

**United States Department of Labor
Employees' Compensation Appeals Board**

ROBERT G. MARCHETTA, Appellant

and

**DEPARTMENT OF THE ARMY, U.S. ARMY
MATERIEL COMMAND, Natick, MA, Employer**

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**Docket No. 05-1540
Issued: January 3, 2006**

Appearances:
William Shanahan, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:

DAVID S. GERSON, Judge
WILLIE T.C. THOMAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On July 14, 2005 appellant filed a timely appeal of the Office of Workers' Compensation Programs' merit decision dated June 23, 2005, denying an increased schedule award for permanent partial impairment of use of both lungs over the 30 percent already granted. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merit schedule award decision in this case.¹

ISSUE

The issue is whether appellant has more than a 30 percent permanent impairment of use of both lungs, for which he received a schedule award.

¹ The Board notes that the record also contains a July 8, 2005 Office decision awarding attorney fees. The Board, however, will not review this decision as it is not contested on appeal.

FACTUAL HISTORY

On December 8, 1993 appellant, then a 51-year-old automotive mechanic, filed an occupational disease claim alleging that he developed a respiratory condition due to exposure to chemical, paint fumes and other irritants while in the performance of duty. Appellant first became aware of his condition and its relationship to his employment on July 16, 1993. Appellant stopped work on December 29, 1993. The Office accepted the condition of aggravation of chronic obstructive pulmonary disease and paid appropriate compensation.

Appellant filed a claim for permanent impairment of his lungs. In a decision dated November 30, 1995, the Office denied the claim for a schedule award, finding that the weight of the medical evidence of record demonstrated that appellant had not sustained any impairment causally related to factors of his federal employment. Appellant subsequently requested a hearing, which was denied by decision dated February 7, 1996. Thereafter, he requested reconsideration, which the Office denied by decision dated May 24, 1996. After filing an appeal, the Board, in an order remanding case, dated August 14, 1998, found that the case was not in posture for decision with respect to the schedule award determination, finding that as the Office had abused its discretion in refusing appellant's request for a hearing as untimely filed. The case was remanded for further action.²

By decision dated October 14, 1998, the Office denied the schedule award claim finding that the weight of the evidence established that appellant did not sustain an impairment causally related to his federal employment. An Office hearing representative, in a decision dated April 28, 1999, remanded the case for further development of the medical evidence regarding permanent impairment.

In a January 21, 2000 decision, the Office granted appellant 15.60 weeks of compensation for a 10 percent permanent impairment of loss of use of the lungs for the period December 20, 1999 to April 8, 2000. In a decision dated May 14, 2000, an Office hearing representative remanded the case for further development of the medical evidence. By decision dated August 31, 2000, the Office found that appellant was not entitled to any additional compensation for permanent impairment to his lungs. Appellant requested a hearing and, by decision dated January 4, 2001, an Office hearing representative remanded the case for further development. Appellant was referred to Dr. Daniel Steigman, a Board-certified internist for a second opinion examination on March 19, 2001. Following review by an Office medical adviser, the Office issued a decision dated May 30, 2001, awarding appellant 46.80 weeks of compensation for a 15 percent permanent impairment of the loss of use of the lungs for the period March 19 to October 23, 2001.³

In an Office hearing representative's decision dated August 23, 2001, the case was remanded for further development of the medical evidence and clarification of Dr. Steigman's application of Table 5-9 in the American Medical Association, *Guides to the Evaluation of*

² Docket No. 96-2177 (issued August 14, 1998).

³ The Office noted that, since appellant had previously received 15.60 weeks of compensation, he would only receive the additional 31.20 weeks of compensation remaining.

Permanent Impairment (A.M.A., *Guides*). Of record was an October 30, 2001 report from Dr. David Christiani, a Board-certified internist and pulmonary specialist and appellant's treating physician, who opined that, under Table 5-12, p. 107 of the fifth edition of the A.M.A., *Guides*⁴ appellant's forced vital capacity (FVC) of 45 percent and forced expiratory volume (FEV)₁ of 47 percent were consistent with a Class 4, 51 to 100 percent impairment of the whole person.

