United States Department of Labor
Employees' Compensation Appeals Board

W.K., Appellant	)	
and	)	**Docket No. 07-944**
	)	**Issued: August 2, 2007**
DEPARTMENT OF THE NAVY, PHILADELPHIA NAVAL SHIPYARD, Philadelphia, PA, 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 February 21, 2007 appellant filed a timely appeal from an Office of Workers' Compensation Programs' decision dated December 7, 2006. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant is entitled to a schedule award for his employment-related bilateral pleural thickening and pleural plaques.

FACTUAL HISTORY

On June 13, 2006 appellant, then a 68-year-old retired electrician, filed a Form CA-2, occupational disease claim, alleging that he sustained asbestosis due to occupational exposure to asbestos. He had retired in 1987 and stated that he was first aware that the condition was employment related on March 17, 2006. The employing establishment acknowledged that a Form CA-2 had been filed on January 10, 1985 due to asbestos exposure. Appellant provided a

report of his job history and numerous medical reports regarding his cardiac and nasal conditions.[1] Pulmonary function studies on December 10, 2003 demonstrated a forced vital capacity (FVC) of 104 percent of predicted, forced expiratory volume in one second ($FEV_{1)}$ of 108 percent of predicted, FEV_1/FVC ratio of 104 percent of predicted and adjusted diffusing capacity of carbon monoxide (Dco) of 85 percent of predicted. A chest x-ray on January 14, 2004 demonstrated bilateral pleural thickening.

In a February 28, 2005 report, Dr. James J. Walsh, Board-certified in internal medicine and pulmonary disease, noted appellant's employment history and symptoms including shortness of breath. He made findings on examination and reviewed a January 28, 2005 computerized tomography (CT) scan of the thorax that showed bilateral multiple areas of pleural thickening.[2] Pulmonary function studies on February 28, 2005 demonstrated an FVC of 109 percent of predicted, FEV_1 of 109 percent of predicted, FEV_1/FVC ratio of 100 percent of predicted and adjusted Dco of 72 percent of predicted, which Dr. Walsh interpreted as normal. Dr. Walsh diagnosed possible very early asbestosis and recommended follow-up and repeat CT scan.

Dr. Walsh continued to submit reports and a June 10, 2005 CT of the thorax demonstrated bilateral pleural plaques, most likely asbestos related. A December 16, 2005 CT was interpreted as showing interstitial lung disease. Pulmonary function studies on March 20, 2006 demonstrated an FVC of 103 percent of predicted, FEV_1 of 105 percent of predicted and FEV_1/FVC ratio of 101 percent of predicted. A high resolution CT of the thorax on March 24, 2006 showed typical asbestos-related pleural disease.

The employing establishment submitted clinic notes dating from March 5, 1985 to October 6, 1986 which acknowledged that appellant had 120 hours of asbestos exposure and that he had participated in an asbestos screening program with a January 10, 1985 chest x-ray read as within normal limits. Pulmonary function studies on August 5, 1985 and August 5, 1986 showed an FVC of 103 percent of predicted and FEV_1 of 103 percent. By letter dated June 13, 2006, the employing establishment conceded that appellant had employment-related asbestos exposure.

In a report dated June 15, 2006, Dr. Karen D. Hoffman, an attending osteopath who practices family medicine, noted appellant's employment history of asbestos exposure, his cardiac history and symptoms of shortness of breath, chest pain and persistent cough, and CT findings of pleural thickening and calcifications. She opined that appellant's pleural disease was due to his federal employment.

By letters dated June 26, 2006, the Office requested that the employing establishment furnish information regarding appellant's asbestos exposure, and informed appellant of the type of evidence needed to support his claim. Appellant submitted a statement in which he again described his employment history, personnel information, that indicated that he had resigned effective April 10, 1987, and a number of publications regarding asbestosis. Following an Office

[1] Appellant underwent a four vessel coronary bypass graft on December 23, 2003 and nasal surgery for a deviated septum on July 27, 2004.

[2] A copy of the CT report is not in the case record.

request, appellant submitted additional information regarding his employment and medical histories.

