United States Department of Labor
Employees' Compensation Appeals Board

E.J., Appellant	)	
	)	**Docket No. 06-1462**
and	)	**Issued: November 29, 2006**
	)	
DEPARTMENT OF THE ARMY, LETTERKENNY ARMY DEPOT, Chambersburg, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 12, 2006 appellant filed a timely appeal from the Office of Workers' Compensation Programs' merit decision dated May 19, 2006. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant is entitled to more than a 25 percent permanent impairment for loss of use of both lungs, for which he has received a schedule award.

FACTUAL HISTORY

On March 17, 2000 appellant, then a 60-year-old munitions destroyer, filed an occupational disease claim alleging that he developed a pulmonary condition due to his

workplace exposure to chemicals and asbestos.[1] The Office originally denied appellant's claim. However, in a decision dated July 16, 2002, it accepted his claim for pleural thickening bilaterally. Appellant retired on August 31, 2000. On July 22, 2002 he filed a claim for a schedule award.

In a decision dated September 13, 2002, the Office denied appellant's claim for a schedule award.

By letter dated September 17, 2002, appellant requested a review of the written record.

In a decision dated March 10, 2003, the hearing representative directed the Office to further develop appellant's entitlement to a schedule award for lung impairment.

In a report dated April 10, 2003, the medical adviser indicated that the existing pulmonary function studies were inadequate to determine impairment. He recommended that appellant be referred for a second opinion examination.

On September 9, 2003 the Office referred appellant for a second opinion evaluation to Dr. Natvarlal Rajpara, a Board-certified pulmonologist. The Office provided Dr. Rajpara with appellant's medical records, a statement of accepted facts, as well as a detailed description of his employment duties. In a medical report dated September 18, 2003, he reviewed the records provided and performed a physical examination of appellant. Dr. Rajpara noted appellant's height as 183 centimeters and reported that, on examination, appellant's breathing sounds were fairly clear. There were no rales or rhonchi and his heart was regular without murmur. Dr. Rajpara advised that there were no chest x-rays available for review. He noted that the pulmonary function test performed on September 18, 2003 revealed a forced expiratory volume in the first second (FEV_1) of 2.69, forced vital capacity (FVC) of 3.75 and a diffusing capacity for carbon dioxide (DLCO) of 16.7 mm, per minute. Appellant had a mild degree of reduction in diffusion capacity due to interstitial lung disease which is found in asbestos exposure. Dr. Rajpara indicated that there was no way to separate the lung damage due to prior cigarette smoking. He found that, in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* this would be a Class 2 ratable pulmonary impairment of between 10 to 25 percent which could be partly assigned to asbestos exposure.[2]

In a report dated October 16, 2003, an Office medical adviser determined that, in accordance with the fifth edition of the A.M.A., *Guides,*[3] appellant had a 25 percent impairment.[4] He noted that appellant reached maximum medical improvement on September 18, 2003. The

[1] In a statement of accepted facts dated May 23, 2002, it was noted that from 1983 to 1985 appellant operated cleaning tanks and vats and handled toxic substances. From 1985 to 1996 appellant worked as a sandblaster, blasting brake shoes with asbestos pads and blasting gaskets off of parts made with asbestos. Appellant wore a helmet with an air breathing apparatus and respirators. During this time he was exposed to asbestos, acetone, ferrous and non ferrous metals, walnut shell abrasive, glass abrasive, dust, fumes and flying abrasives.

[2] *See* A.M.A., *Guides* 107, Table 5.12 (5th ed. 2001).

[3] A.M.A., *Guides* (5th ed. 2001).

[4] *See id.* at 107, Table 5.12 (5th ed. 2001).

Office medical adviser concurred in Dr. Rajpara's determination that, under the A.M.A., *Guides*, appellant was a Class 2 pulmonary impairment of between 10 to 25 percent.[5] He concluded that appellant had a 25 percent impairment of both lungs, which was the maximum allowed in the range.

In a decision dated November 18, 2003, the Office granted appellant a 25 percent impairment of both lungs for the period November 2, 2003 to April 30, 2005.

By letter dated November 14, 2005, appellant requested an additional schedule award. He submitted records from a hospital admission from February 14 to 19, 2005, which noted that he presented with chest congestion and shortness of breath. Appellant was diagnosed with exacerbation of chronic obstructive pulmonary disease, musculoskeletal chest wall pain, diabetes and hypertension. Also submitted was a pulmonary function report prepared by Dr. Peter M. Jablin, a Board-certified pulmonologist, dated August 19, 2005. It revealed an FEV_1 of 2.24 which was 84 percent of predicted (2.68), a FVC of 3.08 which was 78 percent of predicted (3.93) and a FEV_1/FVC of 73.34 which was 107 percent of predicted (68.28). It was noted that the FVC, FEV_1 and FEV_1/FVC were normal. Dr. Jablin noted that the isolated reduction of FEF (forced expiratory flow) 25-75 percent suggested small airway disease; otherwise it was a normal spirometry. There was no response to the inhaled bronchodilator, and the flow volume loop revealed decreased flows at mid-low lung volumes. Dr. Jablin stated that elevated RV/TLC (residual volume, total lung capacity ratio) suggested air trapping and that diffusing capacity was decreased.