Following a decision dated January 7, 2002, in which the Office determined that appellant did not have more than 15 percent impairment of the lungs. In a May 20, 2002 decision, an Office hearing representative found that the August 23, 2001 decision was premature and remanded the case for further medical development. The hearing representative directed appellant to submit a copy of the pulmonary function testing, which formed the basis of Dr. Christiani's October 30, 2001 report, in order that the test be made available to Dr. Steigman prior to repeat pulmonary function testing.

On June 24, 2002 the Office received Dr. Christiani's June 12, 2001 pulmonary function study. Pursuant to the hearing representative's instructions, the Office medical adviser reviewed the June 12, 2001 test and opined that, since such test could not be used to determine asthma, Table 5-9 and 10 of the A.M.A., *Guides* should be used to determine appellant's respiratory impairment. Dr. Levine noted that he had previously assigned a 15 percent total impairment due to asthma in his January 2001 report.

The Office referred appellant, together with a statement of accepted facts and the medical record, for a second opinion evaluation to Dr. Leonard Cosmo, a Board-certified internist specializing in pulmonary disease.⁵

In a September 5, 2002 report, Dr. Cosmo noted the history of injury, reviewed the statement of accepted facts along with the medical record and presented examination findings, including spirometry results. Dr. Cosmo opined that appellant's chronic obstructive pulmonary disease was a result of his long history of tobacco abuse and that his morbid obesity caused significant decreases in the vital capacity. He also noted that appellant had severe degenerative knee disease causing significant physical impairment.

In a September 29, 2002 report, the medical adviser reviewed Dr. Cosmo's September 5, 2002 report and opined that appellant's emphysema was due to tobacco use rather than asthma. Based on this, he opined that Table 5-12 page 107 of the A.M.A., *Guides* should be used to rate appellant's impairment and that the type of exposure claimed would only cause a temporary aggravation of the obstructive lung disease. Using Dr. Cosmo's findings, he opined that appellant fell into a Class 3 impairment, which would equate to 26 percent whole person impairment due to obstructive airways disease. He opined, however, that the calculated

⁴ The A.M.A., *Guides* (5th ed. 2001).

⁵ In a separate letter, the Office noted that at the time of the May 20, 2002 Office hearing representative decision, the hearing representative was under the belief that appellant still resided in Massachusetts as the decision was released to that address. The Office stated that, from a logistical standpoint, it was neither prudent nor practical to have appellant travel from his residence in Florida to be reevaluated by Dr. Steigman and, since the May 20, 2002 remand had ordered repeat pulmonary function testing, it was necessary to have appellant retested and examined by another physician.

impairment was not causally related to appellant's employment but was due to appellant's obesity and severe knee arthritis coupled with the obstructive airways disease.

In an October 2, 2002 letter, the Office found that a medical conflict existed between Dr. Christiani and Drs. Cosmo and Levine with respect to whether appellant's pulmonary impairment was due to occupational exposure. The Office referred appellant, together along with a statement of accepted facts and the case file, to Dr. Eli Freilich, a Board-certified internist specializing in pulmonary disease.

In a January 2, 2003 report, Dr. Freilich noted the history of injury and his review of the medical record and opined that appellant was totally disabled due to his respiratory disease and his other medical problems. He presented findings on physical examination and advised that appellant's O₂ saturation at rest was 94 percent, but noted that the spirometry was "poorly performed and difficult to assess." Routine chest x-rays performed on January 7, 2003 revealed normal findings with clear lungs and no evidence of infiltrate, effusion or pneumothorax. In a January 21, 2003 report, Dr. Freilich opined that appellant's nocturnal oximetry study showed significant nocturnal hypoxemia and appeared to be cyclical, which raised the possibility of sleep apnea. He reported that 48 percent of the time, appellant's O₂ saturation was less than 90 percent during sleep and nearly 30 percent of the time was less than 88 percent.

