monoxide. Dr. Anderson attributed the pulmonary findings to appellant's previous history of tobacco use. He agreed that appellant's federal work history of exposure was an etiology of the chronic bronchitis but found no significant evidence to suggest asbestosis or pneumoconiosis. As to appellant's complaint of smothering at night, Dr. Anderson noted this suggested sleep apnea unrelated to his prior federal employment.

On January 17, 2007 an OWCP medical adviser noted that Dr. Anderson found appellant had chronic bronchitis due to his federal employment but attributed the obstructive lung disease to his prior tobacco use. Based on Dr. Anderson's examination and pulmonary testing, he opined that appellant had no impairment under the fifth edition of the A.M.A., *Guides.* On January 25, 2007 OWCP accepted the claim for chronic bronchitis.

In a May 18, 2007 decision, OWCP denied appellant's schedule award claim finding that he had no ratable impairment to his lungs.

Appellant requested an oral hearing. In an August 24, 2007 decision, an OWCP hearing representative set aside the May 18, 2007 decision based on a conflict in medical opinion

between Dr. Baker and Dr. Anderson regarding appellant's diagnosed pulmonary conditions and any permanent impairment. OWCP was directed to amend the statement of accepted facts to reflect appellant's work exposure to coal dust and asbestos.

Appellant was initially referred to Dr. Manoj H. Majmudar, a Board-certified pulmonary specialist, for an impartial medical examination. In an October 22, 2007 report, Dr. Majmudar found that appellant's pulmonary condition was due to cigarette smoking. He found no evidence of asbestos-related disease or pneumoconiosis. In a November 16, 2007 decision, OWCP denied the schedule award claim. By decision dated June 17, 2008, an OWCP hearing representative vacated the November 16, 2007 decision and remanded the case to obtain a supplemental report from Dr. Majmudar. In an August 14, 2008 addendum, Dr. Majmudar stated that his review of chest x-rays did not demonstrate pneumoconiosis but showed cardiomegaly with marked chronic obstructive pulmonary disease changes and hyperinflation of the lung. He reiterated that appellant's condition was due to prior cigarette smoking and that any lung condition could be aggravated by coal dust and asbestos exposure.

In an August 27, 2008 decision, OWCP denied appellant's schedule award claim. Appellant requested a hearing. In a June 5, 2009 decision, OWCP's hearing representative vacated the August 27, 2008 decision, finding that Dr. Majmudar's supplemental report was not sufficient to resolve the conflict. OWCP was directed to refer appellant to a new impartial Board-certified pulmonary specialist and B-reader.[2]

OWCP referred appellant to Dr. William C. Houser, a Board-certified pulmonary specialist, for an impartial examination. In a March 16, 2010 report, Dr. Houser reviewed appellant's medical and occupational history and the statement of accepted facts. He obtained pulmonary function studies and reviewed studies by Drs. Baker, Anderson, Majmudar and Selby. Dr. Houser stated that a chest x-ray was obtained by Daniel W. Whitehead, a Board-certified radiologist and B-reader, who found category 0/1 (no) pneumoconiosis plus some atelectasis at the left base. Pulmonary function testing showed normal total lung capacity and reduced expiratory reserve volume secondary to obesity.[3] Dr. Houser assessed chronic bronchitis and found no evidence of pneumoconiosis. He stated that on May 7, 2005 Dr. Baker reported readings of two chest x-ray films from February 2 and April 20, 2005, findings of q and s on the first film and s and t on the second film, opacities in the mid and lower lung zones category 1/0 pneumoconiosis. He noted a forced vital capacity 4.22 L (89 percent of predicted) and FEV_1 2.83 L (76 percent of predicted). Dr. Houser explained that Dr. Baker's finding was not class 2 pneumoconiosis but 1/0 pneumoconiosis and, under the sixth edition of the A.M.A., *Guides*,

[2] The record reflects that appellant was referred to Dr. Jeffrey Selby, a Board-certified pulmonologist and B-reader, for a second opinion evaluation. After OWCP obtained his report and requested supplementation, it noted the error in the referral for a second opinion rather than impartial evaluation.

