



From December 6 to 10, 2007, appellant came under the treatment of Dr. Jairo Rodriguez, a Board-certified pulmonologist, for hypersensitivity and pneumonitis, who noted that he presented with symptoms of shortness of breath, soreness of the chest wall, dry cough and wheezing that was aggravated by his work environment. Appellant reported working conditions which consisted of poor circulation in the building, episodes of flooding of carpets and rat and cockroach infestation. On December 6, 2007 he underwent a pulmonary function test performed for Dr. Rodriguez, which revealed a forced expiratory volume in the first second (FEV<sub>1</sub>) of 2.59, forced expiratory volume (FVC) of 3.15. The author noted poor patient effort and advised that the maneuvers were not reproducible and the results should be interpreted with care.

Appellant sought treatment from Dr. Tan Nguyen, a Board-certified otolaryngologist, on January 11, 2008 for allergy and sinus symptoms. Dr. Nguyen noted that allergy testing in November 2007 revealed results of dust, epidermals and molds and recommended immunotherapy and minimization of exposure to these allergens. A July 12, 2008 report from Dr. Ammar Halloum, a Board-certified pulmonologist, opined that appellant had a worsening of his obstructive pulmonary disease due to recent exposure to mold. Dr. Halloum stated that a June 26, 2008 pulmonary function test was objective evidence that appellant's lung function was deteriorating and further exposure to environments where mold was present would worsen his condition. Appellant submitted a February 20, 2008 report from the Occupational Safety & Health Administration, noting unsafe or unhealthful work conditions specifically citing that the floors of the workrooms were not maintained in a clean, dry and drained condition free from pathogenic mold and that the workplace did not have an effective extermination program to prevent the entrance of vermin.

On October 10, 2008 appellant filed a claim for a schedule award. He submitted the pulmonary function test performed by Dr. Rodriguez dated December 27, 2007, which revealed moderate obstructive airways disease, increased diffusing capacity consistent with asthma or cardiovascular process and a restrictive process. The test noted that the results appeared to be valid; however, the acceptable threshold standard was not met. A June 24, 2008 exercise test revealed submaximal effort. Dr. Rodriguez noted based on the oxygen uptake in the range of 20 to 24 kilograms per minute, appellant could perform eight hours of mild to moderate work. On June 26, 2008 appellant underwent a pulmonary function test which revealed airway obstruction. Although the results of the test appeared to be valid, the acceptable threshold standard was not met and there was invalid effort for diffusing capacity for carbon dioxide (DLCO). A June 26, 2008 arterial blood gas report revealed normal PH, partial pressure of carbon dioxide and oxygen (PCO<sub>2</sub>) and partial pressure of oxygen (PO<sub>2</sub>). On August 5, 2008 appellant underwent a pulmonary function test, which revealed severe airway obstruction, reduced lung volumes and concurrent restrictive process. The FEV<sub>1</sub> of 1.16 which was 34 percent of predicted (3.43), a FVC of 2.47 which was 56 percent of predicted (4.41) and a FEV<sub>1</sub>/FVC of 47 which was 60 percent of predicted (78.00). It was noted that the test results met the threshold standards for acceptability and reproducibility. The pulmonologist noted that the results suggested severe airway obstruction. In an October 28, 2008 report, Dr. Rodriguez noted the initial pulmonary function test of December 27, 2007 revealed moderate obstruction and the August 5, 2008 test revealed severe obstruction. He diagnosed reactive airway disease syndrome and bronchiectasis and stated that appellant's condition was progressive. Appellant's lung function was 50 percent of that expected for a person of his age. A March 10, 2008

computed tomography (CT) scan of the chest revealed minimal left basilar bronchiectatic changes with no evidence of interstitial lung disease. A CT scan of the chest dated August 1, 2008 revealed no abnormalities.