In a March 10, 2003 letter, the Office requested that Dr. Freilich provide an addendum report, which responded to the following questions:

"1. Please identify the cause of [appellant's] pulmonary impairment. Is [appellant's] lung impairment, in whole or in part, causally related to his occupational exposure as described in the [s]tatement of [a]ccepted [f]acts? Please explain in detail by giving due consideration to results of pulmonary function studies and other testing performed.

"2 If you find [appellant's] pulmonary impairment to be work related is such impairment permanent or temporary in nature? Please explain the basis for your conclusion. The definition of aggravation is enclosed."

In a March 21, 2003 supplemental report, Dr. Freilich opined that appellant's hypoxemia contributed to his respiratory difficulties. He also opined that appellant's exposure to various chemicals and solvents contributed to his respiratory impairment as they were significant bronchoconstrictors and rationalized that long-term bronchoconstriction and stimulation could lead to increasing respiratory impairment. He opined that appellant's respiratory impairment was permanently aggravated as the continuous stimulation of his airways had led to hypertrophy of the airways and chronic impairment in his respiratory status. Dr. Freilich did not offer an opinion as to the amount or percentage of which a respiratory impairment was involved.

In an April 3, 2003 report, Dr. David I. Krohn, an Office medical adviser, reviewed the medical record. He opined that appellant was best described as having impairment from reactive airways dysfunction syndrome as described on page 102, column 2, paragraph 3 of the A.M.A., *Guides*. He also stated that appellant had a degree of chronic obstructive lung disease due to long-term cigarette smoking, which had been exacerbated by RADS on a permanent basis.

Based on Dr. Freilich's recent evaluation, FEV₁ was reported to be mildly diminished and appellant was reported to manifest a methacholine PC₂₀ at 2mg/mL. Dr. Krohn further noted that there was no evidence on pulmonary function testing for reversibility of FEV₁ and that appellant required daily bronchodilator or inhaled corticosteroid to control symptoms. Utilizing Tables 5-9 and 10 on page 104 of the A.M.A., *Guides*, Dr. Krohn opined that appellant had a total asthma score of 2, which corresponded to a 15 percent impairment of the whole person.

In an April 6, 2003 supplemental report, Dr. Krohn opined that, since appellant's chronic obstructive lung disease was exacerbated by RADS on a permanent basis, Table 5-12 on page 107 of the A.M.A., *Guides* could also be used for purposes of a schedule award determination. Dr. Krohn noted that the most recent pulmonary function study was that of Dr. Cosmo on September 5, 2002, which indicated an FVC of 2.06 (61 percent of predicted), FEV₁ of 1.26 (45 percent of predicted) and a FEV₁/FVC 75 percent predicted. He noted that no determination for Dco or for V02Max was provided in the medical record. Utilizing Dr. Cosmo's September 5, 2002 pulmonary function study results, Dr. Krohn stated that appellant fit into a Class 4 impairment and assigned a 30 percent impairment of the whole person.

In a decision dated April 17, 2003, the Office awarded appellant 93.60 weeks of compensation for a 30 percent permanent impairment of both lungs for the period October 24, 2001 to September 16, 2002.⁶

In an April 16, 2003 letter, appellant requested an oral hearing, which he subsequently changed to a request for a review of the written record on May 11, 2004. In a June 23, 2005 decision, an Office hearing representative affirmed the Office's April 17, 2003 decision. The hearing representative found that the impairment rating was based upon the "most complete and up to date pulmonary function testing, which was done by Dr. Freilich, the referee specialist, who examined and tested the claimant in January 2003."

LEGAL PRECEDENT

Under section 8107 of the Act⁷ and section 10.404 of the implementing federal regulation, schedule awards are payable for permanent impairment of specified body members, functions or organs.⁸ The Act, however, does not 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 A.M.A., *Guides* has been

⁶ The Office originally issued an April 10, 2003 decision awarding appellant a 30 percent permanent impairment to both lungs, but subsequently adjusted the rate of appellant's cost-of-living adjustment in its April 17, 2003 decision.