In a report dated August 7, 2006, Dr. Mark Hammett, a resident physician, and Dr. Kenneth Lankin, Board-certified in family medicine, reviewed the medical record for the employing establishment, including the 2005 pulmonary function tests. They concluded that it was likely that appellant had asbestos exposure at the employing establishment but that, based on the 2005 pulmonary function test, he had no ratable impairment.

On August 29, 2006 the Office referred appellant to Dr. Dineshkumar C. Talati, Board-certified in internal medicine and pulmonary disease, for a second opinion evaluation. Dr. Talati was furnished with the medical record, a statement of accepted facts and a set of questions. After an Office request for information, by letter dated September 15, 2006, appellant advised that he had a pending third-party claim.

Pulmonary function studies on October 16, 2006 demonstrated an FVC of 100 percent of predicted, FEV_1 of 111 percent of predicted, and adjusted Dco of 80 percent of predicted. Dr. Talati interpreted the study as normal. An October 17, 2006 CT of the chest/thorax showed bilateral calcified pleural plaques compatible with previous asbestos exposure and no evidence of significant interstitial fibrosis. In a report dated November 3, 2006, Dr. Talati noted appellant's occupational and medical history and symptoms of worsening shortness of breath. He made findings on examination and noted his review of the October 17, 2006 CT scan and pulmonary function studies of March 20 and October 16, 2006, both of which he stated were normal. Dr. Talati advised that appellant's bilateral pleural plaques with calcification were suggestive of employment-related asbestos exposure and concluded that appellant had no significant pulmonary impairment to limit his activity.

On December 7, 2006 the Office accepted that appellant had employment-related bilateral pleural thickening and pleural plaques. By decision dated December 7, 2006, the Office found that, under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[3] appellant had no impairment at that time and authorized periodic pulmonary studies.

LEGAL PRECEDENT

Under section 8107 of the Federal Employees' Compensation Act[4] and section 10.404 of the implementing federal regulation,[5] schedule awards are payable for permanent impairment of specified body members, functions or organs. The Act, however, does not 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, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The

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

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

A.M.A., *Guides*[6] has been adopted by the Office, and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[7]

Chapter 5 provides the framework for assessing respiratory impairments,[8] and Table 5-12 describes 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 measured 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 of the table, 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]

ANALYSIS

The record in this case includes pulmonary functions studies dated December 10, 2003, February 8, 2005, March 20 and October 16, 2006.[10] Pulmonary impairment due to pulmonary disorders is assessed under Table 5-12 of the A.M.A., *Guides*[11] which refers to the values found in Tables 5-2b through 5-7b.[12] Appellant's pulmonary function studies demonstrate that under Table 5-12 he has a Class 1 or zero percent impairment. The table states:

	FVC	FEV_1	FEV_1/FVC	Adjusted Dco
December 10, 2003	104	108	104	85
February 28, 2005	109	109	100	72
March 20, 2006	103	105	101	---
October 16, 2006	100	111	---	80

[6] A.M.A., *Guides*, *supra* note 3.

[7] *See Joseph Lawrence, Jr.*, *supra* note 3; *James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

[8] A.M.A., *Guides*, *supra* note 3 at 87-115.

[9] *Id.* at 107, Table 5-12; *see Boyd Haupt*, 52 ECAB 326 (2001).

[10] Appellant also submitted a pulmonary function study that was remote in time, dated August 5, 1985. Contemporaneous evidence is entitled to greater probative value than later evidence. *Conard Hightower*, 54 ECAB 796 (2003). This too, however, did not demonstrate ratable values.

[11] A.M.A., *Guides*, *supra* note 3.

[12] *Id.* at 95-100.

To qualify for a ratable impairment under Table 5-12, at least one of the criteria must meet a qualifying value,[13] that is, FVC, FEV_1 or Dco must be less than 60 percent of predicted. None of appellant's pulmonary findings demonstrate qualifying values. He is therefore not entitled to a schedule award for his accepted pulmonary disease.[14]

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that he is entitled to a schedule award for his employment-related bilateral pleural thickening and pleural plaques as his respiratory condition was not ratable under the A.M.A., *Guides*.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated December 7, 2006 be affirmed.

Issued: August 2, 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

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

[14] The Board, however, has long recognized that, if a claimant's employment-related condition worsens in the future, he or she may apply for a schedule award for any ratable impairment. *See Robert E. Cullison*, 55 ECAB 570 (2004).