

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of MICHAEL C. LEYVA and DEPARTMENT OF THE NAVY,
NAVAL AIR STATION, Jacksonville, FL

*Docket No. 00-425; Submitted on the Record;
Issued February 6, 2001*

DECISION and ORDER

Before MICHAEL J. WALSH, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issue is whether appellant established that he sustained greater than an 18 percent lung impairment for which he received a schedule award.

On April 4, 1999 appellant, then a 50-year-old air conditioning sheet metal journeyman, filed an occupational disease claim (Form CA-2a) alleging that he sustained upper respiratory and lung conditions causally related to factors of his federal employment. The Office of Workers' Compensation Programs accepted his claim for chronic obstructive pulmonary disease. Appellant did not stop work.

On July 15, 1999 appellant filed a claim for a schedule award. In support of his claim, appellant submitted a May 9, 1995 amended x-ray report in which Dr. Carl H. Weidenmier, Board-certified in nuclear medicine and radiology, and Dr. Grady R. Hartzog, Board-certified in diagnostic radiology, diagnosed a normal study.

Appellant also submitted a January 20, 1999 report in which Dr. Richard A. Reid, Board-certified in internal medicine and pulmonary disease, noted appellant's complaints, medical history and his examination findings. In progress notes dated January 20 and February 4, 1999, Dr. Reid stated that pulmonary function tests suggested a mild obstructive ventilatory defect. In his February 4, 1999 note, he noted significant worsening since appellant's previous pulmonary function test. In a second note dated February 4, 1999, Dr. Reid noted appellant's complaints and opined that his decreased pulmonary function may have resulted from an error in technique.

Appellant submitted a January 21, 1999 chest x-ray report in which Dr. Timothy Daniel, Board-certified in diagnostic, vascular and interventional radiology, diagnosed left base subsegmental atelectasis versus scar and overinflated lungs suggesting emphysema. In his February 5, 1999 x-ray report, Dr. Kurt Mori, Board-certified in diagnostic, vascular and interventional radiology, diagnosed a normal chest study.

Appellant submitted pulmonary function tests dated June 21, 1995 to February 5, 1999. His January 20, 1999 pulmonary function test demonstrated prebronchodialater values of 102 percent of predicted forced vital capacity (FVC), 79 percent of predicted forced expiratory volume in one second (FEV₁), an actual FEV₁/FVC ratio of 61 and 95 percent of predicted diffusing capacity of carbon monoxide (DCO). Appellant's post bronchodialater values indicated an FVC of 107 percent of predicted and FEV₁ of 89 percent of predicted and a ratio of 65 percent. His February 4, 1999 pulmonary function test showed 94 percent of predicted FVC, 72 percent of predicted FEV₁ and an actual FEV₁/FVC ratio of 60 percent.

Appellant also submitted a brief report dated May 18, 1999 in which Dr. Richard Krygowski, an osteopath, noted appellant's symptoms, diagnostic test results and treatment. Dr. Krygowski stated: "It is my opinion that [appellant's] respiratory symptoms are a result of his occupation."

By memorandum dated July 22, 1999, the Office requested that the Office medical adviser render an opinion on whether appellant sustained permanent impairment of the lungs resulting from chronic obstructive pulmonary disease.

In his report dated July 26, 1999, Dr. George E. Anderson, an Office medical adviser Board-certified in obstetrics and gynecology, applied Table 8, page 162 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed. 1995) to appellant's January 20, 1999 pulmonary function test. The Office medical adviser noted that appellant had an FVC of 102 percent of predicted and FEV₁ of 79 percent, an FEV₁/FVC ratio of 61 percent and a DCO of 95 percent of predicted, and concluded that the test represented a class 2 impairment under the A.M.A., *Guides*. Dr. Anderson averaged 10 percent and 25 percent, the range of impairment represented by appellant's January 20, 1999 pulmonary test, to find an 18 percent impairment and found that he reached maximum medical improvement on that date.

By decision dated July 30, 1999, the Office granted appellant a schedule award for an 18 percent lung impairment for the period from January 20, 1999 to February 17, 2000 for a total of 56.16 weeks of compensation.

The Board finds that appellant's lung impairment is not greater than 18 percent.

The schedule award provision of the Federal Employees' Compensation Act¹ and its implementing regulation² set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of specified 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

¹ 5 U.S.C. § 8107(c).