[3] The slow vital capacity was normal (80 percent of predicted) whereas forced vital capacity was only 60 percent of predicted and forced expiratory volume (FEV_1) was 56 percent of predicted. The single breath diffusion capacity and airway resistance measurements were normal. Due to appellant's submaximal effort, he repeated the spirometry. Dr. Houser indicated the best value was 3.12 L for a forced vital capacity (67 percent of predicted) and FEV^1 2.66L (60 percent of predicted). Peak flow measures were a maximum of 72 percent of predicted. As O_2 saturation at rest was 94 percent it was not necessary to obtain blood gas. As single breath diffusion capacity was normal, a CBC was not obtained.

pulmonary impairment would be class 1. He reviewed the reports of Drs. Anderson, Majmudar and Selby and concluded that the fairly substantial variation in spirometry values was due to appellant's submaximal effort. Dr. Houser explained that tests which were less effort related, such as lung volume study, slow vital capacity and single breath diffusion capacity, were uniformly normal. Using the best postbronchodilator results, he found there was no pulmonary impairment. Using the tests that appeared to be valid, the lowest degree of impairment would be no more than two percent (class 1A). Dr. Houser opined that appellant's chronic bronchitis was secondary to exposure to dust, smoke and fumes from his work as well as from his prior cigarette smoking. He explained that chronic bronchitis associated with physiologic changes was obstructive in nature. In some cases, simple chronic bronchitis was not associated with any pulmonary impairment and 30 to 40 percent of patients with chronic obstructive pulmonary disease/chronic bronchitis who have airway obstruction showed some bronchodilator response.

On April 13, 2010 an OWCP medical adviser recommended that additional clarification be obtained from Dr. Houser regarding the noted discrepancy in prior pulmonary function tests. He noted that Dr. Houser had not signed the studies obtained on pulmonary testing.

On April 21, 2010, Dr. Houser stated that medical literature advised that there should be no more than 10 to 12 percent variation in the forced vital capacity and FEV_1 when retesting the same individual on different days and times within a one-year period of time. He determined that the two best sets of pulmonary function studies, obtained for Drs. Anderson and Selby, found either normal or near normal pulmonary function. Dr. Anderson specifically noted that the guidelines were not met. Dr. Selby's testing, the most recent, was normal for the forced vital capacity and FEV_1 was at the lower limits of normal. Dr. Houser stated that there was no impairment under the sixth edition of the A.M.A., *Guides* using Dr. Shelby's tests. Dr. Anderson reiterated that the testing obtained of appellant in his own office and lab revealed submaximal effort. Dr. Houser opined that his studies did not provide valid results nor did the testing obtained for Drs. Majmudar, Baker and Anderson, each due to evidence of submaximal effort. He noted that appellant was not weak or frail, and since some of the nonvoluntary testing was normal, the presence of lung disease would adequately explain his diminished peak flow rates. Dr. Houser recommended against further testing as it was likely to show submaximal effort. He noted that the lung testing that was not based upon voluntary effort. The lung volume study, slow vital capacity, and single breath diffusion capacity rates were uniformly normal, as were the airway resistance measurements. Dr. Houser stated that individuals with obstructive airway disease generally showed signs of increased airway resistance. Individuals with pneumoconiosis or interstitial lung disease or emphysema showed a reduction in single breath capacity testing. Dr. Houser concluded that appellant's normal total lung capacity excluded any clinically significant restrictive lung disease. He stated that the case was relatively straightforward but was complicated by Dr. Baker's misinterpretation or misrepresentation that appellant had class 2 pulmonary impairment, rather than class 2 pneumoconiosis and a series or invalid pulmonary function results due to submaximal patient effort. Dr. Houser signed the pulmonary function report from March 16, 2010.

