United States Department of Labor
Employees' Compensation Appeals Board

HARRY J. DILLON, Appellant	)	
and	)	**Docket No. 04-1034**
	)	**Issued: May 12, 2005**
DEPARTMENT OF THE NAVY, SEA SYSTEMS COMMAND, Vallejo, CA, Employer	)	

Appearances:
Harry J. Dillon, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chairman
WILLIE T.C. THOMAS, Alternate Member
MICHAEL E. GROOM, Alternate Member

JURISDICTION

On March 8, 2004 appellant filed an appeal of a February 25, 2004 decision of the Office of Workers' Compensation Programs, which denied his claim for a schedule award for impairment of his lungs. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award issue.

ISSUE

The issue is whether appellant is entitled to a schedule award for permanent bilateral impairment to his lungs.

FACTUAL HISTORY

This is appellant's third appeal to the Board. In a February 25, 1998 decision, the Board remanded that case for further development, finding that the Office had not reviewed all the medical evidence of record prior to rejecting his claim for asbestos-related disease.[1] In a

[1] Docket No. 96-1270 (issued February 25, 1998). The Office accepted that appellant was exposed to asbestos during his 21 years as a pipefitter at the employing establishment.

May 22, 2000 decision, the Board found a conflict in medical opinion on the issue of whether appellant had any asbestos-related pulmonary condition.[2] The facts of the case, as set forth in the previous Board decisions, are incorporated by reference.

On remand appellant was referred to Dr. Ahsam Qazi, a Board-certified pulmonary specialist selected as the impartial medical examiner, who found that he had pleural plaques related to asbestos exposure during his federal employment. The Office accepted that appellant sustained pulmonary asbestosis with pleural plagues and authorized medical monitoring of his condition.

On December 23, 2000 appellant filed a Form CA-7 claim for a schedule award due to his accepted condition.

The Office prepared a statement of accepted facts and on October 30 2001 referred appellant to Dr. Martin Schlusselberg, a Board-certified pulmonary specialist, for examination and opinion on the issue of permanent impairment due to his accepted condition.[3] In a November 11, 2001 report, Dr. Schlusselberg reviewed appellant's factual and medical history and diagnosed pulmonary asbestosis with pleural plaques. He noted that pulmonary function studies were obtained and that the diffusion capacity for carbon monoxide (DCO) was 24.3 or 90 percent of the predicted value. Dr. Schlusselberg obtained spirometric testing in his office which revealed forced vital capacity (FVC) of 3.55, or 64 percent of the predicted value; forced expiratory volume in the first second (FEV_1) of 2.96, or 67 percent of the predicted value. He rated appellant as having Class 2 (10 to 25 percent) impairment based on his FVC and FEV_1 measurements.

The medical record was referred to Dr. Charles C. McDonald, a Board-certified internist specializing in pulmonary medicine and Office medical consultant. In a January 2, 2002 report, Dr. McDonald concluded that the case was not in posture for decision on appellant's entitlement to a schedule award. He noted that the report of Dr. Schlusselberg was deficient as the physician did not state whether lung volumes were performed and that the diagnostic tests performed were incomplete. Dr. McDonald recommended that the Office obtain further medical records of diagnostic testing and the computerized tomography (CT) scan of the lungs obtained by Dr. Qazi, the impartial medical specialist.

The October 6, 2000 CT scan of appellant's chest obtained for Dr. Qazi was submitted to the record. It reported findings of two thin pleural plaques without calcification that could be related to previous asbestos exposure, but with no significant mediastinal or lung abnormality found.

The Office requested that Dr. Schlusselberg clarify his medical opinion. In a February 13, 2002 report, he restated his findings on examination of appellant and noted that a repeat set of spirometry studies was obtained in his office. Dr. Schlusselberg indicated that post-

[2] Docket No. 98-2008 (issued May 22, 2000).

