U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of NOE L. FLORES and DEPARTMENT OF THE ARMY, CORPUS CHRISTI ARMY DEPOT, Corpus Christi, Tex.

Docket No. 95-1755; Submitted on the Record;
Issued February 20, 1998

DECISION and ORDER

Before WILLIE T.C. THOMAS, BRADLEY T. KNOTT, A. PETER KANJORSKI

The issue is whether appellant sustained greater than a 25 percent permanent impairment of both lungs for which he received a schedule award.

On September 8, 1987 appellant, then a 55-year-old aircraft mechanic, filed a claim alleging that he sustained asbestosis. By decision dated November 1, 1988, the Office of Workers' Compensation Programs accepted appellant's claim for asbestosis.

On May 29, 1991 appellant submitted a claim for a schedule award.

By letter dated December 15, 1992, the Office referred appellant to Dr. Douglas W. Jenkins, a Board-certified internist specializing in pulmonary diseases, for an evaluation as to the degree of permanent impairment caused by his employment-related pulmonary condition.

In a report dated January 11, 1993, Dr. Jenkins provided a history of appellant's condition and findings on examination. He stated that he did not have available a copy of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*) but he estimated appellant's pulmonary impairment at 80 percent. He provided copies of results of pulmonary function testing. The tests noted that appellant was a 60-year-old hispanic male with a height of 168 centimeters and revealed: forced vital capacity (FVC), predicted 3.58 liters, appellant's best, 2.06, which was 58 percent of predicted; forced expiratory volume in one second (FEV-1), predicted 2.88 liters, appellant's best, 1.59, which was 55 percent of predicted; his FEV-1/FVC ratio of .77; and diffusing capacity of carbon monoxide (DCO), predicted 25.7, appellant's average, 10.5; DCO/VA, predicted 3.84, appellant's average, 3.96. He noted that the tests showed moderate restrictive change and minimal obstructive change and reduced diffusing capacity but in proportion to reduced lung volume.

In a memorandum dated February 9, 1993, Dr. R. Meador, an Office medical adviser and a Board-certified internist specializing in pulmonary diseases, stated that he had reviewed the

medical evidence of record and had determined that appellant had a 25 percent permanent impairment of each lung according to page 125 of the A.M.A., *Guides*, (3d ed., rev. 1990) based on the report of Dr. Jenkins. Dr. Meador stated:

> "From page 125, Table 8, the FVC and FEV-1 fall into Class 3 (30 to 45 percent) while the FEV-1/FVC ratio falls into Class 1 (0 [percent]). The [DCO] is 41 percent of predicted, and this is Class 3; however, the proportionate reduction in lung volumes indicates that the diffusion capacity [DCO] is due to the reduced lung volumes rather than to any change in the lung *per se*. My interpretation of the [DCO]/VA is that the reduced lung volumes are the explanation for the reduced [DCO]; hence, this should not be a consideration in the impairment award. It is logical to attribute the reduced lung volumes to the changes accompanying obesity.
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> "To summarize, there are two factors that place [appellant] in Class 3, and one that indicates he is in Class 1. In view of that, I believe that a figure of 25 percent lung impairment is a reasonable figure.
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> "The date of MMI [maximum medical improvement] is the date of the examination by Dr. Jenkins, January 11, 1993."

By decision dated March 24, 1993, the Office granted appellant a schedule award based on 39 weeks for a 25 percent permanent impairment of both lungs.

In a corrected award dated March 22, 1994, the Office granted appellant an award based on 78 weeks of compensation.

By letter dated July 15, 1994, appellant requested reconsideration of the schedule award decision.

Appellant submitted an April 22, 1992 report of Dr. Gary K. Friedman, Board-certified in both internal and preventive medicine, who stated that chest x-rays of appellant were compatible with asbestos-related pleural disease. He did not provide an opinion as to the degree of appellant's permanent impairment.

By decision dated July 27, 1994, the Office denied appellant's request for further merit review of his claim.

