

<sup>1</sup> 5 U.S.C. §§ 8101-8193.

## **FACTUAL HISTORY**

This case has previously been before the Board. By decision dated April 19, 2010, the Board set aside OWCP's April 6, 2009 decision.<sup>2</sup> The Board found that there was a conflict of medical opinion between appellant's treating physician, Dr. Jairo Rodriguez, who supported an impairment rating of the lungs and the second opinion physician and an OWCP medical adviser, who opined that appellant did not sustain any impairment to the lungs. The Board remanded the case to refer appellant to an impartial medical specialist.<sup>3</sup> The facts of the case as set forth in the Board's prior decision are incorporated herein by reference.

OWCP referred appellant to Dr. Vanessa A. Holland, a Board-certified pulmonologist, selected as the medical referee. In a July 6, 2010 report, Dr. Holland reviewed the medical records and set forth findings on physical examination of appellant. She noted a history of his work-related injury. Dr. Holland noted that appellant's respiratory rate was 12, oxygen saturation was 97 percent on room air, he was in no distress, neck was supple without lymphadenopathy, chest was clear without auscultation and percussion, cardiac examination revealed S1 and S2 without an S3 gallop and the neurological examination was normal. She noted results of past pulmonary function testing. Dr. Holland stated that pulmonary function studies obtained on July 6, 2010 revealed a forced expiratory volume (FEV1) of 1.66 (58 percent of predicted), forced vital capacity (FVC) of 1.70 (48 percent of predicted) a FEV1/FVC ratio of 97.6, a diffusing capacity for carbon dioxide (DLCO) of 7.89 (30.6 of predicted) and the total lung capacity (TLC) was 4.29 (69 percent of predicted). She advised that the studies could not be interpreted, as appellant hyperventilated during the complete test and, therefore, an impairment rating could not be determined. Dr. Holland noted that the chest radiograph on July 6, 2010 revealed minimal atelectasis versus scarring within the lingual and mild biapical pleural thickening. A computerized tomography (CT) scan dated September 29, 2009 revealed minimal left basilar bronchiectasis changes. Dr. Holland opined that maximum medical improvement for the accepted conditions of bronchitis and pneumonitis was 2008. She stated that the pulmonary function studies did not match clinical objective findings. Due to the inability to obtain good pulmonary function tests, a methacholine challenge could not be recommended to see if appellant had reactive airways to evaluate his symptoms.

Appellant submitted a January 13, 2011 report from Dr. Ammar Halloum, a Board-certified pulmonologist, who diagnosed bronchiectasis and recommended a vest for appellant's breathing. On February 10, 2011 he underwent a pulmonary function test which revealed severe airway obstruction with restriction probable. Dr. Halloum noted invalid efforts for DLCO; however, the test results appeared to be valid. He also noted the standard for acceptable maneuvers was not met.

On November 30, 2011 OWCP noted that Dr. Holland was unable to calculate an impairment rating for appellant based on the July 6, 2010 pulmonary function tests because

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<sup>2</sup> Docket No. 09-1496 (issued April 19, 2010).

<sup>3</sup> On October 29, 2007 appellant, a supervisory special agent, claimed a pulmonary condition due to his workplace exposure to mothball vapors, dust contamination, rodent fecal matter and mold. OWCP accepted his claim for bronchitis and pneumonitis due to fumes and vapors. Appellant retired in January 2009.

appellant hyperventilated and the test could not be performed with accuracy. It requested that she repeat the pulmonary testing.

OWCP requested that Dr. Holland provide a supplemental report. It asked that she attempt to administer testing that would allow her to finalize any impairment rating of the lungs. In a February 16, 2012 report, Dr. Holland noted appellant's history and noted examination findings. Appellant's respiratory rate was 14, oxygen saturation was 96 percent on room air, he was in no distress, his neck was supple without lymphadenopathy, chest was clear to auscultation and percussion. Cardiac examination revealed S1 and S2 without an S3 gallop and the neurological examination was normal. Dr. Holland noted that pulmonary function studies obtained on February 16, 2012 revealed FEV1 of 2.29 (84.6 percent of predicted), FVC of 2.51 (74.5 percent of predicted) a FEV1/FVC ratio of 91.6, a diffusing capacity for DLCO of 16.69 (66.9 of predicted) and the TLC was 4.65 (76.1 percent of predicted). She noted that the DLCO was normal when corrected for alveolar volume. Dr. Holland noted no significant response to the bronchodilators and advised that the test had to be repeated multiple times. The spirometry suggested a restrictive defect but the TLC was normal. At the time of the evaluation, appellant was in no distress, his physical examination was normal, oxygen saturation was normal and the pulmonary function studies had to be repeated several times. Dr. Holland again determined that maximum medical improvement for the accepted conditions of bronchitis and pneumonitis was 2008. She advised that appellant continued to complain of shortness of breath, burning sensation in the chest, poor exercise tolerance and frequent cough. In accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*<sup>4</sup> (A.M.A., *Guides*) appellant's condition was class 1 with severity of 8 to 10 percent. Dr. Holland indicated that, pursuant to Table 5-4, page 88, his pulmonary function studies, specifically FVC and DLCO, placed him in class 1. She based her opinion on noted abnormalities documented on a CT scan of the chest that could be the result of pneumonitis documented since 2008 which persisted. Dr. Holland noted that the CT scan of the chest revealed minimal left basilar bronchiectasis.