[3] The record reflects that Dr. Qazi did not respond to the Office's inquiries pertaining to any permanent impairment.

medication testing was obtained which was within normal limits. He noted that his diagnosis was based on the statement of accepted facts. By addendum report dated April 3, 2002, Dr. Schlusselberg reviewed appellant's pulmonary testing results and found that FVC, FEV_1 and FEV_1/FVC were normal. He indicated, however, that the DCO was 51 percent of the predicted value.

On May 29, 2002 Dr. McDonald noted that appellant did not have any demonstrated interstitial fibrosis related to his asbestos exposure, but did have two small pleural plaques for which there were no functional sequelae. He opined that the degree of respiratory impairment secondary to asbestos-related disease was zero percent.

By decision dated June 20, 2002, the Office denied appellant's claim for a schedule award, finding that the medical evidence did not establish that he had any impairment due to his accepted condition.

Appellant requested an oral hearing before an Office hearing representative, which was held on January 30, 2003.

By decision dated April 25, 2003, the Office hearing representative remanded the case for further medical development. He directed that the Office obtain further elaboration of Dr. Schlusselberg's opinion regarding the performance of several requested pulmonary tests.

By report dated July 1, 2003, Dr. Schlusselberg discussed his prior examination and pulmonary testing of appellant, noting that his interpretation was that appellant had mild restrictive lung disease. He noted that post-medication spirometry testing showed FVC of 84 percent of predicted and FEV_1 was 80 percent of the predicted value. Dr. Schlusselberg stated that the FEV_1/FVC ratio was supra-normal which was consistent with restrictive lung disease. He indicated that the date of maximum medical improvement was February 13, 2002. Regarding the extent of pulmonary impairment, Dr. Schlusselberg stated that he applied Table 5-12 of the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[4] to rate appellant as Class 3 (26 to 50 percent) impairment due to the DCO which was 51 percent of the normal predicted value.

In a September 13, 2003 report, Dr. McDonald noted that pulmonary function testing of March 7, 2002 had revealed FVC and FEV_1 measurements well within normal limits and that the lung volumes were also normal at 95 percent, but that diffusion capacity was 17.75 or 51 percent of the predicted value of 35.03. Dr. McDonald reviewed the reports of Dr. Schlusselberg, which rated appellant's impairment as Class 3 based on the diffusing capacity testing. He noted, however, that the set of evaluations from Dr. Schlusselberg were confusing as more than two diffusing capacity measurements had been reported which varied significantly and that Dr. Schlusselberg was apparently relying on test results of March 7, 2002. Dr. McDonald opined that the pulmonary tests reported by Dr. Schlusselberg did not show any restrictive disease. He recommended that a CT scan be obtained of the chest with high resolution images to determine whether interstitial fibrosis was in fact present.

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

On October 7, 2003 the Office determined that Dr. Schlusselberg's evaluation was equivocal and that referral to another second opinion specialist was appropriate to determine the extent of any permanent impairment. On October 23, 2003 the Office referred appellant to Dr. James Pearle, a Board-certified internist specializing in pulmonary disease, for a pulmonary evaluation as to the extent of permanent impairment.

By report dated November 17, 2003, Dr. Pearle reviewed appellant's factual and medical history. He listed his clinical symptomatology of mild dyspnea on exertion over the preceding 10 to 15 years without wheezing, significant cough, sputum production, orthopnea, paroxysmal nocturnal dyspnea or chest pain. He noted that appellant felt that his dyspnea had become minimally worse. Dr. Pearle noted that appellant's lungs were clear to percussion and auscultation without wheezes, rhonchi, rales or rubs and with breath sounds slightly decreased. He stated that a 1993 chest x-ray revealed a very slight increase in interstitial pattern of regular interstitial opacities and a small amount of pleural abnormalities and that pulmonary function studies on March 5, 1993 revealed normal FVC, FEV_1 And FEV_1 divided by FVC ratio and diffusing capacity. Dr. Pearle noted that an October 20, 1994 CT scan described an ill-defined right lung base findings and pleural abnormalities and that a 1998 chest x-ray revealed pleural thickening on the right with focal mass at the left lower lobe. He reviewed the CT scan of 2000 which described a two centimeter pleural plaque with no significant mediastinal or lung abnormalities. Dr. Pearle stated that pulmonary function studies obtained in 2002 revealed a normal FVC and FEV_1 with mild reduction in FEV_1/FVC ratio and moderate reduction in diffusing capacity.

