United States Department of Labor
Employees' Compensation Appeals Board

F.M., Appellant	)	
and	)	**Docket No. 06-632**
	)	**Issued: May 3, 2007**
DEPARTMENT OF HOUSING & URBAN DEVELOPMENT, Washington, DC, Employer	)	

Appearances:
Richard S. O'Connor, Esq., for the appellant
No appearance, for the Director

Oral Argument March 22, 2007

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On January 23, 2006 appellant, through her attorney, filed a timely appeal from a November 22, 2005 merit decision of a hearing representative of the Office of Workers' Compensation Programs affirming a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award decision.

ISSUE

The issue is whether appellant has more than a 20 percent bilateral lung impairment for which she received a schedule award.

FACTUAL HISTORY

On June 27, 1988 appellant, then a 47-year-old secretary, filed a traumatic injury claim alleging that she sustained laryngitis due to inhaling an irritant on June 13, 1988 in the performance of duty. The Office accepted the claim for acute laryngitis, neurotic depression,

extrinsic asthma, chronic obstructive asthma, unspecified substance and an unspecified disorder of the nervous system. Appellant received compensation for total disability beginning January 1989.

Appellant filed a claim for a schedule award. On February 6, 2004 the Office requested that she submit a medical report from her attending physician addressing the extent of any permanent impairment in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001). On February 13, 2004 the Office referred appellant to Dr. Jeff B. Hales, a Board-certified internist, for a second opinion evaluation.

In a report dated February 26, 2004, Dr. Grace Ziem, appellant's attending physician who specializes in occupational medicine, related that she had not achieved maximum medical improvement. She opined that appellant had a 50 percent impairment due to the results of a November 7, 2003 pulmonary function test, a 25 percent impairment due to asthma, a 15 to 20 percent impairment due to laryngitis and a 35 percent impairment due to a disorder of the nervous system.

In a report dated March 22, 2004, Dr. Hales diagnosed interstitial lung disease, scleroderma and CREST syndrome.[1] Pulmonary function studies performed on that date for Dr. Hales measured appellant's forced vital capacity (FVC) as 2.22 liters or 72 percent of normal before bronchodilator and 2.14 liters or 70 percent of normal after bronchodilator. Her forced expiratory volume in the first second (FEV_1) was 2.00 liters, or 81 percent of normal before bronchodilator and 1.93 liters, or 78 percent of normal after bronchodilator. The ratio of FVC to FEV_1 was 90 liters. Appellant's diffusing capacity for carbon monoxide (D_{CO}) measured 12.7 liters or 53 percent of normal, before bronchodilator. Dr. Hales found that appellant provided good effort on the pulmonary function study. He interpreted the results as showing a "[m]ild to moderate restrictive defect with a moderate decrease in gas exchange." He noted that the D_{CO} diffusing capacity was "normal when corrected for volume" and that she had no "significant improvement after bronchodilators." In his narrative report, Dr. Hales stated:

> "Pulmonary function tests demonstrate no significant obstruction with mild improvement to bronchodilators. She does have mild to moderate restriction as well as significantly diminished gas transfer at 53 percent predicted.
>
> "Chest x-ray reveals an enlarged cardiac shadow with prominent right atrium and right ventricle in addition to subtle interstitial lung markings bilaterally.
>
> "[Appellant] is a 63-year-old female who has underlying interstitial lung disease as well as scleroderma and CREST syndrome. She also has episodic reactivity to her lung disease and has been exposed to inhalational irritants and chemicals during work back in 1988. [She] is possibly developing pulmonary hypertension

[1] CREST syndrome is an acronym for Calcinosis, Raynaud's phenomenon, Esophageal dysfunction, Sclerodactyly and Telangiectasia.

as well related to her underlying connective tissue disease and interstitial lung disease given findings on physical exam[ination] today, *i.e.*, prominent S2 and peripheral edema…."

Dr. Hales indicated that appellant's inhalation exposure could "trigger laryngitis and interstitial lung disease" and possibly scleroderma, all of which had "insidiously progressive underlying lung disease." He found that she may be at maximum medical improvement but noted that she should be evaluated for pulmonary hypertension. Dr. Hales stated: "I believe that [appellant] does have permanent impairment of lung function given the findings of crackles on physical exam[ination] and x-ray findings of interstitial change as well as diminished gas transfer. The current indices are 53 percent. She is also subjectively very dyspneic and unable to perform significant activity." Dr. Hales concluded that based on the pulmonary function studies appellant had a "Class III impairment based on a D_{CO} of 53 percent."

An Office medical adviser reviewed Dr. Hales' report on May 29, 2004. He found that appellant had a Class II impairment based an FVC of 72 percent of normal and an FEV_1 of 81 percent of normal. The Office medical adviser determined that this constituted a 20 percent whole person impairment according to Table 5-12 on pages 107 of the A.M.A., *Guides*. He converted the 20 percent whole person impairment to a 10 percent impairment of each lung. The Office medical adviser opined that appellant reached maximum medical improvement on March 22, 2004. He further noted that her scleroderma was not related to any impairment in lung function.

By decision dated November 1, 2004, the Office granted appellant a schedule award for a 20 percent bilateral lung impairment. The period of the award ran for 31.20 weeks from March 22 to October 26, 2004.

Appellant, through her attorney, requested an oral hearing. At the hearing, held on September 22, 2005, counsel argued that the opinion of Dr. Hales, a pulmonologoist, outweighed the findings of the Office medical adviser, an orthopedist.