⁷ 5 U.S.C. § 8107.

⁸ The Board notes that the lungs are not a specified body member under the Act. The Act was amended effective September 7, 1974, authorizing a schedule award for loss or loss of use of "any other important external or internal organ of the body as determined by the Secretary" and pursuant to regulation, the Office has provided for a schedule award for lung impairment. 20 C.F.R. § 10.404; *Eugene Van Dyke*, 53 ECAB 706 (2002).

adopted by the Office and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.⁹

Chapter 5 of the fifth edition of the A.M.A., *Guides* provide that permanent impairment of the lungs is determined on the basis of pulmonary function tests, *i.e.*, the FVC and the one second FEV₁, the ratio between FEV₁ and FVC and Dco. The values for predicted and observed normal values for FEV₁, FVC and Dco are found in Tables 5-2a through 5-7b.¹⁰ With regard to respiratory or pulmonary impairments, the A.M.A., *Guides* provides a table consisting of four classes of respiratory impairment based on a comparison of observed values for certain ventilatory function measures and their respective predicted values.¹¹ For Classes 2 through 4, the appropriate class of impairment is determined by whether the observed values fall alternatively within identified standards for FVC, FEV₁, DLCO¹² or maximum oxygen consumption (V02Max). For each of the FVC, FEV₁ and DLCO results, an observed result will be placed within Class 2, 3 or 4, if it falls within a specified percentage of the predicted value for the observed person.¹³ For V02Max, an observed result will be placed within Class 2, 3 or 4 if it falls within a specified range of oxygen volume.¹⁴ For example, a person within a Class 2 impairment, equaling 10 to 25 percent impairment of the whole person, if the FVC, FEV₁ or Dco is above 60 percent of the predicted value and less than the lower limit of normal.¹⁵ Section 5.10 of the A.M.A., *Guides* advises that at least one of the criteria must be fulfilled to provide an individual with an impairment rating.¹⁶

The A.M.A., *Guides* also sets forth special guidelines for evaluating impairment in individuals with asthma. Using Table 5-9, page 104, the scores for postbronchodilator FEV₁, reversibility of FEV₁ (or PC₂₀, Provocative Concentration that causes a 20 percent fall in FEV₁) and the minimum medication needed to control the individual's asthma are added to obtain a summary score for respiratory impairment. Table 5-10 assigns impairment classes and percentages to the summary score. In determining the percentage impairment for a particular class, the examiner needs to consider how the person's asthma affects the ability to perform activities of daily living.¹⁷

⁹ See *Joseph Lawrence, Jr.*, 53 ECAB 331 (2002); *James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

¹⁰ A.M.A., *Guides*, *supra* note 4 at 95-100.

¹¹ See A.M.A., *Guides*, at 107, Table 5.12.

¹² This is characterized in the A.M.A., *Guides* as the DLCO test.

¹³ With respect to Class 2, the observed value must also be less than the lower limit of normal. The predicted normal values and the predicted lower limits of normal values for the FVC, FEV₁ and DLCO tests are delineated in separate tables. A.M.A., *Guides*, pages 95-100, Tables 5-2a through 5-7b.

¹⁴ The A.M.A., *Guides* provides alternate means for measuring such volumes.

¹⁵ See A.M.A., *Guides*, at 107, Table 5.12.

¹⁶ *Id.* at 107.

¹⁷ *Id.* at 102-04.

As explained by the procedure manual,¹⁸ 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 particular 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.