By letter dated August 3, 1994, appellant requested reconsideration of the schedule award decision and submitted copies of medical reports relating to medical conditions other than his employment injury, asbestosis.

By decision dated September 26, 1994, the Office denied appellant's request for further merit review.

By letter dated October 23, 1994, appellant requested reconsideration of a schedule award decision. He provided no new evidence but gave his own opinion that he had a 50 percent permanent impairment of each lung.

By decision dated November 15, 1994, the Office denied appellant's request for further merit review of his claim.

By letter dated January 10, 1995, submitted through his representative, appellant requested reconsideration of the schedule award decision and submitted additional evidence including medical evidence already of record. Appellant also submitted pages from the "Advocacy Manual: FECA Claims" relating generally to the computation of schedule awards.

By decision dated January 13, 1995, the Office denied appellant's request for further merit review of the schedule award decision.[1]

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

An employee seeking compensation under the Federal Employees' Compensation Act has the burden of establishing the essential elements of his claim by the weight of the reliable, probative, and substantial evidence,[2] 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.[3]

Under section 8107 of the Act and section 10.304 of the implementing federal regulations,[4] schedule awards are payable for permanent impairment of specified body members, functions, or organs.[5] However, neither the Act nor the regulations specify the manner in which the percentage of impairment for a schedule award 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 evaluating schedule losses and the Board has concurred in such adoption.[6]

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[1] On March 20, 1995 appellant filed the current appeal with the Board. The appeal was dismissed by the Board on August 7, 1995 because appellant indicated that he wished to pursue a reconsideration request with the Office. By decision dated November 22, 1995, the Board reinstated that appeal at appellant's request. A decision by the Office dated December 13, 1995, is therefore null and void as the Office and the Board may not have simultaneous jurisdiction over the same issue in the same case. *Douglas E. Billings*, 41 ECAB 880 (1990). Following the docketing of an appeal with the Board, the Office does not retain jurisdiction to render a further decision regarding a case on appeal until after the Board relinquishes its jurisdiction. Any decision rendered by the Office on the same issues for which an appeal is filed are null and void. *Jimmy W. Galetka*, 43 ECAB 432, 433-44 (1992).

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

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

[4] 20 C.F.R. § 10.304.

[5] 5 U.S.C. § 8107(a).

[6] *James Kennedy, Jr.*, 40 ECAB 620, 626 (1989); *Charles Dionne*, 38 ECAB 306, 308 (1986).

Before the A.M.A., *Guides* may be utilized, however, a description of appellant's impairment must be obtained from appellant's attending physician. The Federal (FECA) Procedure Manual provides that, in obtaining medical evidence required for a schedule award, the evaluation made by the attending physician must include a "detailed description of the impairment which includes, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation, or other pertinent description of the impairment."[7] This description must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its restrictions and limitations.[8]

With regard to respiratory or pulmonary impairment, 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. The appropriate class of impairment is determined by the observed values for either the FVC, FEV-1 or DCO measures by their respective predicted values. If one of the three ventilatory function measures, FVC, FEV-1, or DCO or the ratio of FEV-1 to FVC, stated in terms of the observed values, is abnormal to the degree described in Classes 2 to 4, then the individual is deemed to have an impairment which would fall into that particular class of impairments, either Class 2, 3 or 4, depending on the severity of the observed value.[9]

Under Class 1, the individual is deemed to have no impairment if the FVC, FEV-1, and DCO observed values are greater than or equal to 80 percent of their respective predicted values and the ratio, FEV-1/FVC, is greater than or equal to 70 percent of the predicted ratio. Under Class 2, the individual is deemed to have mild impairment (10 to 25 percent of the whole person) if the FVC, FEV-1, or DCO observed is between 60 and 79 percent of its predicted value or the ratio, FEV-1/FVC, is between 60 and 69 percent of the predicted value.[10]