In a May 11, 2012 report, Dr. H. Mobley, OWCP's medical adviser, reviewed the medical evidence and found that appellant reached maximum medical improvement on February 16, 2012. He noted that February 16, 2012 pulmonary function studies of Dr. Holland were repeated multiple times with findings of FEV1 of 2.29 (84.6 percent of predicted), FVC of 2.51 (74.5 percent of predicted) and DLCO of 16.69 (66.9 of predicted but normal with correction for alveolar volume). Dr. Holland noted normal saturation, bronchiolar dilators without effect, a CT scan revealed minimal lingular bronchiectasis and a chest x-ray revealed minimal scarring. Dr. Mobley indicated that she reported episodes of bronchitis and pneumonitis, minimal bronchiectasis, complaints of chest burning sensation, night cough, weekly wheezing and lung medications. He concurred with Dr. Holland that, pursuant to Table 5-4, Pulmonary Dysfunction, appellant had a class 1 pulmonary impairment. Dr. Mobley noted that she did not provide modifiers but he accepted her impression of "severe." Under Table 5-4, page 88, Pulmonary Dysfunction, the key factor, objective test results, for diffusing capacity for carbon dioxide was 66.9 percent, therefore, appellant was a class 1, with a mid-range default value which yielded a grade C default impairment of six percent whole person impairment.

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<sup>4</sup> A.M.A., *Guides* (6<sup>th</sup> ed. 2009).

Dr. Mobley noted that 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. He addressed nonkey factors and utilized the net adjustment formula to find a net adjustment +2, which correlated to a grade E with 10 percent whole person impairment. Dr. Mobley converted the whole person rating for one lung was 20 percent impairment.

In a decision dated May 17, 2012, OWCP granted appellant a schedule award for 20 percent lung impairment. The award covered 31.2 weeks from February 16 to September 21, 2012.

### **LEGAL PRECEDENT**

The schedule award provision of FECA<sup>5</sup> and its implementing federal regulations<sup>6</sup> 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.<sup>7</sup> For decisions issued beginning May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.<sup>8</sup>

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).<sup>9</sup> Chapter 5 of the A.M.A., *Guides* addresses the framework to be used for addressing the pulmonary system.<sup>10</sup> Table 5-4, Pulmonary Dysfunction, describes four classes of pulmonary dysfunction based on an assessment of history, physical findings and objective tests, including a comparison of observed values for certain ventilatory function measures and their respective predicted values.<sup>11</sup> The appropriate class of impairment is determined by the observed values for either the FVC, FEV1 or diffusing capacity of carbon monoxide (Dco), measured by their respective predicted values. If one of the three ventilatory function measures, FVC, FEV1 or Dco or the ratio of FEV1 to FVC, stated in terms of the observed values, is abnormal to the degree described in classes 2 to 4, then the individual is deemed to have an impairment which

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<sup>5</sup> 5 U.S.C. § 8107.

<sup>6</sup> 20 C.F.R. § 10.404.

<sup>7</sup> *Id.* at § 10.404(a).

<sup>8</sup> FECA Bulletin No. 09-03 (issued March 15, 2009).

<sup>9</sup> A.M.A., *Guides* (6<sup>th</sup> ed. 2008), section 1.3, the ICF, Disability and Health: A Contemporary Model of Disablement.

<sup>10</sup> *Id.* at 77-99.

<sup>11</sup> *Id.* at 88.

would fall into that particular class of impairments, either class 2, 3 or 4, depending on the severity of the observed value.<sup>12</sup>

OWCP's procedures provide that all claims involving impairment of the lungs will be evaluated by first establishing the class of respiratory impairment, following the A.M.A., *Guides* as far as possible. Awards are based on the loss of use of both lungs and the percentage for the applicable 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 in the schedule award.<sup>13</sup> The procedures further provide that, after obtaining all necessary medical evidence, the file should be routed to the medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.<sup>14</sup>

### ANALYSIS

OWCP accepted that appellant developed bronchitis and pneumonitis due to exposure to fumes and vapors, in his employment. The Board previously determined that a conflict in medical opinion arose as to whether he sustained permanent impairment to the lungs. OWCP referred appellant to Dr. Holland to resolve the conflict.

Where there exists a conflict of medical opinion and the case is referred to an impartial specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, is entitled to special weight.<sup>15</sup> The Board finds that the opinion of Dr. Holland is sufficiently well rationalized and based upon a proper factual background such that it is entitled to special weight and establishes that appellant sustained 20 percent lung impairment.