On May 11, 2010 the OWCP medical adviser found that Dr. Houser answered all questions and clarified that the discrepancies found on pulmonary testing were due to submaximal effort. For this reason, the recent pulmonary function test obtained for Dr. Houser were not valid and repeat testing was not indicated. The medical adviser noted that Dr. Houser

found the only valid pulmonary function test to be for Dr. Selby in 2009 that was reported normal. He concurred with the result and stated that appellant had no ratable permanent impairment. The medical adviser noted that Dr. Houser determined that Dr. Baker had rated impairment based on invalid pulmonary function test studies.

By decision dated May 14, 2010, OWCP denied appellant's schedule award claim. It also determined that he did not establish pneumoconiosis as a result of his federal employment. The weight of the medical opinion was accorded to Dr. Houser, as the impartial specialist.

Appellant requested a hearing, which was held on September 1, 2010. In an August 5, 2010 statement, Dr. Baker stated that review of a September 10, 2009 CT showed thickening of the interlobular septa. There also appeared to be diffuse thickening of pulmonary parenchymal consistent with early coal workers pneumoconiosis. In an August 2, 2010 form regarding appellant's March 16, 2010 chest x-ray, Dr. Baker again listed a 1/0 profusion with small opacities but indicated there were no pleural abnormalities consistent with pneumoconiosis.

In a September 3, 2010 report, Dr. Baker addressed the pulmonary studies obtained for Drs. Anderson, Majmudar, Selby and Houser. He stated that appellant's pulmonary impairment worsened since he was first examined in 2005. Dr. Baker stated that occupational pneumoconiosis, chronic bronchitis and chronic obstructive pulmonary disease were progressive and could cause gradual worsening of his impairment. He noted that it was generally felt that obstructive airway disease, regardless of etiology, resulted in inflammatory lung changes despite removal from the offending agent and continued inflammation would result in progressive lung damage. Dr. Baker opined that appellant's worsened condition was due to occupational pneumoconiosis, chronic bronchitis and chronic obstructive pulmonary airway disease.

By decision dated October 21, 2010, an OWCP hearing representative set aside the May 14, 2010 decision to seek clarification from Dr. Houser as to whether appellant had evidence of chronic obstructive pulmonary disease and pneumoconiosis. Dr. Houser was also to address the two percent class 1A impairment to which he referred.

In a November 23, 2010 report, Dr. Houser noted that Dr. Baker had performed the initial examination and listed category 1 pneumoconiosis (not category 2) and class 2 pulmonary function impairment. One of the initial interpretations was that appellant had category 2 pneumoconiosis. Dr. Houser stated that the chest radiograph performed at his facility was read as category 0/1 pneumoconiosis by Dr. Whitehead, a B-reader. He stated that category 0/1 was negative for pneumoconiosis; the minimal threshold for a positive chest radiograph was category 1/0 pneumoconiosis. Regarding the pulmonary function studies, Dr. Houser reiterated that there was a great discrepancy between those performed by Drs. Baker, Anderson, Majmudar, Selby and the studies he obtained. The only explanation for the degree of discrepancy in repeated pulmonary function measurements was patient effort, not underlying disease. Dr. Houser stated that, while the diagnosis provided for the pulmonary function study testing conducted in his laboratory was chronic obstructive pulmonary disease; this was not a firm diagnosis, rather an indication from testing. He explained that chronic obstructive pulmonary disease included both emphysema and chronic bronchitis. Dr. Houser stated that the diagnosis of chronic bronchitis was clinical, which the American Thoracic Society defined as "chronic cough with sputum production for at least three months in two consecutive years." He found that appellant had

chronic bronchitis, which was one form of chronic obstructive pulmonary disease. Dr. Houser stated that the diagnosis associated with class 1A impairment, two percent, was chronic bronchitis, based upon the studies for Dr. Anderson. He indicated that other spirometry measures did not represent valid or reproducible results. Dr. Houser opined that appellant did not have pneumoconiosis and noted that Dr. Baker was the only physician to have supported a finding of pneumoconiosis. The evaluations provided by the other physicians of record did not support such a diagnosis on chest x-ray or CT scan.