The Act provides that, if there is a disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.¹⁹ The implementing regulation states that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician of an Office medical adviser or consultant, the Office shall appoint a third physician to make an examination. This is called a referee examination and the Office will select a physician who is qualified in the appropriate specialty and who has had no prior connection with the case.²⁰

ANALYSIS

The Office accepted that appellant sustained employment-related aggravation of his chronic obstructive pulmonary disease and awarded him a schedule award which totaled a 30 percent permanent impairment to both lungs. Appellant's treating physician, Dr. Christiani, opined that appellant's respiratory impairment arose from appellant's employment factors while the Office referral physician, Dr. Cosmo, and the Office medical adviser, Dr. Levine, opined that appellant's respiratory impairment was due to factors other than appellant's employment. Thus, the Office properly declared a conflict in medical opinion pursuant to section 8123 and referred appellant and the case to Dr. Freilich for an impartial medical examination. Dr. Freilich submitted reports dated January 2 and 21, 2003, which noted his findings and provided an addendum report of March 21, 2003. Dr. Freilich, however, did not offer an opinion as to the percentage of impairment or provide a valid pulmonary function study.

In situations where there are opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.²¹ As a general rule in schedule award cases, the physician should describe the impairment in sufficient detail to permit clear visualization of the impairment and the restrictions and limitations that have resulted.²² Although the report of an impartial specialist may be routinely referred to an Office medical adviser in schedule award situations, if a medical interpretation is required, the Office medical adviser should note any

¹⁸ Federal (FECA) Procedure Manual, Part 3 -- Medical, Schedule Awards, Chapter 3.700.4(c)(1) (August 1995).

¹⁹ 5 U.S.C. §§ 8101-8193, 8123.

²⁰ 20 C.F.R. § 10.321.

²¹ *Manuel Gill*, 52 ECAB 282 (2001).

²² Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.a(2) (June 2003).

medical errors found, such as improper application of the A.M.A., *Guides*, but should not attempt to clarify or expand the opinion of the medical referee.²³

In the instant case, there was a conflict under section 8123(a). In order to properly resolve the conflict, it is the impartial medical specialist who should provide a reasoned opinion as to an impairment to a scheduled member of the body in accordance with the A.M.A., *Guides*.²⁴ Dr. Freilich did not indicate that he had reviewed the A.M.A., *Guides* or provided an opinion as to the percentage of impairment in this case. He noted that his pulmonary function test was “poorly performed and difficult to assess.” Dr. Freilich’s reports, thus, are not sufficient to assess appellant’s respiratory impairment under the A.M.A., *Guides* as there was no valid pulmonary function study. Dr. Krohn, the Office medical adviser, utilized the results from Dr. Cosmo’s September 5, 2002 pulmonary function study to find a 30 percent impairment under Table 5-12 of the A.M.A., *Guides*. An Office medical adviser may review the opinion, but the resolution of the conflict is the responsibility of the impartial medical specialist.²⁵ Although Dr. Krohn reviewed Dr. Freilich’s clinical findings, he ultimately used Dr. Cosmo’s pulmonary function test to rate appellant’s impairment. The Office hearing representative’s decision mistakenly found that the impairment rating was based upon the “most complete and up to date pulmonary function testing ... done by Dr. Freilich.” Accordingly, the case will be remanded to the Office to properly resolve the conflict. As Dr. Freilich’s supplemental report was unable to cure the deficiencies noted, the Office should select a new impartial medical specialist for a rationalized opinion on the issues in this case.

CONCLUSION

The Board finds that the report of Dr. Freilich is not sufficient to resolve the conflict in the medical evidence with respect to appellant’s impairment of the lungs for which he received a schedule award. The case will be remanded for further medical development consistent with this decision.

²³ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.5(c) (March 1994).

²⁴ *Thomas J. Fragale*, 55 ECAB ____ (Docket No. 04-835, issued July 8, 2004).

²⁵ *Id.*; see also Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Award*, Chapter 3.700.3 (June 2003).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated June 23, 2005 be set aside and the case remanded for action consistent with this decision of the Board.

Issued: January 3, 2006
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Willie T.C. Thomas, Alternate Judge
Employees' Compensation Appeals Board

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