United States Department of Labor
Employees' Compensation Appeals Board

L.I., Appellant	)	
and	)	**Docket No. 07-232**
	)	**Issued: April 11, 2007**
DEPARTMENT OF LABOR, MINE SAFETY & HEALTH ADMINISTRATION, Mount Carbon, WV, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On November 3, 2006 appellant filed a timely appeal from April 27 and August 11, 2006 decisions of the Office of Workers' Compensation Programs, adjudicating his schedule award claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant is entitled to a schedule award for his accepted pneumoconiosis.

FACTUAL HISTORY

On November 27, 2004 appellant, then a 62-year-old coal mine safety and health specialist, filed an occupational disease claim alleging that he developed pneumoconiosis due to exposure to coal dust and silica since 1975. His duties included collecting dust samples from underground and surface coal mines while mining operations were in progress. Appellant was

exposed to coal and rock dust for up to five days a week for four to eight hours a day. He indicated that he had smoked one pack of cigarettes a day for 40 years. On November 8, 2004 Dr. Michael B. Ward, an osteopathic physician specializing in family medicine, stated that on October 4, 2004 appellant was diagnosed with pneumoconiosis due to coal dust exposure, based on a chest x-ray and pulmonary function studies. On June 16, 2005 the Office accepted appellant's claim for pneumoconiosis.[1] On June 28, 2005 appellant filed a claim for a schedule award.

On April 15, 2005 the Office referred appellant to Dr. Dominic J. Gaziano, a Board-certified internist specializing in pulmonary disease and critical care, together with medical records and a statement of accepted facts, for an evaluation of his pneumoconiosis and whether he had any permanent impairment causally related to this condition. The Office asked him to include the results of pulmonary function studies, including pre and postbronchodilator spirometry and diffusing capacity for carbon monoxide (Dco) testing.

On June 9, 2005 Dr. Gaziano provided findings on physical examination and the results of pulmonary testing. He diagnosed work-related pneumoconiosis. The spirometry test results[2] revealed a FVC of 4.02 liters, which was 88 percent of the predicted 4.57. Forced expiratory volume in one second (FEV_1) was 2.83 liters or 89 percent of the predicted 3.19. The ratio of FEV_1, FVC and FEV_1, FEV_1/FVC, was 70 or 100 percent of the predicted 70 percent. Dr. Gaziano stated:

> "Chest X-ray: Chest x-ray taken in my office on [June 2, 2005] showed rounded opacities … throughout all lung zones of a 1/1 profusion. Scattered calcified granulomata were noted throughout the lungs.
>
> "Pulmonary Function Test: Spirometry was normal. Diffusing capacity for carbon monoxide [Dco] was normal.[3] Bronchodilators were not done because the prebronchodilator spirometry was normal. The effort was valid on both diffusion and spirometry."
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> "[Appellant performed well on spirometry and the results are valid. Several attempts were made with diffusion and near-maximal effort achieved, however, the best inspired volume was 88 [percent] of predicted and 90 [percent] of predicted would have represented a maximal effort.

[1] Pneumoconiosis is a condition characterized by permanent deposition of substantial amounts of particulate matter, usually of occupational or environmental origin and by the tissue reaction to its presence. It may range from relatively harmless forms of anthracosis or siderosis to the destructive fibrosis of silicosis. *Dorland's Illustrated Dictionary* at 1318 (27th ed. 1988).

[2] Spirometry is the measurement of the lungs, by means of a spirometer, of the forced vital capacity (FVC) and its subdivisions, as well as the measurement of the speed of airflow achieved in performance of this maneuver. American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides* 5th ed. 2001) 603, 93-100.

[3] Dr. Gaziano did not provide any actual test measurements for Dco.

> "It is my opinion, to a reasonable degree of certainty, that [appellant] has coal workers' pneumoconiosis and that this condition and any impairment is aggravated by cigarette smoking of approximately 40 … years.
>
> "Using the [A.M.A, *Guides*] 5th [ed. 2001], the FVC, FEV_1 and FEV_1/FVC fall in the [zero] [percent] impairment of the whole person. The diffusing capacity falls within the normal range, however, is 91 [percent] of the lower limit of normal. This, I believe, is contributed to by the lack of a full inspiration and the presence of cigarette use. With these factors in consideration he would fall in functional Class [2] of 10 [to] 25 [percent] impairment, however, I believe the impairment would be at the lower range of 10 [percent]."

On August 31, 2005 Dr. Daniel D. Zimmerman, a Board-certified internist and a district medical adviser, stated that Dr. Gaziano had not provided the postbronchodilator test results from the pulmonary function testing of appellant, as required for an impairment rating for the lungs. He advised the Office to request the postbronchodilator test results for appellant from Dr. Gaziano.

In a February 24, 2006 memorandum to Dr. Zimmerman, an Office claims examiner stated that Dr. Gaziano's staff advised that the postbronchodilator test was not performed on appellant. It was not needed because the pulmonary function test was normal and the predicted and actual FEV_1/FVC were both 70 percent. The claims examiner asked Dr. Zimmerman if there was sufficient medical evidence to determine whether appellant was entitled to a schedule award for his accepted pneumoconiosis.

