

The Office accepted that appellant sustained multiple third degree burns, a fracture of the left distal radius, a fracture of the medial malleolus and an inhalation injury.

On September 22, 1998 appellant filed a claim for a schedule award. He submitted an August 30, 1998 report from Dr. Marion H. Jordan, a Board-certified surgeon, stating that pulmonary function test results revealed, on consecutive measurements, forced vital capacity values of 68 and 69 percent of predicted normal and Forced Expiratory Volume in the first second (FEV₁) of 60 and 63 percent of predicted normal, which were adequate to qualify for the midrange of a Class 2 impairment of the whole person. Dr. Jordan concluded that appellant had a 25 percent permanent impairment of the whole person due to pulmonary impairment and also rated appellant's permanent impairments of the arms and legs. Appellant submitted results of pulmonary function tests done in November 1987, October 1990, October 1992, April 1995 and July 1996.

On September 14, 1999 the Office issued schedule awards for the following permanent impairments: 15 percent of the right leg; 42 percent of the right arm; and 16 percent of the left arm. Appellant requested a hearing and an Office hearing representative, in a May 26, 2000 decision, affirmed the schedule awards for the extremities and remanded the case for referral to a Board-certified pulmonary specialist to ascertain the extent of any permanent impairment of the lungs as a result of the October 21, 1989 plane crash. Appellant requested reconsideration, which the Office denied in a July 18, 2001 nonmerit decision. The Board affirmed this decision on July 26, 2002, but noted that the claim for a schedule award for the lungs was in an interlocutory posture.¹

Meanwhile, the Office referred appellant, his medical records and a statement of accepted facts to Dr. Sammy Hung, a Board-certified pulmonary specialist, for an evaluation of any permanent impairment of his lungs related to his employment injury. In a November 24, 2000 report, accompanied by pulmonary function tests and a computerized tomography (CT) scan done on October 3, 2000, Dr. Hung diagnosed recurrent chronic bronchitis, asthmatic bronchitis and post-inflammatory pulmonary fibrosis. He concluded that appellant's FEV₁ of 60 percent of predicted constituted a 40 percent impairment of the lungs and that his recurrent asthmatic bronchitis constituted a 20 percent impairment of the lungs, for a total of 60 percent. On October 30, 2002 Dr. Charles C. McDonald, a Board-certified pulmonary specialist, reviewed the medical evidence as an Office medical consultant and interpreted the October 3, 2000 CT scan as showing no diffuse lung disease and no bronchiectasis and the October 3, 2000 pulmonary function tests as showing mild obstruction with no bronchodilator response. Dr. McDonald concluded that appellant had a 15 percent permanent impairment of the lungs, based on the October 3, 2000 pulmonary function test.

On March 21, 2003 the Office issued a schedule award for a 15 percent permanent impairment of each lung.

Appellant requested a hearing, which was held on November 19, 2003. He subsequently submitted additional medical evidence. In a September 24, 2003 report, accompanied by an August 26, 2003 CT scan and August 1, 2003 pulmonary function tests, Dr. Neal T. Miyasaki, a

¹ Docket No. 02-126 (issued July 26, 2002).

Board-certified internist, stated that appellant had “some air flow obstruction which is secondary to bronchiectasis,² and a degree of reversible bronchospasm, the former of which easily predisposes him toward recurrent infections. I think taking into consideration the point that the bronchiectasis was no doubt the result of either smoke inhalation or trauma to the chest, as well as recurrent pneumonia, this is a direct result of his injury suffered in the plane crash and I think his disability certainly is greater than 15 percent and would be at least, in my estimate 40 to 50 percent.” In a December 29, 2003 report, Dr. Miyasaki stated that his pulmonary function test demonstrated air flow obstruction with a borderline response to bronchodilator and an asthmatic component shown by his airway resistance going down after bronchodilator. Dr. Miyasaki concluded that the presence of asthma, bronchiectasis verified by the recent CT scan and airway obstruction resulted in at least 40 percent total body disability.

By decision dated February 13, 2004, an Office hearing representative found that Dr. Miyasaki’s reports warranted further development of the evidence to accurately assess appellant’s pulmonary impairment and remanded the case for referral to a Board-certified pulmonary specialist. On February 27, 2004 the Office referred appellant, his medical records and a statement of accepted facts to Dr. James J. Hershon, a Board-certified pulmonary specialist, for an evaluation of the permanent impairment of his lungs. In an April 30, 2004 report, accompanied by a CT scan done on March 9, 2004, Dr. Hershon noted appellant’s symptom of chronic cough with sputum production, his ability to climb two to four flights of stairs and his need for antibiotics at least one to two times per year and stated that the March 9, 2004 CT scan demonstrated “irregular opacities in the left lower lobe with evidence of dilatation of the airways which is consistent with bronchiectasis.... He also has some evidence of scarring in the right lower lobe as well. After reviewing the results of the August 2003 pulmonary function test showing FEV₁ at 65 percent of predicted, Dr. Hershon stated:

“Taking into consideration his FEV₁, he certainly, by the A.M.A., guidelines, fits as a [C]lass [2] which is 10 percent to 25 percent of impairment of the whole person. However, in addition to his impairment of FEV₁, he also has chronic sputum production and cough associated with bronchiectasis, which has been clearly defined by his CT scans. His bronchiectasis is secondary to lung injuries he sustained in the airplane crash as a result of the smoke inhalation and probable bronchial pneumonia of the left lower lobe resulting in permanent damage to the airways therefore resulting in bronchiectasis. Given this additional injury to his lung which is not easily quantified but does involve at least one-fifth of his pulmonary reserve, it will be reasonable to estimate his degree of impairment is approximately 40 percent with regard to his respiratory system taking into account his decreased FEV₁, his chronic symptoms and the injury to his left lower lobe manifested by bronchiectasis.”