Dr. Pearle diagnosed mild chronic bronchitis and emphysema related to appellant's history of cigarette smoking and pleural plaques likely related to his accepted asbestos exposure. However, he concluded that appellant's pleural plaques were minimal and had no functional or clinical significance and were not premalignant. Dr. Pearle remarked that appellant's plural findings should not be considered as "asbestosis," which was defined as interstitial fibrosis of the lung secondary to asbestos exposure. He noted that the features required for the diagnosis of asbestosis were a reduction in vital capacity, reduction in diffusing capacity, evidence of interstitial fibrosis on chest x-ray or CT scan and rales on physical examination. Dr. Pearle stated that appellant had a normal vital capacity on pulmonary function testing, no rales on physical examination and no interstitial fibrosis on the most recent chest x-rays and computerized axial tomography (CAT) scan. He noted the reduction in diffusion capacity on testing in 2002, which was 51 percent of the predicted value, and stated that appellant had mild chronic bronchitis and emphysema probably related to cigarette smoking. The asbestos-related pleural plaques were likely related to his asbestos exposure but of no functional or clinical significance. Dr. Pearle rated appellant as having Class 3 (26 to 50 percent) impairment based on the reduction of diffusing capacity.

In a report dated January 6, 2004, Dr. McDonald reviewed Dr. Pearle's findings and stated that appellant had no permanent impairment of his lungs. Appellant was found to have clear lung fields and insufficient evidence of interstitial fibrosis, but did have some pulmonary disability due to smoking-related airways obstruction and probably emphysema. Dr. McDonald indicated that his complaints of dyspnea on exertion were likely related to chronic bronchitis and emphysema related to cigarette smoking and was not a typical feature of asbestos-related disease.

He indicated that appellant's asbestos-related pulmonary impairment was zero percent. Dr. McDonald identified the date of appellant's maximum medical improvement was November 17, 2003 the date of Dr. Pearle's examination.

By decision dated February 25, 2004, the Office denied appellant's claim for a schedule award, finding that the reports of Dr. Pearle and Dr. McDonald constituted the weight of the medical evidence and established that appellant had no ratable pulmonary impairment due to his accepted condition.

LEGAL PRECEDENT

Under section 8107 of the Federal Employees' Compensation Act[5] and section 10.404 of the implementing federal regulations,[6] schedule awards are payable for permanent impairment of specified body members, functions or organs. However, neither the Act nor the regulations 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, the Office has adopted the A.M.A., *Guides*, as the appropriate standard for determining the percentage of impairment and the Board has concurred in such adoption.[7] Since February 1, 2001 Office procedures direct the use of the fifth edition of the A.M.A., *Guides* for rating permanent impairment.[8]

Section 8107(c)(22) of the Act provides for payment of compensation for permanent loss or loss of use, of any important external or internal organ of the body as determined by the Secretary of Labor.[9] On April 1, 1987 the Secretary of Labor added the lungs as organs to the compensation schedule.[10]

With regard to respiratory or pulmonary impairments, the A.M.A., *Guides* provides a table listing the criteria for estimating the permanent impairment using pulmonary function and exercise test results. Table 15-12, page 107, lists 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, DCO measures or maximum oxygen consumption (VO2MAX). For each of the observed results obtained, a classification of impairment may be made if it falls within a

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *See Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

[8] *See Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

[9] 5 U.S.C. § 8107(c)(22).

[10] *See* 20 C.F.R. § 10.404(a).

specified percentage of the predicted value for the individual tested.[11] If one of the ventilatory function measures stated in terms of the observed values is abnormal to the degree described in Classes 2 to 4, the individual is deemed to have impairment which would fall into that particular class, depending on the severity of the observed value. The individual will be within Class 1 and deemed to have no impairment if the observed value is greater than or equal to the lower limit of normal for the specific pulmonary function measure.

