U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of WILLIAM O. SIMMONS, JR. and DEPARTMENT OF THE NAVY, CHARLESTON NAVAL SHIPYARD, Charleston, S.C.

Docket No. 97-798; Submitted on the Record;
Issued December 17, 1998

DECISION and ORDER

Before GEORGE E. RIVERS, DAVID S. GERSON,
BRADLEY T. KNOTT

The issue is whether appellant is entitled to a schedule award for a ratable impairment, causally related to his accepted conditions of bronchitis, asthma and asbestosis.

On March 3, 1994 appellant, then a 50-year-old wharfbuilder, filed a claim for bronchitis with some asthma. He retired from federal employment in 1995, and on November 6, 1995 he filed a claim for a schedule award. On February 21, 1996 appellant filed a claim for pulmonary obstructive disease and asbestosis. The Office of Workers' Compensation Programs accepted appellant's claim for bronchitis and ultimately also for asthma and asbestosis.

On July 8, 1996 the Office referred appellant to a second opinion specialist, Dr. William R. Cook, a Board-certified pulmonologist, for evaluation of injury-related residuals. By report dated August 14, 1996, Dr. Cook reviewed appellant's symptoms of shortness of breath, wheezing and cough, and evaluated his examination and testing results. Dr. Cook noted that chest x-rays demonstrated no parenchymal abnormalities, no pleural thickening or pleural calcifications, no ill-defined diaphragmatic or cardiac outline, and no other abnormalities. He noted that appellant's spirometry was totally within normal limits, that all flow rates were normal, that there was no change after bronchodilators, that lung volumes were normal, and that total lung capacity was 91 percent of predicted. Dr. Cook noted that single breath diffusing capacity was within normal limits and that a resting room air arterial blood gas was normal. Dr. Cook noted that appellant had chronic bronchitis that began in 1992 and which left a residual cough, wheeze and shortness of breath. He diagnosed appellant's condition as asthmatic bronchitis due to diisocyanate exposure and opined that it was probably permanent. Dr. Cook found no evidence for any other pulmonary conditions and no evidence for asbestos-related diseases.

The only medical evidence of record supporting a different diagnosis and different pulmonary function testing results was a May 16, 1994 report from Dr. L. Christine Oliver, a Board-certified pulmonologist, who, over two years earlier and prior to the cessation of

appellant's occupational exposure, found that a chest x-ray revealed bilateral pleural plaques, the cause of which, she speculated, was pleural scarring caused by asbestos, and a decreased forced vital capacity (FVC), the cause of which she did not determine. Dr. Oliver noted that her testing demonstrated a forced vital capacity of 75 percent of predicted, whereas the Board notes that Dr. Cook's testing after appellant ceased to be occupationally exposed demonstrated an improved forced vital capacity of 85 percent of predicted.

On October 15, 1996 an Office medical adviser reviewed the most recent testing results and noted that appellant's FVC was 85 percent of predicted, that his forced expiratory volume (FEV_1) was 102 percent of predicted, that his FEV_1/FVC was 87 percent of predicted, and that his diffusion of carbon monoxide was 104 percent of predicted. Referring to the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, 4th Edition (1993), page 162, Table 8, addressing classes of respiratory impairment, the Office medical adviser determined that, with appellant's testing results, he fell within Class 1, or zero percent impairment of the whole person. The Board notes that Class 1 requires that a claimant's FVC be equal to or greater than 80 percent of predicted, his FEV_1 be equal to or greater than 80 percent of predicted, his FEV_1/FVC be equal to or greater than 70 percent of predicted, and his DCO be equal to or greater than 70 percent of predicted, and that all of appellant's most recent testing values clearly fell within that category, being greater than the minimum levels required. The Office medical adviser opined that the date of appellant's date of maximum medical improvement was August 29, 1996.

By decision dated April 19, 1996, the Office accepted that appellant sustained pulmonary injury consistent with exposure to asbestos but denied appellant's claim for a schedule award, finding that he had no ratable permanent impairment according to the A.M.A., G*uides*. It noted, however, that since appellant had sustained asbestos-related disease, he was authorized to receive periodic medical examinations at Office expense for clinical, radiologic, and pulmonary function monitoring.

