



injury. On September 22, 1998 appellant filed a claim for a schedule award.<sup>1</sup> On March 21, 2003 the Office issued a schedule award for a 15 percent permanent impairment for each lung. By decision dated February 13, 2004, an Office hearing representative set aside the March 21, 2003 decision and remanded for further development of the medical evidence. In a report dated April 30, 2004, Dr. James J. Hershon, a Board-certified pulmonary specialist, noted that an August 2003 pulmonary function test (PFT) showed a forced expiratory volume<sub>1</sub> of 65 percent of the predicted value which placed appellant into Class 2 under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5<sup>th</sup> ed. 2001). He further noted that a Class 2 impairment at Table 5-12, page 107 of the A.M.A., *Guides* amounts to a 10 to 25 percent impairment of the whole person. In a report dated May 20, 2004, Dr. Charles C. McDonald, a Board-certified pulmonary specialist and an Office medical adviser, concurred that appellant's actual PFT results established that he had a Class 2 impairment of 10 to 25 percent impairment of the whole person under the A.M.A., *Guides*. He found that a 30 percent bilateral lung impairment was "reasonable under these circumstances." In a decision dated June 15, 2004, the Office granted appellant a schedule award for an additional 15 percent impairment for each lung, for a total 30 percent for each lung.

In an August 9, 2005 decision,<sup>2</sup> the Board set aside the Office's June 15, 2004 decision. The Board found that, while both Dr. Hershon and Dr. McDonald properly found that appellant's PFT results placed him in Class 2 of Table 5-12 of the A.M.A., *Guides*, which amounted to 10 to 25 percent impairment of the whole person, neither Dr. Hershon nor Dr. McDonald indicated specifically where appellant's impairment fit within this range. The Board also noted that the A.M.A., *Guides* provided for pulmonary impairment beyond that indicated by PFT results under Table 5-12 and specifically mentioned bronchiectasis as a condition that could cause such an impairment. As neither Dr. Hershon nor Dr. McDonald provided a specific percentage for the additional impairment due to bronchiectasis, the Board remanded the case to the Office for development of the medical evidence regarding these factors. The Board instructed the Office to request a supplemental report from Dr. Hershon as the examining physician of record, for an explanation of how the whole person impairment provided by Table 5-12 is converted to a specific percentage impairment for each lung. The complete facts of this case are set forth in the Board's August 9, 2005 decision and are herein incorporated by reference.

By letter dated October 3, 2005, the Office asked Dr. Hershon to submit a supplemental report and address the issues raised by the Board in its August 9, 2005 decision. However, Dr. Hershon did not respond to its request in a timely manner. The Office, therefore, referred appellant to a new second opinion examiner, Dr. Jamie Marie Bigelow, Board-certified in internal medicine. In a report dated February 6, 2005, Dr. Bigelow stated findings on examination, reviewed the medical history, the case file, the statement of accepted facts and the PFT results and concluded:

"Drawing directly from [the A.M.A., *Guides*], [T]able 5-12 and [appellant's] most recent PFT of August 2, 2003, [appellant] falls into the mid range of [C]lass 2

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<sup>1</sup> By decision dated September 14, 1999, the Office awarded appellant 15 percent for the right leg, 42 percent for the right arm and 16 percent for the left arm.

<sup>2</sup> Docket No. 05-633 (issued August 9, 2005).

impairment or approximately 18 percent. [Appellant] has a trend toward a bronchodilator response but does not meet ATS criteria for such response, nor does [he] give a history consistent with asthma, so I did not believe asthma scoring is applicable. However for three reasons I feel his rating of 18 percent should be increased. First, when taking into account [appellant's] supernormal PFT results from 1987, prior to the accident, [he] has a larger than otherwise appreciated decrement in lung function due to the accident. More importantly, however, a patient's impairment from a disease like bronchiectasis is not best quantified with a test such as PFTs. The A.M.A., *Guides* recognize 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 this case, [appellant] has had significant impact on his activities of daily living such as listed in Table 1-2 [page 4] of the A.M.A., *Guides*...<sup>3</sup> Bronchiectasis is a disease that puts a patient at significant risk of future problems.... Bronchiectasis itself predisposes a patient to pneumonia, pulmonary hypertension and massive hemoptysis, all of which can have fatal consequences.

Unfortunately, while A.M.A., *Guides* recognize the inability of PFT's to quantify the impairment in bronchiectasis, it does not provide guidelines for other factors to do so. Therefore, for the reasons I have outlined [above], I believe his rating should be increased to 30 percent.

Lastly in order to quantify the amount of bronchiectasis in each lung, I would need to see the actual computerized axial tomography [CAT] scans. I feel I do not have enough precise data in the CAT scan reports."

