U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of WILLIAM A. ROMANESK and DEPARTMENT OF THE NAVY, NAVAL AIR STATION, Jacksonsville, FL

Docket No. 00-525; Submitted on the Record;
Issued December 8, 2000

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
VALERIE D. EVANS-HARRELL

The issue is whether appellant is entitled to more than a 26 percent permanent impairment for loss of use of both lungs, for which he has already received a schedule award.

The Board has duly reviewed the case record in this appeal and finds that appellant is not entitled to more than a 26 percent permanent impairment for loss of use of both lungs, for which he has already received a schedule award.

On March 3, 1996 appellant, then a 61-year-old aircraft sheet metal mechanic, filed a claim for an occupational disease (Form CA-2) alleging that on January 5, 1995 he first realized that his asbestosis was caused or aggravated by his employment.

By letter dated January 9, 1997, the Office of Workers' Compensation Programs accepted appellant's claim for asbestosis.

The Office received an October 31, 1996 medical report from Dr. Isabella K. Sharpe, a Board-certified internist and appellant's treating physician, indicating that appellant had asbestosis and asbestos-related pleural disease. On the same date, an Office medical adviser reviewed appellant's medical records, including Dr. Sharpe's report, and determined that appellant had a 13 percent permanent impairment of each lung.

By decision dated February 11, 1997, the Office granted appellant a schedule award for a 26 percent impairment loss of use of both lungs for the period October 31, 1996 through August 10, 1997.

On July 9, 1998 appellant filed a claim (Form CA-7) for an additional schedule award.

In an October 15, 1999 decision, the Office found that appellant was not entitled to an additional schedule award.

The schedule award provision of the Federal Employees' Compensation Act[1] and its implementing regulation,[2] set forth the number of weeks of compensation to be paid for permanent loss, or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage of loss of use.[3] 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 under the law for 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 American Medical Association, *Guides to the Evaluation of Permanent Impairment* has been adopted by the Office and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[4]

In a July 17, 1998 letter, the Office advised appellant that he had previously received a schedule award for permanent partial impairment of his lungs. The Office further advised appellant to submit a detailed rationalized medical report from his treating physician supportive of an additional award.

By letter dated February 9, 1999, the Office advised Dr. Sharpe to determine whether appellant had any additional impairment based on the fourth edition of the A.M.A., *Guides*. Dr. Sharpe submitted a March 8, 1999 medical report. In this report, Dr. Sharpe indicated his findings on physical examination and appellant's medical treatment. She opined that appellant's pulmonary function had deteriorated and the diffusing capacity of the lung for carbon monoxide had fallen which would explain this tremendous desaturation with exercise. Dr. Sharpe further opined that appellant was much more disabled than he was previously and in fact appellant was 100 percent disabled. She noted that appellant was unable to do simple minimal exercise for three minutes. In an accompanying addendum, Dr. Sharpe opined that, based on the fourth edition of the A.M.A., *Guides*, appellant had a 26 to 50 percent moderate impairment of the whole person. She further stated that appellant was in the advanced part of that with his profound desaturation with minimal exercise, and thus, she believed that 50 percent was more than fair to the employing establishment and at least fair to appellant. Dr. Sharpe finally stated that this would increase and that this was not appellant's final disability.

On April 21, 1996 an Office medical adviser reviewed Dr. Sharpe's report and stated that it was not expected that a schedule award for asbestosis would increase seriously since 1997. The Office medical adviser recommended that the Office obtain a second opinion.

By letter dated June 29, 1999, the Office referred appellant along with a statement of accepted facts, a list of specific questions and medical records to Dr. Jack J. Salah, a Board-certified internist, for a second opinion examination. Dr. Salah submitted a copy of a pulmonary

[1] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[2] 20 C.F.R. § 10.304.

[3] 5 U.S.C. § 8107(c)(19).

[4] *See James J. Hjort*, 45 ECAB 595 (1994); *Luis Chapa, Jr.*, 41 ECAB 159 (1989); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

function study, which was performed at his request. He provided, in a July 21, 1999 medical report, a history of appellant's accepted condition, medical treatment and employment. His report further provided his findings on physical and objective examination. Dr. Salah reported the following:

> "(1) Mild extrinsic respiratory ventilatory deficit. This may be related to either a mild exogenous obesity/or pleural thickening (latter would be secondary to asbestos exposure in the past although not accompanied by frank findings of asbestosis/parenchymal lung disease).
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> (2) There is no indication of interstitial lung disease/asbestosis based on current findings (or on prior chest computerized tomography (CT) in July 1998).
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> (3) There is a very mild/borderline obstructive ventilatory deficit on spirometry (consistent with borderline chronic obstructive pulmonary disease of questionable clinically significance) - inhaled ipratropium (Atrovent) at three puffs three times a day or four times a day for a six week trial followed by follow up spirometry maybe worth while diagnostically.
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> (4) No evidence of oxygen desaturation with low to moderate levels of exercise. It should be noted that the, reported desaturation to 58 percent (associated with a difficult to understand bradycardia of 37 both variables with suggested life threatening changes and more likely artifactual) were described in Dr. Sharps office while the patient was riding at low levels of work on a bicycle. This is likely artifacts secondary to poor pulse perfusion, which is a common technical problem during exercise (*i.e.* poor pickup of the post oximetry which will under-read both the pulse and the oxygenation). If there is any questions regarding this, a formal cardiopulmonary exercise test with exercise arterial blood gas studies (ABG) would more clearly define this.
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> (5) [Appellant] is felt to be a maximum medical improvement with A.M.A., class II impairment (10 to 25 percent) based on current objective findings and pulmonary opinion.
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> (6) If further delineation of his pulmonary status is desired (*i.e.* if the data is felt to be discordant with prior examiner) or if [appellant] experiences future dyspnea which seems out of proportion to the objective findings, then cardiopulmonary exercise test (metabolic exercise study) with ABG's, as well as a repeat CT scan with thin sections should resolve those issues."

The Board concludes that Dr. Salah correctly applied the A.M.A., *Guides* in determining that appellant has no more than a 26 percent permanent impairment for loss of use of both lungs. In this connection, Dr. Salah reported a FEV_1 (Forced Expiratory Volume) of 76 percent of the predicted 3.61 liters; a FVC (Forced Vital Capacity) of 76 percent of the predicted 4.53 liters; and DLCO (Carbon Monoxide Diffusing Capacity) of 4.31 of the 7.21 liters predicted. All of the foregoing values fell within the 10 to 25 percent, mild impairment of the whole person under Table 8 of the A.M.A., *Guides* regarding respiratory impairments. Appellant has failed to

provide probative, supportable medical evidence that he has greater than the 26 percent impairment already awarded.

The October 15, 1999 decision of the Office of Workers' Compensation Programs is hereby affirmed.

Dated, Washington, DC
December 8, 2000

David S. Gerson
Member

Willie T.C. Thomas
Member

Valerie D. Evans-Harrell
Alternate Member