Under Class 3, the individual is deemed to have moderate impairment (30 to 45 percent of the whole person) if the FVC observed value is between 51 and 59 percent of its predicted value or the FEV-1 or DCO observed value is between 41 and 59 percent of its respective predicted value or the FEV-1/FVC ratio is between 41 and 59 percent of the predicted ratio. Under Class 4, the individual is deemed to have severe impairment (50 to 100 percent of the whole person) if the FVC observed value is less than or equal to 50 percent of its predicted value or the FEV-1 or DCO observed value is less than or equal to 40 percent of its respective predicted value or the FEV-1/FVC ratio is less than or equal to 40 percent of the predicted ratio.[11]

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[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6(c) (March 1995); *see John H. Smith*, 41 ECAB 444, 448 (1990).

[8] *Alvin C. Lewis*, 36 ECAB 595, 596 (1985).

[9] A.M.A., *Guides*, 125, Table 8.

[10] *Id.*

[11] *Id.*

In this case, in a report dated January 11, 1993, Dr. Jenkins, an Office referral physician and Board-certified specialist in pulmonary diseases, provided findings on examination and the results of pulmonary function testing but he did not provide an opinion of appellant's permanent impairment based upon the A.M.A., *Guides*.

Dr. Meador, an Office medical adviser and Board-certified internist specializing in pulmonary diseases, applied the results of pulmonary tests contained in Dr. Jenkins' report and determined that appellant had a 25 percent permanent impairment of both lungs. Dr. Meador stated:

> "From page 125, Table 8, the FVC and FEV-1 fall into Class 3 (30 to 45 percent) [of the whole person] while the FEV-1/FVC ratio falls into Class 1 (0 percent). The [DCO] is 41 percent of predicted, and this is Class 3; however, the proportionate reduction in lung volumes indicates that the diffusion capacity [DCO] is due to the reduced lung volumes rather than to any change in the lung *per se*. My interpretation of the [DCO]/VA is that the reduced lung volumes are the explanation for the reduced [DCO]; hence, this should not be a consideration in the impairment award. It is logical to attribute the reduced lung volumes to the changes accompanying obesity.
>
> "To summarize, there are two factors that place [appellant] in Class 3, and one that indicates he is in Class 1. In view of that, I believe that a figure of 25 percent lung impairment is a reasonable figure."

The A.M.A., *Guides* (3d ed., rev. 1990) provides at page 121:

> "The interpretations of the FVC, FEV1, FEV1/FVC ratio and DCO are given in Table 8. Results for all four measures of lung function must be in the normal range for a person to be considered not impaired according to physiologic parameters. At least one of these measures should be abnormal to the degree described in a given class definition if an impairment is to be rated in that class."

In this case, appellant's FVC and FEV1 were, respectively, 58 percent and 55 percent of predicted which places them in Class 3 according to Table 8 at page 125 of the A.M.A., *Guides*. His FEV1/FVC ratio of 77 percent is classified as Class 1 according to Table 8. Dr. Meador opined that appellant had a 25 percent permanent impairment. However, according to Table 8, a 25 percent impairment is Class 2 and none of appellant's impairments is rated as Class 2. Therefore, there is no basis consistent with the A.M.A., *Guides* for Dr. Meador's determination that appellant had a 25 percent permanent impairment.

As there is no medical report of record which conforms with the A.M.A., *Guides*, this case must be remanded for further development of the medical evidence. On remand, this case should be referred to an appropriate medical specialist or to a different Office medical adviser for an evaluation of appellant's permanent impairment which is consistent with the evaluation procedures of the A.M.A., *Guides*.

The decisions of the Office of Workers' Compensation Programs dated January 13, 1995 and November 15, September 26 and July 27, 1994 are set aside and the case is remanded for further action consistent with this decision of the Board.

Dated, Washington, D.C.
February 20, 1998

Willie T.C. Thomas
Alternate Member

Bradley T. Knott
Alternate Member

A. Peter Kanjorski
Alternate Member