In a supplemental report dated May 31, 2006, Dr. Bigelow stated that the CAT scan reports were inadequate because they did not precisely quantify the amount of bronchiectasis per lobe. She stated, however, that this more accurate quantification would have any impact on appellant's PFTs or on the evaluation of his ability to carry out his activities of daily living and therefore would not affect his overall impairment rating.

In a July 13, 2006 decision, the Office denied appellant's claim for an additional schedule award, finding that Dr. Bigelow's report represented the weight of the medical evidence. The Office stated that Dr. Bigelow properly based her rating of 30 percent bilateral lung impairment on pulmonary function testing and the impact on appellant's activities of daily living. It noted that Dr. Bigelow considered the CAT scan reports in the record inadequate because they did not precisely quantify the amount of bronchiectasis per lobe. However, given Dr. Bigelow's opinion that a review of the CAT scans and a more accurate quantification would have had any impact on the rating factors used under the A.M.A., *Guides* for rating an impairment based on bronchiectasis, the Office determined that the PFT and the effect on daily living activities were sufficient factors for rating such impairment.

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<sup>3</sup> Dr. Bigelow noted marked decrease in appellant's exercise capacity, significant interference in his social and sexual activity and interruption with restful, nocturnal sleep pattern.

## LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.<sup>4</sup> The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. The implementing regulations have adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.<sup>5</sup> Effective February 1, 2001, schedule awards are determined in accordance with the A.M.A., *Guides* (5<sup>th</sup> ed. 2001).<sup>6</sup>

A claim for an increased schedule award may be based on new employment exposure; however, additional occupational exposure is not a prerequisite. Absent additional employment exposure, an increased schedule award may also be based on medical evidence demonstrating that the progression of an employment-related condition has resulted in a greater permanent impairment than previously calculated.<sup>7</sup>

## ANALYSIS

The Office referred to the claim to a new pulmonary specialist, Dr. Bigelow, who examined appellant on May 3, 2006 and found that he had a 30 percent whole person impairment due to his bilateral lung impairment under the A.M.A., *Guides*. Dr. Bigelow found, based on appellant's most recent PFT of August 2003, that his Class 2 impairment amounted to approximately 18 percent of the whole person under Table 5-12 of the A.M.A., *Guides*. She rated an additional impairment of 12 percent by factoring in the significant impact on his activities of daily living imposed by bronchiectasis, for a total 30 percent impairment, pursuant to the instruction provided by the A.M.A., *Guides* at section 5.10.<sup>8</sup> Dr. Bigelow was unable to quantify the amount of bronchiectasis in each lung through CT scans because they did not precisely quantify the amount of bronchiectasis per lobe. She stated, however, that even if the CT scans had permitted a more accurate quantification this would have no impact on appellant's PFTs or on the evaluation of his ability to carry out his activities of daily living; thus, it would not have affected appellant's overall impairment rating. Based on these findings, the Office properly converted appellant's 30 percent whole person impairment rating to a 30 percent

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<sup>4</sup> 5 U.S.C. § 8107(a), (c). With respect to the loss of use, of a lung, the applicable regulation provides that, for a total or 100 percent loss of use, of a single lung, an employee shall receive 156 weeks' compensation. 20 C.F.R. § 10.404(a). Regarding loss of use due to lung impairments, as in the instant case, the Office has determined that the percentage of impairment will be multiplied by 312 weeks (twice the award for loss of function of one lung) to obtain the number of weeks payable. Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.4 (November 1998).

<sup>5</sup> 20 C.F.R. § 10.404 (1999).

<sup>6</sup> Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (June 2003); FECA Bulletin No. 01-05 (January 29, 2001).

<sup>7</sup> *Linda T. Brown*, 51 ECAB 115 (1999).

<sup>8</sup> A.M.A., *Guides* 107.

bilateral impairment of the lungs.<sup>9</sup> Inasmuch as Dr. Bigelow's impairment rating conforms to the A.M.A., *Guides*, her finding constitutes the weight of the medical evidence.<sup>10</sup> Appellant has not provided any probative medical evidence that he has more than 30 percent bilateral lung impairment.<sup>11</sup>

### **CONCLUSION**

The Board finds that appellant failed to establish that he has more than 30 percent impairment for each lung.

### **ORDER**

**IT IS HEREBY ORDERED THAT** the July 13, 2006 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 21, 2007  
Washington, DC

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

David S. Gerson, Judge  
Employees' Compensation Appeals Board

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

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<sup>9</sup> *Id.*; see Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.4 (August 2002).

<sup>10</sup> *Bobby L. Jackson*, 40 ECAB 593, 601 (1989).

<sup>11</sup> *Mike E. Reid*, 51 ECAB 543, 547-48 (2000).