On May 20, 2004 Dr. McDonald again reviewed the medical evidence and stated:

“Appellant’s actual pulmonary function test established an A.M.A., guideline Class [2] degree of respiratory impairment which is 10 [to] 25 percent. I agree

² Bronchiectasis: chronic dilatation of the bronchi marked by fetid breath and paroxysmal coughing, with the expectoration of mucopurulent matter. Dorland’s *Illustrated Medical Dictionary* (30th ed. 2003).

with Dr. Hershon that the presence of bronchiectasis and chronic sputum production would increase his impairment rating. Dr. Hershon did note that he currently had a chronic morning cough with sputum production and required antibiotics one to two times per year.

“Dr. Hershon stated that one[-]fifth of his pulmonary reserve was involved, *i.e.*, the left lower lobe. I agree that the bronchiectasis seen on the two CT scans involved the left lower lobe, but it appears to be localized to two segments. Bronchiectasis on the August 26, 2003 CT scans was noted to be present in the posterior and lateral basilar segments of the left lower lobe. This would therefore involve approximately half of the left lower lobe. There is no adequate means by which to quantify the extent of respiratory impairment based solely upon the presence of bronchiectasis on CT scan.

“The [f]ifth [e]dition of the A.M.A., *Guides* The American Medical Association, [*Guides to the Evaluation of Permanent Impairment*] does not adequately provide for respiratory impairment ratings under these circumstances. Given appellant’s chronic cough and repeated need for antibiotics, I would agree that his impairment rating should be increased given the now well documented evidence for bronchiectasis. An increased impairment level of 30 percent would appear to be reasonable under these circumstances.”

On June 15, 2004 the Office issued appellant a schedule award for an additional 15 percent permanent impairment of each lung, for a total of 30 percent.

By letter dated November 10, 2004, appellant requested reconsideration, contending that Dr. McDonald should not have reviewed the medical record a second time, as this created a potential biased situation and that Dr. McDonald never explained how he selected 30 percent impairment. By decision dated December 14, 2004, the Office found that appellant’s argument was previously considered by the Office and was not sufficient to warrant review of its prior decision.

LEGAL PRECEDENT

The schedule award provision of the Act³ and its implementing regulation⁴ sets 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, the Act 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 to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulation as the

³ 5 U.S.C. § 8107.

⁴ 20 C.F.R. § 10.404 (1999).

appropriate standard for evaluating schedule losses. With regard to the lungs, the A.M.A., *Guides* provides, at Table 5-12, for four classes of impairment of the whole person, using pulmonary function test results and also states:

“The classification system in Table 5-12 considers only pulmonary function measurements for an impairment rating. It is recognized that pulmonary impairment can occur that does not significantly impact pulmonary function and exercise test results but that does impact the ability to perform activities of daily living, such as with bronchiectasis.

“In these limited cases, the physician may assign an impairment rating based on the extent and severity of pulmonary dysfunction and the inability to perform activities of daily living (see Table 1-2). Measured losses of pulmonary function and corresponding impairment classes, result in a loss in the ability to perform some activities of daily living. The physician can use these associations as a reference. A detailed description with supporting, objective documentation of the type of pulmonary impairment and its impact on the ability to perform activities of daily living is required.”⁵

ANALYSIS

The examining Board-certified pulmonary specialist, Dr. Hershon and the Office medical consultant, Dr. McDonald, who also is Board-certified in pulmonary diseases, agree that appellant’s pulmonary function test results place him in Class 2 of Table 5-12 of the A.M.A., *Guides*. As an FEV₁ measurement of 60 percent or more of predicted but less than the lower limit of normal constitutes a Class 2 impairment, appellant’s FEV₁ of 65 percent of predicted shows this classification is correct. Table 5-12 states that a Class 2 impairment is 10 to 25 percent of the whole person. Neither Dr. Hershon nor Dr. McDonald indicated where appellant’s impairment fits into this range.

As noted above, the A.M.A., *Guides* also provides for a pulmonary impairment beyond that provided for by pulmonary function test results rated by Table 5-12 and specifically mentions bronchiectasis as a condition that can cause such an impairment. The A.M.A., *Guides* indicates that such an impairment should be assigned an impairment rating based on the inability to perform activities of daily living. This was not the method used by Dr. Hershon or Dr. McDonald, neither of whom provided a specific percentage for the additional impairment due to bronchiectasis.

The case will be remanded to the Office for development of the medical evidence on these points, preferably by Dr. Hershon, whose opinion, as that of an examining physician, takes precedence over that of a nonexamining physician when considering subjective factors and

⁵ Section 5-10. Section 5.1 states: “To establish the specific impairment percentage, consider both the severity and prognosis of the condition and how the impairment affects the individual’s ability to perform the activities of daily living listed in Table 1-2.”

values within ranges.⁶ In addition, an explanation is needed how the whole person impairment provided by Table 5-12 is converted to a specific percentage impairment of each lung.⁷

CONCLUSION

Further development of the medical evidence is necessary to properly determine the percentage of impairment of appellant's lungs.

ORDER

IT IS HEREBY ORDERED THAT the June 15, 2004 decision of the Office of Workers' Compensation Programs is set aside and the case remanded to the Office for action consistent with this decision of the Board, to be followed by an appropriate decision on the degree of permanent impairment of appellant's lungs.⁸

Issued: August 9, 2005
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

⁶ *Michelle L. Collins*, 56 ECAB ____ (Docket No. 05-443, issued May 18, 2005).

⁷ *Robert Carlton Lookabaugh*, 30 ECAB 605 (1979).

⁸ Given the disposition of the first issue, it is not necessary for the Board to address the second, nonmerit issue.