On March 8, 2006 Dr. Zimmerman stated that appellant could not receive a 10 percent impairment rating, as found by Dr. Gaziano, because appellant did not make a full effort at inspiration in the evaluation of his Dco. He indicated that the other test results in appellant's pulmonary function testing provided no basis for an impairment rating using Table 5-12 at page 107. Dr. Zimmerman stated:

> "Since poor effort in the testing process precludes an impairment rating based on the [A.M.A.,] *Guides*[,] and the mechanics of breathing as shown in the pulmonary function test on [June 2, 2005] are consistent with a [zero] [percent] impairment rating from Table 5-12, the impairment ratings for the [right and left] lungs are [zero] [percent]. The schedule awards are [zero] [percent] …."

By decision dated April 27, 2006, the Office denied appellant's claim for a schedule award on the grounds that the medical evidence did not establish that he had any permanent impairment of his lungs causally related to his accepted pneumoconiosis.[4]

[4] An April 21, 2006 Office decision was reissued on April 27, 2006 because a copy of appellant's appeal rights was not included.

On May 22, 2006 appellant requested reconsideration. He provided copies of a December 28, 2005 "termination" examination submitted to the employing establishment with his application for retirement.[5]

In a June 26, 2006 memorandum, Dr. Zimmerman stated that the additional evidence submitted was not sufficient to establish appellant's entitlement to a schedule award for his accepted pneumoconiosis.

By decision dated August 11, 2006, the Office performed a merit review of the additional evidence submitted and denied appellant's schedule award claim.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[6] and its implementing regulation[7] 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*[8] has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.

Chapter 5 of the fifth edition of the A.M.A., *Guides* (The Respiratory System) provides that permanent impairment of the lungs is determined on the basis of pulmonary function tests, *i.e.*, the FVC or forced vital capacity, the FEV_1 or forced expiratory volume in one second, the ratio between FVC and FEV_1 and the Dco or the diffusing capacity for carbon monoxide in the blood.[9] In order to be considered nonimpaired (Class 1), an individual must meet all of the listed criteria in the Class 1 column of Table 5-12 (with the exception of V02 max), *i.e.*, all of the Class 1 criteria for FVC, FEV_1, FEV_1/FVC or Dco.[10] At least one of the listed criteria in the columns for Class 2, 3 and 4, for FVC, FEV_1, FEV_1/FVC and Dco, must be fulfilled to place an individual in any class with an impairment rating.[11] The values for predicted and observed normal values for FVC, FEV_1 and Dco are found in Tables 5-2a through 5-7b.[12] The A.M.A., *Guides* provides

[5] The spirometry test results from this termination examination were not signed by a physician.

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

[9] A.M.A., *Guides* 93-94, *see also* 87, 101. Section 5.4d at page 93-94, "Forced Expiratory Maneuvers (Simple Spirometry)" explains the testing procedures for FVC, FEV_1 and FEV_1/FVC. Section 5.4e at page 94, "Diffusing Capacity for Carbon Monoxide," explains the testing procedures for Dco.

[10] *Id.*

[11] *Id.*

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

a table consisting of four classes of respiratory impairments 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, Dco or maximum oxygen consumption (VO2Max). For each of the FVC, FEV_1 and Dco 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. For example, a person is within Class 2 impairment, equaling 10 to 25 percent impairment of the whole person, if the FVC, FEV_1 or Dco is above 60 percent of the predicted value and less than the lower limit of normal.[14]

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.[15]

ANALYSIS

Dr. Gaziano indicated that appellant's FEV_1/FVC was 70 percent and he did not indicate any wheezing on physical examination. Section 5.4d of the A.M.A., *Guides* states that spirometry testing should be repeated after bronchodilator administration if FEV_1/FVC is below 0.70 or if there is wheezing on physical examination. Appellant did not meet this criteria. Therefore, according to the A.M.A., *Guides*, post bronchodilator test results are not required for a determination of appellant's respiratory impairment.

Dr. Gaziano's spirometry test results for appellant revealed a FVC of 4.02 liters, which was 88 percent of the predicted 4.57. The FEV_1 was 2.83 liters or 89 percent of the predicted 3.19. He found that appellant had a zero percent impairment based on FVC, FEV_1 and FEV_1/FVC and the A.M.A., *Guides*. Dr. Gaziano found that appellant had a Class 2 impairment of 10 percent based on his diffusing capacity. However, he provided no actual Dco test measurements. As noted, test results for Dco are required for a respiratory impairment rating based on the A.M.A., *Guides.* Therefore, further development of the medical evidence is required as to appellant's Dco. As there is no medical report which conforms to the A.M.A., *Guides*, this case must be remanded for further development of the medical evidence.

CONCLUSION

The Board finds that this case is not in posture for a decision. The case requires further development of the medical evidence. On remand, this case should be referred to an appropriate

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

[14] *See id.*

[15] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700(4)(c)(1) (November 1998).

medical specialist for an evaluation of appellant's permanent impairment which is consistent with the procedures of the A.M.A., *Guides*. After such further development as the Office deems necessary, it should issue an appropriate decision on appellant's claim for schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated August 11 and April 27, 2006 are set aside and the case is remanded for further development consistent with this decision.

Issued: April 11, 2007
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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