ANALYSIS

The Office accepted that appellant sustained pleural plaques secondary to asbestos exposure in his federal employment. The issue on appeal is whether he sustained any pulmonary impairment due to his accepted condition.

Dr. Schlusselberg provided several medical reports pertaining to his examination of appellant. On November 11, 2001 he noted findings on spirometric testing and rated appellant's impairment as Class 2 for the FVC and FEV_1 measures. However, Dr. Schlusselberg did not report that he obtained any postbronchodilator spirometric testing, as is required under the protocols of the A.M.A., *Guides*. This report did not specifically list appellant's height, a measurement required under the various tables of Chapter 15 for determining the predicted normal values and lower limits of normal values. Dr. Schlusselberg noted that the DCO was obtained at Corona Regional Medical Center, but did not list any specifics as to the testing measures obtained and merely noted that the result was 90 percent of the predicted value. His February 12, 2002 report indicated that postbronchodilator medical spirometry results were obtained, showing improvement to the premedication testing. Dr. Schlusselberg did not specifically list appellant's height or discuss how he applied any of the specific tables of Chapter 15. He noted that he did not have all of appellant's records to review and that additional testing would be conducted. In an April 3, 2002 report, the physician listed the results of pulmonary function measures but did not provide information as to appellant's height. Dr. Schlusselberg indicated that the FVC, FEV_1 and FEV_1/FVC were now normal but did not list any comparison of specific pre- or postbronchodilator testing measurements. The specific date of the examination results upon which he relied was not listed. He indicated that the DCO was now 51 percent of the predicted value but the report did not provide any final impairment classification. These reports of Dr. Schlusselberg are of diminished probative value in determining the extent of appellant's pulmonary impairment. He did not list complete findings on examination of appellant or of the pulmonary function studies obtained. Dr. Schlusselberg's findings are vague and require extrapolation from the specific tables to infer appellant's height and are not specific as to the pre- and post medication measurements.

Following remand by an Office medical adviser, Dr. Schlusselberg provided a July 1, 2003 report in which he listed appellant's age but again did not provide a measurement of his

[11] The predicted normal values and the predicted lower limits of normal values are delineated in Tables 5-2a through 5-7b, pages 95-100. The individual's age and height are taken into consideration in determining the average or mean predicted normal values in Table 5-2a through 5-7a. The lower limits of normal for the measurement of interest is calculated based on Tables 5-2b through Table 5-7b based on the convention of the lower limit of normal lying at the fifth percentile or below the upper 95 percentile of the reference population. Variations in the calculations are to be made based on recommended ethnic adjustments. Spirometric readings are obtained both pre- and postbronchodilator medication and the reading indicating the best effort is used to assess impairment.

height. He stated that he obtained additional spirometric studies on examination but listed the impairment rating in terms of the DCO results obtained on March 7, 2002, which was listed as 51 percent of the predicted value.[12] Dr. Schlusselberg did not report the results of any additional DCO testing of appellant in 2003. He indicated that the date of maximum medical improvement was February 13, 2002 and that under Table 5.12 of the A.M.A., *Guides*[13] appellant had Class 3 (26 to 50 percent) impairment.

The Office referred Dr. Schlusselberg's report to the Office medical consultant, Dr. McDonald, who on September 15, 2003 provided a report noting that appellant's FVC and FEV_1 were well within normal limits and that the lung volumes were also normal at 95 percent, but that diffusion was 17.75 which was 51 percent of the predicted value of 35.03. He noted that appellant had dyspnea on exertion and had rare rhonchi at the bases and decreased breath sounds. Dr. McDonald noted that diffusion capacity was 90 percent of the predicted and that spirometry yielded a VC of 3.55 liters which was 64 percent of predicted value. He noted that a second set of spirometry tests revealed a VC of 4.21 liters, which was 76 percent of the predicted value and that after bronchodilators the VC increased to 4.63 or 84 percent of predicted value, which showed mild restriction in the prebronchodilator test. Dr. McDonald concluded that spirometry showed that restrictive physiology was not present. He noted that the evaluation from Dr. Schlusselberg was confusing as he did not independently confirm the diagnosis of pleural plaques or asbestosis and that he diagnosed restrictive disease when the pulmonary testing did not confirm this diagnosis. Dr. McDonald found that the case was not in posture for decision as a CT scan and additional pulmonary function testing was required.