By decision dated November 22, 2005, the Office hearing representative affirmed the November 1, 2004 decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing federal regulation,[3] 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, 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 for all

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

claimants, the Office has adopted the A.M.A., (5th ed. 2001) as the uniform standard applicable to all claimants.[4]

Chapter 5 of the fifth edition of the A.M.A., *Guides* provides that permanent impairment of the lungs is determined on the basis of pulmonary function tests, *i.e.*, the FVC and the one second FEV_1, the ratio between FEV_1 and FVC and D_{CO}. The values for predicted and observed normal values for FEV_1, FVC and D_{CO} are found in Tables 5-2a through 5-7b.[5] 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.[6] 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, D_{CO} or maximum oxygen consumption (VO2Max). For each of the FVC, FEV_1 and D_{CO} 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.[7] For example, a person is within a Class 2 impairment, equaling 10 to 25 percent impairment of the whole person, if the FVC, FEV_1 or D_{CO} is above 60 percent of the predicted value and less than the lower limit of normal.[8] 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.[9]

As explained in the Office's procedure manual, 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.[10]

ANALYSIS

The Office accepted that appellant sustained acute laryngitis, neurotic depression, extrinsic asthma, chronic obstructive asthma and an unspecified disorder of the nervous system due to a June 13, 1988 employment injury. Appellant filed a claim for a schedule award. In a report dated February 26, 2004, Dr. Ziem opined that she had a 50 percent impairment due to the results of a November 7, 2003 pulmonary function studies, a 25 percent impairment due to asthma, a 15 to 20 percent impairment due to laryngitis and a 35 percent impairment due to an

[4] *Id*. at § 10.404(a).

[5] A.M.A., *Guides* at 95-100. The pulmonary function tables are based on gender, age and height.

[6] *Id*. at 107, Table 5-12.

[7] The predicted normal values and the predicted lower limits of normal values for the FVC, FEV_1 and D_{CO} tests are delineated in Tables 5-2a through 5-7b.

[8] A.M.A., *Guides* 107, Table 5-12.

[9] *Id*. at 107.

[10] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.4(c)(1) (March 2005).

unspecified disorder of the nervous system. She did not explain how she calculated appellant's impairment due to asthma and laryngitis under the A.M.A., *Guides*. Additionally, disorders of the nervous system are not covered members for purposes of a schedule award under the Act.[11] Consequently, Dr. Ziem's opinion is insufficient to establish the extent of appellant's permanent impairment.

The Office referred appellant to Dr. Hales for a second opinion evaluation. In a report dated March 22, 2004, Dr. Hales diagnosed interstitial lung disease, scleroderma and CREST syndrome. He found that appellant had a permanent impairment in her lung function given the physical examination findings of crackles, x-ray findings of interstitial disease and decreased gas transfer. Dr. Hales interpreted a March 22, 2004 pulmonary function study as showing "significantly diminished gas transfer at 53 percent predicted." He concluded that appellant had a Class III impairment due to D_{CO} values of 53 percent.

On May 29, 2004 an Office medical adviser reviewed Dr. Hales' March 22, 2004 report. He opined that appellant had a Class II impairment as the pulmonary function test showed a FVC of 72 percent of normal and an FEV_1 of 81 percent of normal. The Office medical adviser found that this constituted a Class II impairment according to Table 5-12 on pages 107 of the A.M.A., *Guides*.[12] Table 5-12 provides a range from a 10 to 25 percent whole person impairment for individuals with a Class II respiratory disorder. The Office medical adviser determined that appellant had a 20 percent whole person impairment. The Board notes, however, that the A.M.A., *Guides* states that "[a]t least one of the listed criteria [in Table 5-12] must be fulfilled to place an individual in any class with an impairment rating."[13] The criteria for a Class III impairment under Table 5-12 is a FVC of between 51 to 59 percent of predicted or an FEV_1 of 41 to 59 percent of predicted or D_{CO} values of less than 59 percent of predicted.[14] Appellant's D_{CO} is 53 percent of predicted normal, which satisfies one of the listed criteria for a Class III impairment.[15] The Office medical adviser provided no explanation for his finding that appellant had a Class II impairment given that her D_{CO} value of 53 percent indicated that she had a Class III impairment.[16]

[11] *See* 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[12] The Board notes that the Office medical adviser utilized the FVC and FEV_1 results before bronchodilator without providing any explanation. The A.M.A., *Guides* on page 93 provides that the spirogram which indicates the best effort should be used. In this case, the post bronchodilator values for FVC and FEV_1 also constitute a Class II impairment according to Table 5-12 on page 107.

[13] A.M.A., *Guides* at 107.

[14] *Id*.

[15] *See supra* note 6.

[16] It is unclear whether either Dr. Hales or the Office medical adviser adjusted the spirometric values based on appellant's race. The A.M.A., *Guides* notes that the spirometric values for North American whites are greater than for North American blacks and recommends multiplying predicted normal values for FVC, FEV_1 and D_{CO} values by 0.88, 0.88 and 0.93, respectively. *Id*. at 94.

Accordingly, the case will be remanded for the Office to obtain clarification from the Office medical adviser regarding the extent of appellant's pulmonary impairment. After such further development as deemed necessary, the Office shall issue a *de novo* decision.

CONCLUSION

The Board finds that the case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs' hearing representative dated November 22, 2005 is set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: May 3, 2007
Washington, DC

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

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

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