OWCP referred the matter to Dr. Holland, on July 6, 2010. Dr. Holland reviewed appellant's history, reported findings and noted an essentially normal physical examination. She noted that July 6, 2010 pulmonary function studies could not be interpreted as he hyperventilated during the complete test making the results invalid. OWCP subsequently requested a supplemental report.<sup>16</sup> In a February 16, 2012 report, Dr. Holland noted findings including results of pulmonary function studies obtained on February 16, 2012. These revealed FEV1 of

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<sup>12</sup> *Id.*

<sup>13</sup> Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.4(d)(1) (January 2010).

<sup>14</sup> Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002). *See id.* at Chapter 2.810.8(k) (September 2010) (if a case has been referred for a referee evaluation to resolve the issue of permanent impairment, it is appropriate for the district medical adviser to review the calculations to ensure the referee physician appropriately used the A.M.A., *Guides*).

<sup>15</sup> *Aubrey Belnavis*, 37 ECAB 206 (1985).

<sup>16</sup> *See Phillip H. Conte*, 56 ECAB 213 (2004) (when OWCP secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from the specialist requires clarification or elaboration, it has the responsibility to secure a supplemental report from the specialist for the purpose of correcting a defect in the original report).

2.29 (84.6 percent of predicted), FVC of 2.51 (74.5 percent of predicted) a FEV1/FVC ratio of 91.6, a DLCO of 16.69 (66.9 of predicted) and the TLC was 4.65 (76.1 percent of predicted). Dr. Holland noted that the DLCO was normal when corrected for alveolar volume. She noted no significant response to the bronchodilators and indicated that the test was repeated multiple times. Dr. Holland further noted the spirometry suggested a restrictive defect but the TLC was normal. She advised that at the time of the evaluation appellant was in no distress, his physical examination was normal and oxygen saturation was normal. Dr. Holland indicated that he continued to complain of shortness of breath, burning sensation in the chest, poor exercise tolerance and frequent cough. She opined that pursuant to Table 5-4, page 88, appellant's pulmonary function studies, specifically the FVC and DLCO, would correlate to class 1. Dr. Holland noted in accordance with the A.M.A., *Guides* his 8 to 10 percent impairment.

On May 11, 2012 Dr. Mobley reviewed Dr. Holland's report. He found that appellant reached maximum medical improvement on February 16, 2012. Dr. Mobley noted findings of the pulmonary function studies obtained by Dr. Holland on February 16, 2012. He concurred with her to determine that pursuant to Table 5-4, page 88, Pulmonary Dysfunction, appellant was a class 1. Dr. Mobley noted that, while Dr. Holland did not provide modifiers, he accepted her impression of "severe." He noted that pursuant to Table 5-4, page 88, Pulmonary Dysfunction, the key factor, objective test results, for diffusing capacity for carbon dioxide was 66.9 percent qualified as class 1, with a mid-range default value which yielded a grade C default impairment of six percent whole person impairment. Dr. Mobley noted nonkey factors and found a net adjustment of +2, which correlated to a grade E for 10 percent whole person impairment. He noted conversion of whole person to lung impairment was 20 percent impairment.<sup>17</sup>

Dr. Mobley properly applied the A.M.A., *Guides* to Dr. Holland's reports and reached an impairment rating of 20 percent for one lung. This evaluation conforms to the A.M.A., *Guides* and establishes that appellant has 20 percent of one lung.

On appeal, appellant argued that he sustained a greater impairment and that the period of his award of 31.2 weeks is inadequate, rather, he should be granted 156 weeks.<sup>18</sup> He asserts that he has progressive lung disease caused by his work which is not reversible. The Board noted that Dr. Holland and Dr. Mobley rated pulmonary impairment in accordance with the A.M.A., *Guides*. Dr. Mobley properly found that 10 percent whole person impairment represented 20 percent lung impairment consistent with OWCP's procedures.<sup>19</sup> The record does not contain any probative medical evidence to establish greater impairment under the sixth edition of the A.M.A., *Guides*.

A schedule award under FECA and its regulations is paid for permanent impairment involving the loss or loss of use of certain members of the body. These schedule award provisions allow for the payment of compensation for a specific number of weeks as

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<sup>17</sup> See *supra* note 13.

<sup>18</sup> 20 C.F.R. § 10.404(b) provides for 156 weeks of compensation for total or 100 percent, loss of use of a lung.

<sup>19</sup> See *supra* note 13.

prescribed.<sup>20</sup> In the instant case, appellant does not have a total or 100 percent loss of the lung, but a 20 percent loss. As he has no more than a 20 percent loss of use of one lung, he is entitled to 31.2 weeks of compensation. OWCP properly determined the number of weeks of compensation to which appellant is entitled.

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 20 percent impairment of one lung, for which he received a schedule award.<sup>21</sup>

### **ORDER**

**IT IS HEREBY ORDERED THAT** the May 17, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 29, 2013  
Washington, DC

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

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

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

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<sup>20</sup> *Supra* note 5; *supra* note 6.

<sup>21</sup> With his request for an appeal, appellant submitted additional evidence. However, the Board may not consider new evidence on appeal; *see* 20 C.F.R. § 501.2(c).