² 20 C.F.R. § 10.404 (1999).

Office and the Board has concurred in such adoption, as an appropriate standard for evaluating scheduled losses.³

The period covered by a schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of the injury.⁴ Thus, an employee is not eligible to receive a schedule award until he has reached maximum medical improvement. Maximum medical improvement means that the physical condition of the injured member of the body has stabilized and will not improve further.⁵ The question of when maximum medical improvement has been reached is a factual one depending upon the medical findings in the record.⁶

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, FEV₁ or DCO measures by their respective predicted values. If one of the three ventilatory function measures, FVC, FEV₁, DCO or the ratio of FEV₁ to FVC, stated in terms of observed values, is abnormal to the degree described in classes two to four, then the individual is deemed to have an impairment which would fall into that particular class of impairments, either class two, three or four, depending upon the severity of the observed value.⁷

Under class 1, the individual is deemed to have no impairment if the FVC, FEV₁ and DCO observed values are greater than or equal to 80 percent of their respective predicted values and the FEV₁/FVC ratio is greater than or equal to 70 percent of the respective ratio. Under class 2, the individual is deemed to have a mild impairment of 10 to 25 percent if the FVC, FEV₁ or DCO observed value is between 60 and 79 percent of its respective predicted value or the FEV₁/FVC ratio is between 60 and 69 percent of the predicted value.⁸ Under Class 3, the individual is deemed to have a moderate impairment of 30 to 45 percent if the FVC observed value is between 51 and 59 percent of its predicted value or the FEV₁ or DCO observed value is between 41 and 59 percent of its respective predicted value or the FEV₁/FVC ratio is between 41 and 59 percent of the predicted ratio. Under class 4, the individual is deemed to have severe impairment of 50 to 100 percent if the FVC observed value is less than or equal to 50 percent of its predicted value or the FEV₁ or DCO observed value is less than or equal to 40 percent of its respective predicted value or the FEV₁/FVC ratio is less than or equal to 40 percent of the predicted ratio.⁹

³ *Thomas P. Gauthier*, 34 ECAB 1060, 1063 (1983).

⁴ *Eugenia L. Smith*, 41 ECAB 409, 413 (1990); *Yolanda Librera*, 37 ECAB 388 (1986).

⁵ *Joseph R. Waples*, 44 ECAB 936, 940 (1993); *Marie J. Born*, 27 ECAB 623, 629 (1976).

⁶ *Id.*

⁷ A.M.A., *Guides* at 162, Table 8.

⁸ *Id.*

⁹ *Id.*

Under the Office's implementing regulation, the total loss of use of both lungs entitles an employee to 312 weeks of compensation.¹⁰ Multiplying an employee's percentage of lung impairment by 312 will produce the number of weeks for which he is entitled to receive a schedule award.

The Board finds that the February 4, 1999 reports submitted by Dr. Reid are of diminished probative value as his report did not conform with the protocols of the A.M.A., *Guides*.

In the instant case, Dr. Reid furnished a January 20, 1999 pulmonary function test which revealed a prebronchodilator FEV₁ of 79 percent of predicted and post bronchodilator of 89 percent of predicted.¹¹ According to the A.M.A., *Guides*, the FEV₁ percentage comparisons for that test correspond to a Class 2, mild respiratory impairment (10 to 25 percent) of the whole person. Since Dr. Reid did not provide an impairment rating in accordance with the A.M.A., *Guides*, the Office medical adviser reviewed the results of the January 20, 1999 pulmonary function test in conjunction with Table 8, page 162 of the 4th edition of the A.M.A., *Guides* and concluded that appellant had an 18 percent respiratory impairment of each lung. The record contains no probative medical evidence to indicate that appellant sustained an impairment of greater than the 18 percent awarded. The Board, therefore, concurs with the Office's finding that appellant has an 18 percent impairment of both lungs.

The July 30, 1999 decision of the Office of Workers' Compensation Programs is hereby affirmed.

Dated, Washington, DC
February 6, 2001

Michael J. Walsh
Chairman

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member

¹⁰ 20 C.F.R. § 10.404(a) (1999).

¹¹ The Board notes that these values correspond with those found in Table 4, page 158 of the A.M.A., *Guides* for a male 50 years old with a height of 185 centimeters, appellant's age and height.