On November 25, 2008 the Office referred appellant for a second opinion evaluation to Dr. Douglas W. Jenkins, a Board-certified pulmonologist. It provided Dr. Jenkins with appellant's medical records, a statement of accepted facts and a detailed description of his employment duties. In a December 17, 2008 report, Dr. Jenkins reviewed the records provided to him and examined appellant. He noted a chest x-ray obtained in his office revealed minimal atelectasis with no evidence of bronchiectasis. Dr. Jenkins diagnosed cough and dyspnea, otherwise unspecified. He stated that appellant's complaints of cough and shortness of breath were not supported by objective evidence and advised that these symptoms may be caused by the prescribed inhibitor Ramipril. Dr. Jenkins reviewed the extensive testing appellant underwent including the pulmonary function test performed under his direction. He noted that appellant was unable to perform the pulmonary function test and he found no physiologic explanation for this result. Dr. Jenkins advised that appellant showed minimal breathing effort during testing and during his physical examination and noted that most of the recent pulmonary function tests also demonstrated inadequate effort. He stated that exposure to molds and rodent droppings could cause simple allergies which would be manifested as rhinitis, sinusitis or asthma. However, Dr. Jenkins found no evidence of substantial exposure to corrosive gases and could not find a reasonable connection between appellant's current symptoms and his employment. He noted that the potential for simple allergies based on environmental exposure was present; however, he found no evidence of allergic phenomenon. Dr. Jenkins advised that in the absence of a pulmonary function test the evaluator must rely on the best objective information available. He noted that blood gas testing revealed normal values for oxygen, carbon dioxide and PH and a CT scan showed minimal changes that would not be expected to impair overall pulmonary function. Similarly, a June 24, 2008 exercise test showed submaximal effort but was otherwise normal and indicated the ability to perform eight hours of mild to moderate work. Dr. Jenkins opined that appellant's observed levels of exercise supported that his lung function was normal. He opined that the objective measures of pulmonary function were normal and pursuant to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,<sup>1</sup> (A.M.A., *Guides*) appellant had no lung impairment.

On March 31, 2009 an Office medical adviser concurred with Dr. Jenkins determination that, under with the A.M.A., *Guides*, appellant had no impairment of the lungs. He noted that appellant reached maximum medical improvement on December 17, 2008. The medical adviser noted that Dr. Jenkins performed pulmonary function studies; however, appellant was incapable of performing the test. He further opined that Dr. Jenkins could not identify any impairment based on submaximal effort during testing and concluded that appellant sustained zero percent impairment of the lungs.

In a decision dated April 6, 2009, the Office denied appellant's claim for a schedule award.

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<sup>1</sup> A.M.A., *Guides* (5<sup>th</sup> ed. 2001).

## LEGAL PRECEDENT

An employee seeking compensation under the Federal Employees' Compensation Act<sup>2</sup> has the burden of establishing the essential elements of his claim by the weight of the reliable, probative and substantial evidence,<sup>3</sup> including that he sustained an injury in the performance of duty as alleged and that his disability, if any, was causally related to the employment injury.<sup>4</sup>

The schedule award provision of the Act<sup>5</sup> and its implementing regulations<sup>6</sup> 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. 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* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.

With regard to respiratory or pulmonary impairments, 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.<sup>7</sup> 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<sub>1</sub>, DLCO<sup>8</sup> or maximum oxygen consumption (VO2Max). For each of the FVC, FEV<sub>1</sub> and DLCO 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.<sup>9</sup> For VO2Max, an observed result will be placed within Class 2, 3 or 4 if it falls within a specified range of oxygen volume.<sup>10</sup> A person will fall within Class 1 and be deemed to have no impairment, if the FVC, FEV<sub>1</sub>, ratio of FEV<sub>1</sub> to FVC and DLCO are greater than or equal to the lower limit of normal, or the VO2Max is greater than or equal to a specified oxygen volume.<sup>11</sup>

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<sup>2</sup> 5 U.S.C. §§ 8101-8193.