In a December 14, 2010 report, OWCP's medical adviser concurred with Dr. Houser's opinion that appellant did not have pneumoconiosis causally related to his federal employment. He noted that Dr. Houser clarified that appellant had chronic bronchitis, a form of chronic obstructive pulmonary disease. The medical adviser noted that the diagnosis of chronic obstructive pulmonary disease and chronic bronchitis were one in the same. Dr. Houser found the diagnosis associated with class 1A impairment, two percent, was chronic bronchitis based on the best pulmonary function tests. The medical adviser noted that there were great discrepancies in the pulmonary testing or record which was attributed to poor and variable effort by appellant.

By decision dated January 3, 2011, OWCP denied the schedule award claim. It also found that the medical evidence did not support pneumoconiosis as related to appellant's federal employment. The weight of medical opinion was accorded to Dr. Houser.

Appellant requested a hearing, which was held on May 3, 2011. He submitted a January 2011 letter inviting him to participate in a national clinical trial of medication for treatment of chronic obstructive pulmonary disease.

In a July 25, 2011 decision, an OWCP hearing representative affirmed the January 3, 2011 decision.

LEGAL PRECEDENT -- ISSUE 1

A claimant seeking benefits under FECA has the burden of establishing the essential elements of his claim by the weight of the reliable, probative and substantial evidence, including that an injury was sustained in the performance of duty as alleged and that any specific condition or disability claimed is causally related to the employment injury.[4]

The medical evidence required to establish a causal relationship is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[5]

[4] 20 C.F.R. § 10.115(e), (f) (2009); *see Jacquelyn L. Oliver*, 48 ECAB 232, 235-36 (1996).

[5] *Victor J. Woodhams*, 41 ECAB 345, 351-52 (1989).

When there exist opposing medical opinions of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual and medical background, will be given special weight.[6]

When OWCP obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, OWCP must secure a supplemental report from the specialist to correct the defect in the original report.[7] However, when the impartial specialist is unable to clarify or elaborate on the original report or if a supplemental report is also vague, speculative or lacking in rationale, OWCP must submit the case record and a detailed statement of accepted facts to a second impartial specialist for the purpose of obtaining a rationalized medical opinion on the issue.[8]

ANALYSIS -- ISSUE 1

OWCP accepted that appellant sustained chronic bronchitis in his federal employment as an electrician. It denied that he developed pneumoconiosis causally related to his work duties. The Board finds that the weight of medical evidence, as represented by the opinion of Dr. Houser, the impartial specialist, establishes that appellant did not sustain pneumoconiosis.

Dr. Baker, an attending physician, opined that appellant had occupational pneumoconiosis due to his federal employment. Dr. Anderson, a second opinion physician, found that appellant did not have radiographic evidence of pneumoconiosis and attributed his pulmonary condition to his tobacco use. Due to this disagreement between appellant's physician and OWCP's second opinion physician, OWCP properly found that there was a conflict of medical opinion necessitating referral to an impartial medical specialist.

OWCP initially designated Dr. Majmudar as the impartial medical examiner; but his reports were found insufficient to resolve the conflict in medical opinion. It then referred appellant to a second impartial medical specialist, Dr. Houser, to resolve the conflict in medical opinion.[9]

Dr. Houser provided an accurate history of injury and provided detailed findings on physical examination. He obtained additional x-rays from Dr. Daniel Whitehead, a Board-certified specialist and certified B-reader, who found no evidence (category 0/1) to support the diagnosis of pneumoconiosis related to appellant's occupational exposure. The pulmonary function testing obtained for Dr. Houser showed normal total lung capacity and a reduced

[6] *R.C.*, 58 ECAB 238 (2006); *Bernadine P. Taylor*, 54 ECAB 342 (2003). *See* 5 U.S.C. § 8123(a).

[7] *Raymond A. Fondots*, 53 ECAB 637, 641 (2002); *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232 (1988); *Ramon K. Ferrin, Jr.*, 39 ECAB 736 (1988).

[8] *Nancy Keenan*, 56 ECAB 687 (2005); *Roger W. Griffith*, 51 ECAB 491 (2000); *Talmadge Miller*, 47 ECAB 673 (1996).