On November 17, 2003 Dr. Pearle reviewed appellant's medical treatment and his clinical symptomatology. He noted that a 1993 chest x-ray revealed a very slight increase in interstitial pattern of regular interstitial opacities and a small amount of pleural abnormalities and that pulmonary function studies on March 5, 1993 revealed normal FVC, FEV_1 and FEV_1 divided by FVC ratio and diffusing capacity. Dr. Pearle stated that an October 20, 1994 CT scan described an ill-defined right lung base findings and pleural abnormalities and that a 1998 chest x-ray revealed pleural thickening on the right with focal mass at the left lower lobe. He noted that a CT scan in 2000 described a two centimeter pleural plaque with no significant mediastinal or lung abnormalities. Dr. Pearle added that pulmonary function studies obtained in 2002 revealed a normal FVC and FEV_1 with mild reduction in FEV_1/FVC ratio and moderate reduction in diffusing capacity. He noted that features required for the diagnosis of asbestos were reduction in FVC, reduction in diffusing capacity, evidence of interstitial fibrosis on chest x-ray or CT scan and rales on physical examination. Dr. Pearle noted that appellant had none of these.

Dr. Pearle diagnosed mild chronic bronchitis and emphysema probably related to cigarette smoking and pleural plaques likely related to asbestos exposure, but of no functional or clinical significance. However, his report reflects that he did not obtain any additional diagnostic CT scan or perform any pulmonary function studies. Rather, Dr. Pearle reviewed the prior

[12] Dr. Schlusselberg indicated that postmedication testing in 2003 for FVC was 84 percent of the predicted value and FEV-1 was 80 percent of the predicted value.

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

medical reports of record and explained the basis for his conclusion that appellant did not have asbestosis, or interstitial fibrosis. However, his opinion on pulmonary impairment is not well rationalized. Dr. Pearle noted the test results obtained by Dr. Schlusselberg, including the DCO measurement which was 51 percent of the predicted value and stated that appellant had respiratory impairment that should be considered as Class 3 impairment. He did not adequately explain the basis for the reduction in DCO or for relying on the test measures obtained by Dr. Schlusselberg, which contain various omissions as noted above. It is not clear that Dr. Pearle was attributing appellant's pulmonary impairment to the diagnosed chronic bronchitis and emphysema or his history of cigarette smoking rather than as a result of any asbestos exposure.

Although Dr. McDonald, an Office medical consultant, concluded that appellant had no pulmonary impairment, the pulmonary function studies of reliable physicians are not well rationalized as to the issue of permanent impairment. Dr. Schlusselberg did not provide testing that has been established as conforming to the protocols of the A.M.A., *Guides* and Dr. Pearle did not perform any additional pulmonary function measurements. Both physicians, however, did provide impairment ratings of appellant's pulmonary condition. The reports of the physicians do not adequately explain the issue of impairment in light of the unreliable nature of the pulmonary testing measures of record. As the Office has attempted to develop the medical evidence of record, it has the obligation to assure that a proper evaluation of any pulmonary impairment is made.[14]

CONCLUSION

The Board finds that the case is not in posture for decision on whether appellant has any permanent pulmonary impairment causally related to his accepted asbestos exposure. The case will be remanded to the Office for further medical development of the claim to be followed by a *de novo* decision on appellant's schedule award claim.

[14] *See Robert Kirby*, 51 ECAB 474 (2000).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated February 25, 2004 is set aside. The case is remanded to the Office for further action in conformance with this decision of the Board.

Issued: May 12, 2005
Washington, DC

Alec J. Koromilas
Chairman

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member