United States Department of Labor
Employees' Compensation Appeals Board

H.D., Appellant	)	
and	)	**Docket No. 06-1499**
	)	**Issued: January 30, 2007**
DEPARTMENT OF THE NAVY, MARE ISLAND NAVAL SHIPYARD, Vallejo, CA, 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 June 19, 2006 appellant filed a timely appeal of the June 7, 2006 merit decision of the Office of Workers' Compensation Programs, which denied a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d), the Board has jurisdiction over the merits of appellant's claim for a schedule award.

ISSUE

The issue is whether appellant is entitled to a schedule award for an employment-related pulmonary impairment.

FACTUAL HISTORY

Appellant, a 65-year-old retired pipe fitter, has an accepted occupational disease claim for pulmonary asbestosis (ICD-9/501) with pleural plaques (ICD-9/511).[1] He filed a claim for a schedule award on December 23, 2000. By decision dated February 25, 2004, the Office found that appellant was not entitled to a schedule award.[2] On appeal, the Board set aside the February 25, 2004 decision and remanded the claim for additional medical development followed by the issuance of a *de novo* decision.[3]

On remand, the Office referred appellant to Dr. Tariq Jamil, a Board-certified internist specializing in pulmonary disease. Dr. Jamil examined appellant on June 20, 2005, obtained chest x-rays and administered a pulmonary function study.[4] Physical examination of the lungs revealed bilateral air entry and no rhonchi or wheezes. Dr. Jamil noted a 31-year history of occupational exposure to asbestos, ending in 1995. He also reported that appellant was an ex-smoker, with a history of a ½ pack of cigarettes per day from 1974 to 1984. Dr. Jamil interpreted the pulmonary function study as normal and he noted that the x-rays showed no acute pulmonary infiltrates and were otherwise unremarkable. His diagnoses included history of diabetes mellitus, 31-year history of exposure to asbestos and shortness of breath on exertion. With respect to the latter diagnosis, Dr. Jamil noted appellant's prior smoking history and he indicated the need to rule out chronic obstructive pulmonary disease, bronchial asthma or bronchitis. Dr. Jamil did not provide an impairment rating, but noted that appellant reached maximum medical improvement on June 20, 2005.

On September 9, 2005 the Office's medical adviser, Dr. Charles C. McDonald, reviewed the medical evidence and found zero percent functional loss of use of bilateral lungs.[5] He noted that appellant's recent examination showed no evidence of interstitial fibrosis. Dr. McDonald diagnosed "history of asbestos exposure" and "asbestos-related pleural plaques as a result of asbestos exposure." He further noted there was no evidence of asbestosis.

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[1] Appellant was exposed to asbestos during his 21-year tenure at the employing establishment. He first became aware of his pulmonary condition on February 8, 1995 and he retired effective February 28, 1995. The Office based its acceptance of the claim on the December 14, 2000 independent medical evaluation of Dr. Ahsan Qazi, a Board-certified internist specializing in pulmonary disease.

[2] The Office initially denied the schedule award on June 20, 2002. However, on April 25, 2003 an Office hearing representative set aside the denial and remanded the case for further medical development.

[3] Docket No. 04-1034 (issued May 12, 2005). The Board's May 12, 2005 decision is incorporated herein by reference.

[4] Additional objective studies had been scheduled, but appellant failed to appear for the testing.

[5] Dr. McDonald is Board-certified in internal medicine with a subspecialty in pulmonary disease. His involvement in this case dates back to August 9, 1994, when he initially examined appellant. Dr. McDonald has also served as an Office consultant and medical adviser in this case. He was on one side of a medical conflict that was ultimately resolved by Dr. Qazi, who diagnosed pulmonary asbestosis. On the question of appellant's entitlement to a schedule award, the Office has referred the case to Dr. McDonald on 4 prior occasions. Notwithstanding the Office's acceptance of the claim for pulmonary asbestosis, Dr. McDonald has steadfastly maintained the position that appellant does not have asbestosis.

The Office subsequently received a September 1, 2005 supplemental report from Dr. Jamil. He interpreted an August 29, 2005 arterial blood gas (ABG) study as normal. In light of the normal chest x-ray and normal objective studies, Dr. Jamil found that appellant had zero percent impairment under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001).[6]

The Office again referred the case file to its medical adviser, Dr. McDonald. In an October 30, 2005 report, Dr. McDonald noted the normal results of the August 29, 2005 ABG, and indicated that his prior opinion remained unchanged. He reiterated that there was no evidence of "interstitial fibrosis (asbestosis)." Dr. McDonald also explained that appellant's asbestos-related pleural plaques did not have any functional affect.