[9] While OWCP referred appellant to Dr. Selby prior to Dr. Houser, it noted the error of requesting a second opinion examination rather than an impartial review.

expiratory reserve volume that he attributed to appellant's obesity. Dr. Houser agreed that appellant had chronic bursitis due to his federal employment. He reviewed the pulmonary testing obtained by the physicians of record and noted significant variations that were due to submaximal effort by appellant. The tests that were not effort related, such a lung volume, slow vital capacity and single breath diffusion capacity were uniformly normal. Using the test that appeared to be most valid, the lowest degree of impairment would be no more than two percent, class 1A. Dr. Houser found no evidence of pneumoconiosis and explained that Dr. Baker's findings from the February 2 and April 20, 2005 x-rays were not class 2 pneumoconiosis but 0/1.

In an April 21, 2010 supplement, Dr. Houser stated that the pulmonary function studies obtained for Dr. Selby represented the best effort and revealed that appellant had normal or near normal pulmonary function. He stated that the other pulmonary function tests, including that from his office, were not valid due to appellant's submaximal efforts. Dr. Houser reiterated that appellant was not weak or frail and that the nonvoluntary test results were normal. He noted that the absence of any clinically significant restrictive disease excluded the diagnosis of pneumoconiosis. Dr. Houser noted that Dr. Baker's report had complicated the matter by misinterpreting a series of pulmonary function results. On November 23, 2010 he noted the discrepancy in the pulmonary function testing. Dr. Houser stated that appellant had chronic bronchitis, a form of chronic obstructive pulmonary disease and the diagnosis was associated with a class 1A impairment. All the other spirometry results did not show valid or reproducible results that could be explained by submaximal effort rather than underlying disease.

On December 14, 2010 an OWCP medical adviser reviewed Dr. Houser's reports and concurred that appellant did not have pneumoconiosis. He stated that Dr. Houser clarified the diagnosis by noting that chronic bronchitis was a form of chronic obstructive pulmonary disease.

The Board finds that Dr. Houser's opinion is sufficient to establish that appellant did not sustain pneumoconiosis causally related to his federal employment. Dr. Houser supported that appellant had chronic bronchitis, the accepted condition and a form of chronic obstructive pulmonary disease. He based his opinion on the statement of accepted facts and review of the medical record. Dr. Houser obtained diagnostic testing and provided extensive medical rationale for his conclusion that the x-rays did not support a finding of pneumoconiosis. He advised that only Dr. Baker had supported this diagnosis, but noted that it was not confirmed by the other examining physicians. The Board finds that Dr. Houser's opinion is well rationalized and based on a complete, accurate factual and medical history. Therefore, OWCP properly accorded his opinion special weight.

On September 3, 2010 Dr. Baker opined that appellant's pulmonary condition had worsened since the 2005 evaluation and was due to occupational pneumoconiosis, chronic bronchitis and chronic obstructive pulmonary disease. With regard to the diagnosed pneumoconiosis, he provided limited objective evidence to establish a positive pneumoconiosis diagnosis. Dr. Baker concluded that a September 10, 2009 CT scan appeared to be diffuse thickening of pulmonary parenchymal consistent with early coal workers pneumoconiosis. However, in the August 2, 2010 form regarding the reading of appellant's March 16, 2010 chest x-ray, he specifically opined that, while appellant had 1/0 profusion of small opacities, there were no pleural abnormalities consistent with pneumoconiosis. The March 16, 2010 chest x-ray was negative for pneumoconiosis. As Dr. Baker was on one side of the conflict that Dr. Houser

resolved, the additional reports from the physician are insufficient to overcome the weight accorded Dr. Houser's report as the impartial medical specialist or to create a new conflict.[10]

Dr. Houser supported that appellant has chronic bronchitis, a form of chronic obstructive pulmonary disease, causally related to federal employment. He did not find that appellant has pneumoconiosis causally related to his work as an electrician.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

On appeal, counsel argued that the objective testing of record supported the causal relationship between appellant's pneumoconiosis and his employment. As noted, however, Dr. Houser provided a well-rationalized opinion based on a complete background, review of the accepted facts and medical records and examination findings. His opinion is entitled to the special weight of medical opinion.