By second decision dated October 15, 1996, the Office again denied appellant's claim for a schedule award, explaining that Dr. Cook's examination and testing demonstrated that he had a Class 1 rating, which meant that he had no evidence of impairment which would qualify him for a schedule award under the Federal Employees' Compensation Act.

On appeal appellant argues that he has had to increase his medication to compensate for decreased breathing ability.

The Board, however, finds that appellant is not entitled to a schedule award for a ratable impairment, causally related to his accepted conditions of bronchitis, asthma and asbestosis.

Section 8107 of Title 5 of the U.S. Code provides that if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function.[1]

Under section 8107 of the Act[2] and section 10.304 of the implementing federal regulation,[3] schedule awards are payable for the permanent impairment of specified bodily members, function, or organs. However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice for all claimants, the Office has adopted the A.M.A., *Guides*, as a standard for determining the percentage of impairment, and the Board has concurred in such adoption.[4]

In this case the Office medical adviser used Dr. Cook's August 14, 1996 report testing results, and noted that appellant's FVC was 85 percent of predicted, that his forced expiratory volume (FEV_1) was 102 percent of predicted, that his FEV_1/FVC was 87 percent of predicted, and that his diffusion of carbon monoxide was 104 percent of predicted. Referring to the A.M.A., *Guides*, 4th Edition (1993), page 162, Table 8, addressing classes of respiratory impairment, the Office medical adviser determined that, with appellant's testing results, he fell within Class 1, or zero percent impairment of the whole person. The Board notes that, according to the applicable section of the A.M.A., *Guides*, Class 1 requires that a claimant's FVC be equal to or greater than 80 percent of predicted, his FEV_1 be equal to or greater than 80 percent of predicted, his FEV_1/FVC be equal to or greater than 70 percent of predicted, and his DCO be equal to or greater than 70 percent of predicted, and that all of appellant's most recent testing values clearly fell within that category, being greater than the minimum levels required, as noted above. The Board finds that this was a correct application of the A.M.A., *Guides*, and consequently demonstrates that, based upon the current medical evidence of record before the Board at this adjudication, appellant does not qualify for a schedule award as he falls within Class 1 which has a zero percent impairment rating.

The Board further notes that there is no other probative medical evidence of record which demonstrates any impairment greater than that found by Dr. Cook. The incomplete pulmonary function testing results provided by Dr. Oliver over two years before Dr. Cook's evaluation and before appellant ceased being occupationally exposed to the implicated factors of employment, are of diminished probative value because they are incomplete and because appellant was still exposed to causative factors after recordation of those results, such that they would not accurately determine what any occupationally-related permanent impairment might be. Consequently, Dr. Cook's thorough and complete evaluation and testing results constitute the

[1] 5 U.S.C. § 8107(a). It is thus the claimant's burden of establishing that he sustained a permanent impairment of a scheduled member or function as a result of his employment injury; *see Raymond E. Gwynn*, 35 ECAB 247 (1983) (addressing schedule awards for members of the body that sustained an employment-related permanent impairment); *Philip N.G. Barr*, 33 ECAB 948 (1982) (indicating that the Act provides that a schedule award be payable for a permanent impairment resulting from an employment injury).

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.304.

[4] *See, e.g., Francis John Kilcoyne*, 38 ECAB 168 (1987).

weight of the medical opinion evidence of record and indicate that appellant has no ratable impairment which would entitle him to a schedule award. As, however, appellant bears the burden of proof to establish a greater degree of impairment, and as his accepted condition of asbestosis entitles him to future pulmonary functioning testing and clinical and radiologic monitoring, any subsequently obtained evidence demonstrating a greater degree of permanent impairment may be submitted to the Office with a request for reconsideration of his entitlement to a schedule award.

Accordingly, the decisions of the Office of Workers' Compensation Programs dated October 15 and April 19, 1996 are hereby affirmed.

Dated, Washington, D.C.
December 17, 1998

George E. Rivers
Member

David S. Gerson
Member

Bradley T. Knott
Alternate Member