By decision dated November 16, 2005, the Office denied appellant's claim for a schedule award. Appellant requested an oral hearing. In a January 31, 2006 decision, the hearing representative set aside the November 16, 2005 decision and remand the case for additional medical development.

Another pulmonary function study was administered on March 16, 2006. In a May 12, 2006 report, Dr. Jamil indicated that in view of the mildly decreased forced expiratory volume$_1$ (FEV_1) and diffusing capacity (DLCO) on the March 16, 2006 pulmonary function study appellant had an impairment of 10 to 25 percent under the A.M.A., *Guides* (5th ed. 2001).

Dr. McDonald reviewed the case file on May 30, 2006 and found no impairment present. He noted, among other things, that Dr. Jamil did not document an asbestos-related condition in his latest report. Additionally, while Dr. McDonald acknowledged that the May 30, 2006 DLCO result was 73 percent of the predicted value, he explained that appellant had a normal diffusing capacity when corrected for volume of distribution, as represented by the DLCO/VA result. Thus, he concluded that the most recent spirometry results showed no evidence of impairment.

In a decision dated June 7, 2006, the Office found that appellant was not entitled to a schedule award.

LEGAL PRECEDENT

The Federal Employees' Compensation Act and the implementing regulation set forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[7] The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. The implementing regulations have adopted the American Medical Association, *Guides to the Evaluation of Permanent Impairment* as the appropriate

[6] Dr. Jamil referenced the A.M.A., *Guides* 107, Table 5-12.

[7] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404 (2006). For total, or 100 percent loss of use of a lung, an employee shall receive 156 weeks of compensation. 20 C.F.R. § 10.404(a).

standard for evaluating schedule losses.[8] Effective February 1, 2001, schedule awards are determined in accordance with the A.M.A., *Guides* (5th ed. 2001).[9]

ANALYSIS

Proceedings under the Act are not adversarial in nature and the Office is not a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence to see that justice is done.[10] Once the Office undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[11]

The Board finds that the Office medical adviser's May 30, 2006 report is not probative for purposes of determining the extent of appellant's pulmonary impairment. Although Dr. McDonald concluded that appellant had no impairment, he did not specifically relate his findings to the A.M.A., *Guides* (5th ed. 2001).[12] In particular, he offered no justification under the A.M.A., *Guides* for substituting what appears to be a qualifying DLCO result for what he characterized as a normal DLCO/VA result. Although Dr. McDonald reported appellant's total lung capacity as 7.8 no such result appears on the March 16, 2006 pulmonary function report.[13] Lastly, the Board notes that the issue in the present case is not whether appellant has asbestosis. However, Dr. McDonald continues to offer his opinion on this particular point. And he has consistently questioned other physicians' opinions based on their so-called lack of documentation of asbestosis. Dr. McDonald's opinion regarding permanent impairment is premised on his belief that appellant does not have asbestosis and, therefore, does not have any employment-related impairment because, as he explains, pleural plaques alone do not limit lung function. While Dr. McDonald may disagree with the diagnosis of asbestosis, as the Office's medical adviser he should conduct his review within the framework of the Office's statement of accepted facts, which clearly indicates that appellant's claim has been accepted for employment-related pulmonary asbestosis.[14]

Given the deficiencies in Dr. McDonald's May 30, 2006 report, the Office should not have relied on his findings as a basis for denying appellant's claim for a schedule award.[15]

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[8] 20 C.F.R. § 10.404 (1999).

[9] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (June 2003); FECA Bulletin No. 01-05 (issued January 29, 2001).

[10] *Horace L. Fuller*, 53 ECAB 775, 777 (2002); *James P. Bailey*, 53 ECAB 484, 496 (2002); *William J. Cantrell*, 34 ECAB 1223 (1983).

[11] *Richard F. Williams*, 55 ECAB 343, 346 (2004).

[12] *Lela M. Shaw*, 51 ECAB 372, 374 (2000).

[13] The March 16, 2006 PFS lists appellant's "TLC" as 7.08.

[14] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.7d (April 1993).

[15] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6d (August 2002).

Accordingly, the Office did not properly discharge its responsibilities in developing the record.[16] The case is remanded to the Office so that it may refer the claim file to a medical adviser to ascertain whether appellant has a ratable pulmonary impairment under the A.M.A., *Guides* (5th ed. 2001). After the Office has developed the case record to the extent it deems necessary, a *de novo* decision shall by issued.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the June 7, 2006 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further action consistent with this decision.

Issued: January 30, 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

[16] *Richard F. Williams, supra* note 11.