The medical evidence was referred to the Office medical adviser. In a report of that date, the Office medical adviser determined that, in accordance with the A.M.A., *Guides*, appellant still had a 25 percent impairment.[6] He noted that the FEF 25-75 percent was reduced and, according to Table 5-12, page 107 of the A.M.A., *Guides*, the above values were Class 2, with a ratable pulmonary impairment of between 10 to 25 percent.[7] The medical adviser determined that impairment of both lungs was 25 percent, which was the maximum allowed in the range. The date of maximum medical improvement was unchanged at September 18, 2003.

In a decision dated May 19, 2006, the Office denied appellant's claim for an additional schedule award.

LEGAL PRECEDENT

An employee seeking compensation under the Federal Employees' Compensation Act[8] has the burden of establishing the essential elements of his claim by the weight of the reliable,

[5] *See id.*

[6] *Id*.

[7] *See id.*

[8] 5 U.S.C. §§ 8101-8193.

probative and substantial evidence,[9] including that he sustained an injury in the performance of duty as alleged and that his disability, if any, was causally related to the employment injury.[10]

The schedule award provision of the Act[11] and its implementing regulation[12] sets 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, the Act 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 to 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 adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.

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.[13] For classes 2 through 4, the appropriate class of impairment is determined by whether the observed values fall alternatively within identified standards for FVC, FEV_1, DLCO,[14] or maximum oxygen consumption (VO2Max). For each of the FVC, FEV_1 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.[15] For VO2Max, an observed result will be placed within Class 2, 3, or 4 if it falls within a specified range of oxygen volume.[16] A person will fall within Class 1 and be deemed to have no impairment, if the FVC, FEV_1, ratio of FEV_1 to FVC, and DLCO are greater than or equal to the lower limit of normal, or the VO2Max is greater than or equal to a specified oxygen volume.

ANALYSIS

The Office accepted that appellant developed pleural thickening bilaterally and paid appropriate compensation. Appellant received a schedule award for 25 percent impairment for both lungs on November 18, 2003. This schedule award was based on the September 18, 2003, report of Dr. Rajpara, an Office referral physician. Dr. Rajpara reported results of pulmonary

[9] *Donna L. Miller*, 40 ECAB 492, 494 (1989); *Nathaniel Milton*, 37 ECAB 712, 722 (1986).

[10] *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

[11] 5 U.S.C. § 8107.

[12] 20 C.F.R. § 10.404 (1999).

[13] *See* A.M.A., *Guides* 107, Table 5.10 (5th ed. 2001).

[14] This is characterized in the A.M.A., *Guides* as the DLCO test.

[15] 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, FEV_1 and DLCO tests are delineated in separate tables. A.M.A., *Guides* 95-100, Tables 5-2a to 5-7b.

[16] The A.M.A., *Guides* provides alternate means for measuring such volumes.

function testing and opined that appellant had a Class 2 impairment, for which 10 to 25 percent impairment is appropriate. The Office medical adviser concurred with Dr. Rajpara's findings. He opined that appellant had 25 percent impairment.

On appeal, appellant asserts that he is entitled to a schedule award greater than the 25 percent previously awarded. He submitted a pulmonary function report prepared by Dr. Jablin, dated August 19, 2005. It revealed a FEV_1 of 2.24 which was 84 percent of predicted, a FVC of 3.08 which was 78 percent of predicted and a FEV_1/FVC of 73.34 which was 107 percent of predicted. Dr. Jablin noted that the isolated reduction of FEF 25-75 percent suggested a small airway disease; otherwise a normal spirometry. There was no response to the inhaled bronchodilator, and the flow volume loop revealed decreased flows at mid-low lung volumes.

In a December 6, 2005 report, the Office medical adviser applied the A.M.A., *Guides* to the information provided in Dr. Jablin's August 19, 2005 report. He found that the results of the pulmonary function tests placed appellant in Class 2 respiratory impairment. As noted this allows for impairment of 10 to 25 percent.[17] Table 5-12 of the A.M.A., *Guides* indicates that, in finding a Class 2 impairment, the value should be below predicted normal but FVC should be greater than or equal to 60 percent of the lower limit of predicted normal and the FEV_1 greater than or equal to 60 percent of predicted. Appellant's values for these tests as recorded by Dr. Jablin were 78 percent and 84 percent of the lower limit of predicted normal, respectively. The Office medical adviser properly found that appellant's impairment to his lungs remained under Class 2. The reports of the Office medical adviser and Dr. Jablin do not establish greater pulmonary impairment.

The Board finds that the Office medical adviser applied the proper standards to the findings of Dr. Jablin's August 19, 2005 pulmonary function studies. He determined that appellant's studies were within Class 2. As appellant previously received a schedule award for 25 percent impairment for both lungs, he is not entitled to an additional award.[18]

CONCLUSION

The Board finds that appellant has not established that he has more than 25 percent permanent impairment of both lungs, for which he has received a schedule award.

[17] *See* A.M.A., *Guides* 107, Table 5.12 (5th ed. 2001).

[18] Office procedures state that impairment to the lungs should be evaluated in accordance with the A.M.A., *Guides*, insofar as possible, noting that the percentage of "whole man" impairment will be multiplied by 312 weeks (twice the award for loss of function of one lung) to obtain the number of weeks payable; all such awards will be based on the loss of use of both lungs. *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(a)(1) (August 2002).

ORDER

IT IS HEREBY ORDERED THAT the May 19, 2006 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 29, 2006
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

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