LEGAL PRECEDENT -- ISSUE 2

The schedule award provision of FECA,[11] and its implementing federal regulations,[12] 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.[13] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[14] The claimant has the burden of proving that the condition for which a schedule award is sought is causally related to his or her employment.[15]

ANALYSIS -- ISSUE 2

OWCP accepted that appellant sustained chronic bronchitis but denied his claim for a schedule award. As noted, it properly found a conflict as to the extent and nature of any permanent pulmonary impairment.

[10] *Dorothy Sidwell*, 41 ECAB 857, 874 (1990).

[11] 5 U.S.C. § 8107.

[12] 20 C.F.R. § 10.404.

[13] *Id*. at § 10.404(a).

[14] FECA Bulletin No. 09-03 (issued March 15, 2009); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[15] *Veronica Williams*, 56 ECAB 367, 370 (2005).

Dr. Houser, the impartial specialist, initially opined that, based upon pulmonary testing which appeared to be valid, the lowest degree of impairment would be no more than two percent, or class 1A. He noted that there was a fairly substantial variation in spirometry values due to appellant's submaximal effort. In an April 21, 2010 report, Dr. Houser indicated that the two best sets of pulmonary function studies, obtained for Dr. Anderson and Dr. Selby, indicated either normal or near normal pulmonary function. Dr. Anderson specifically noted that the guidelines were not met while Dr. Selby's testing was normal for the forced vital capacity and the FEV_1 was at the lower limits of normal. Using Dr. Selby's tests, he opined that there was no impairment under the sixth edition of the A.M.A., *Guides*.

On May 11, 2010 an OWCP medical adviser agreed that Dr. Selby's pulmonary function tests of 2009 and 2010 were normal and there was no ratable impairment. On November 23, 2011 Dr. Houser clarified that his earlier impairment rating of two percent or class 1A was based on studies performed by Dr. Anderson. On December 14, 2010 an OWCP medical adviser noted the diagnosis associated with class 1A impairment or two percent was based on the best pulmonary function tests.

The Board finds that additional clarification is required. Dr. Houser found that the only valid pulmonary function tests were performed by Dr. Selby and there was no ratable impairment as those values were normal. However, he later indicated a class 1A impairment of two percent for chronic bronchitis based on Dr. Anderson's pulmonary function studies. Dr. Houser should clarify whether Dr. Anderson's pulmonary function testing is valid and explain how he rated two percent impairment. Table 5-4, page 88 of the A.M.A., *Guides* provides a default rating of six percent for a class 1 impairment based on pulmonary dysfunction. Page 87 of the A.M.A., *Guides* states that, after the preliminary impairment rating is obtained, it is then adjusted based on results from nonkey factors, such as history and physical examination. In evaluation the cause of abnormality in any of the listed measures, only valid pulmonary dysfunction consistent with and concordant with the validated pathology should be considered. If the individual is considered to have no impairment, all the listed criteria of the objective testing section in Table 5-4 except for VO_2 max (maximal oxygen uptake) must be met. For all other classes, at least one of the listed criteria must be fulfilled. Dr. Houser did not provide sufficient explanation as to how an impairment rating of two percent was obtained, but did attribute the impairment to the accepted chronic bronchitis. Consequently, the Board will remand the case to OWCP to obtain a supplemental report from Dr. Houser conforming with the sixth edition of the A.M.A., *Guides*. Following such further development as deemed necessary, it should issue an appropriate decision.

CONCLUSION

The Board finds that appellant did not establish that he sustained pneumoconiosis causally related to his federal employment. The case is not in posture for decision as to whether appellant established permanent impairment due to his accepted chronic bronchitis.

ORDER

IT IS HEREBY ORDERED THAT the July 25, 2011 decision of the Office of Workers' Compensation Programs is affirmed, in part, denying the condition of pneumoconiosis. The decision is set aside for further development on the schedule award claim.

Issued: December 19, 2012
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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