<sup>3</sup> *Donna L. Miller*, 40 ECAB 492, 494 (1989); *Nathaniel Milton*, 37 ECAB 712, 722 (1986).

<sup>4</sup> *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

<sup>5</sup> 5 U.S.C. § 8107.

<sup>6</sup> 20 C.F.R. § 10.404 (1999).

<sup>7</sup> See A.M.A., *Guides*, Table 5.10 at 107 (5<sup>th</sup> ed. 2001).

<sup>8</sup> This is characterized in the A.M.A., *Guides* as the DLCO test.

<sup>9</sup> With respect to Class 2, the observed value must also be less than the lower limit of normal. The predicted normal values and the predicted lower limits of normal values for the FVC, FEV<sub>1</sub> and DLCO tests are delineated in separate tables. A.M.A., *Guides* 95-100, Tables 5-2a through 5-7b.

<sup>10</sup> The A.M.A., *Guides* provides alternate means for measuring such volumes.

<sup>11</sup> See *id.* at 108.

## ANALYSIS

On appeal, appellant contends that he is entitled to a schedule award for permanent impairment of the lungs. The Office accepted his claim for bronchitis and pneumonitis due to fumes and vapors. The Board finds that there is a conflict in medical opinion between Dr. Jenkins and Office medical adviser, for the Office and Dr. Rodriguez, appellant's treating physician.

Dr. Jenkins, reviewed the pulmonary function test performed under his direction and noted that appellant was unable to perform the test and he found no physiologic explanation for this result. He noted that appellant exhibited minimal breathing effort while being tested, during his physical examination and during the other recent pulmonary function tests. Dr. Jenkins opined that the objective measures of pulmonary function were normal including a June 26, 2008 arterial blood gas report, a CT scan and an exercise test of June 24, 2008; therefore, there was no lung impairment pursuant to the A.M.A., *Guides*. The Office medical adviser concurred in Dr. Jenkins' determination. By contrast, Dr. Rodriguez performed a pulmonary function test on August 5, 2008 that revealed severe airway obstruction and reduced lung volumes which indicated concurrent restrictive process. He noted that the results of the test met the acceptability threshold standards for acceptability and reproducibility. Dr. Rodriguez noted FEV<sub>1</sub> of 1.16 was 34 percent of predicted,<sup>12</sup> FVC of 2.47 was 56 percent of predicted<sup>13</sup> and an FEV<sub>1</sub>/FVC of 47 was 60 percent of predicted, which pursuant to the A.M.A., *Guides*, would correlate to a ratable pulmonary impairment.<sup>14</sup> He determined that the work-related exposure was the competent producing factor for appellant's subjective and objective findings. Dr. Rodriguez supported an impairment rating of the lungs, while the second opinion physician and Office medical adviser opined that appellant did not sustain permanent impairment to the lungs.

Section 8123(a) of the Act provides in pertinent part: "If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."<sup>15</sup> When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of the Act, to resolve the conflict in the medical evidence.<sup>16</sup> The Board finds that the Office should have referred appellant to an impartial medical specialist to resolve the medical conflict regarding the extent of permanent impairment, if any, arising from appellant's accepted employment injury.

Therefore, in order to resolve the conflict in the medical opinion, the case will be remanded to the Office to refer appellant, along with the case record and a statement of accepted facts, to an impartial medical specialist. After such further development as the Office deems

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<sup>12</sup> *Id.* at 107, Table 5-12.

<sup>13</sup> *Id.*

<sup>14</sup> *Id.*

<sup>15</sup> 5 U.S.C. § 8123(a).

<sup>16</sup> *William C. Bush*, 40 ECAB 1064 (1989).

necessary, an appropriate decision should be issued regarding the extent of appellant's lung impairment.

**CONCLUSION**

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

**ORDER**

**IT IS HEREBY ORDERED THAT** the April 6, 2009 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further action consistent with this decision.

Issued: April 19, 2010  
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