United States Department of Labor
Employees' Compensation Appeals Board

C.F., Appellant	)	
	)	
and	)	**Docket No. 09-603**
	)	**Issued: September 29, 2009**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, St. Cloud, MN, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 31, 2008 appellant filed a timely appeal from the October 21, 2008 decision of the Office of Workers' Compensation Programs denying a schedule award. 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 pursuant to 5 U.S.C. § 8107 for a permanent impairment to his lungs.

FACTUAL HISTORY

On June 21, 2007 appellant, then a 72-year-old former pipe fitter and boiler plant operator, filed an occupational claim (Form CA-2) alleging that he sustained asbestosis as a result of his federal employment. The reverse of the claim form indicated that he had retired in 1997.

The Office referred appellant to Dr. Thomas Mulrooney, a pulmonary specialist, for an opinion as to causal relationship between a pulmonary condition and his federal employment. In a report dated January 25, 2008, Dr. Mulrooney provided a history and results on examination. He stated that the pulmonary function measurements showed normal values for lung volumes, with "a slight reduction (65 percent of predicted) in diffusion capacity." The pulmonary function test dated January 16, 2008 showed forced vital capacity (FVC) of 4.29, forced expiratory volume in first second (FEV_1) of 3.08 and 18.58 diffused capacity for carbon monoxide (Dco). Dr. Mulrooney opined that appellant had asbestosis causally related to his federal employment. Based on his report, the Office accepted asbestosis.

On February 12, 2008 appellant filed a claim for a schedule award. In a letter dated March 10, 2008, the Office requested that he submit medical evidence as to a permanent impairment under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). In a report dated May 1, 2008, Dr. Mulrooney noted that "the diffusing capacity is at the lower end of the normal range."[1] He opined that, "No whole-body impairment exists under applicable criteria in "A.M.A., *Guides* to disability". This decision is based on the normal measurements of pulmonary function and the applicable tables that are published in the A.M.A., *Guides*."

In a report dated August 27, 2008, an Office medical adviser reviewed the medical evidence. He noted a slight reduction in diffusion capacity. The Office medical adviser stated that there was no anatomical loss of the lung or significant decrease in pulmonary function and therefore appellant was a Class 1 with no lung impairment.

By decision dated October 21, 2008, the Office determined that appellant was not entitled to a schedule award. It found that the medical evidence did not show impairment to the lungs.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing federal regulations,[3] set 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. 5 U.S.C. § 8107 provides that, if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function.[4] Neither the Act nor the regulations specify the manner in which the percentage of impairment for a schedule award shall be determined. For consistent results and to ensure equal justice for all claimants the Office

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[1] It appears that Dr. Mulrooney was acting as an attending physician, he indicated that appellant was referred by another attending physician, Dr. Gary Strandemo, Board-certified in family practice.

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

[4] 5 U.S.C. § 8107. This section enumerates specific members or functions of the body for which a schedule award is payable and the maximum number of weeks of compensation to be paid, additional members of the body are found at 20 C.F.R. § 10.404(a).

has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[5] As of February 1, 2001, the 5th edition of the A.M.A., *Guides* was to be used to calculate schedule awards.[6]

Chapter 5 of the fifth edition of the A.M.A., *Guides* provides that permanent impairment of the lungs is determined on the basis of pulmonary function tests, *i.e.,* the FVC and the one second FEV_1, the ratio between FEV_1 and FVC and Dco. The values for predicted and observed normal values for FEV_1, FVC and Dco are found in Tables 5-2a through 5-7b.[7] 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.[8] 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 a 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.[9] Section 5.10 of the A.M.A., *Guides* advises that at least one of the criteria must be fulfilled to provide an individual with an impairment rating.

Office procedures state that impairment to the lungs should be evaluated in accordance with the A.M.A., *Guides*, insofar as possible, noting that the percentage of whole man impairment will be multiplied by 312 weeks (twice the award for loss of function of one lung) to obtain the number of weeks payable; all such awards will be based on the loss of use of both lungs.[10]

ANALYSIS

The Office denied a schedule award for impairment to the lungs on the grounds that the medical evidence did not establish an impairment under the A.M.A., *Guides.* As part of the development of the case, a pulmonary function test was performed on January 16, 2008. With regard to Dco, the diffusing capacity for carbon monoxide, the reported result was 18.58. Dr. Mulrooney noted a diffusion capacity of 65 percent of predicted and referred to the diffusion capacity as being "at the lower end" of the normal range. The Office medical adviser generally noted a "slight reduction" in diffusing capacity without further explanation. Neither physician

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[5] *A. George Lampo*, 45 ECAB 441 (1994).

[6] FECA Bulletin No. 01-05 (January 29, 2001).

[7] A.M.A, *Guides* 95-100. The pulmonary function tables are based on gender, age and height and contain predicted normal and predicted lower limit of normal values.

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

[9] *Id.* at 107.

[10] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(a)(1) (August 2002).

specifically discussed Tables 5-12 and 5-6b in this regard. Under Table 5-6b, the predicted lower limit of normal diffusing capacity for a 72-year-old male with a height of 170 centimeters (cm) Dr. Mulrooney reported appellant's height as 67 inches in his January 25, 2008 report was 20.1.[11] As noted above, according to Table 5-12, a Dco of less than the lower limit of normal and more than 60 percent of predicted normal is a Class 2 impairment (10 to 25 percent).

The medical evidence does not adequately address the issue or explain why appellant did not have an impairment under Tables 5-12 and 5-6b based on the reported Dco results. The case will be remanded to the Office for additional development. On remand, the Office should secure medical evidence with a rationalized medical opinion regarding a permanent impairment under the A.M.A., *Guides* for respiratory disorders. After such further development as the Office deems necessary, it should issue an appropriate decision.

CONCLUSION

The Board finds that the case must be remanded to the Office for further development of the medical evidence regarding a permanent impairment to the lungs.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated October 21, 2008 is set aside and the case remanded for further action consistent with this decision of the Board.

Issued: September 29, 2009
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

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

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[11] In his May 1, 2008 report, Dr. Mulrooney reported appellant was 69 inches tall or 175.3 centimeters. The predicted lower limit of normal diffusing capacity for a 72-year-old man whose height is 176 cm. is 22.5.