United States Department of Labor
Employees' Compensation Appeals Board

J.G., Appellant	)	
and	)	**Docket No. 09-1714**
	)	**Issued: April 7, 2010**
DEPARTMENT OF THE NAVY, PHILADELPHIA NAVAL SHIPYARD, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
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 June 16, 2009 appellant, through his attorney, filed an appeal from a July 23, 2008 merit decision of the Office of Workers' Compensation Programs denying his claim for 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 for permanent impairment of the lungs.

FACTUAL HISTORY

On September 21, 1988 appellant, then a 61-year-old inspector, filed an occupational disease claim alleging that he sustained a pulmonary condition causally related to factors of his federal employment. He did not stop work. The Office accepted appellant's claim for asbestos exposure resulting in pleural thickening.

By decision dated June 29, 1989, the Office denied appellant's claim for compensation and a schedule award. It found that the medical evidence did not establish that he sustained any permanent impairment of the lungs.

On March 27, 2007 appellant filed a claim for a schedule award. On April 9, 2007 the Office requested that he have his attending physician submit an impairment evaluation in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) (A.M.A., *Guides*). On April 17, 2007 appellant's attorney requested that the Office hold the schedule award claim in abeyance as he was in receipt of compensation for temporary total disability.

By decision dated July 26, 2007, the Office denied appellant's claim for a schedule award as he did not submit any evidence to establish that he had permanent impairment due to his accepted condition of pleurisy without effusion or current tuberculosis.

On July 31, 2007 appellant requested an oral hearing. At the hearing held on December 19, 2007, he described his exposure to asbestos during the course of his federal employment.

In a report dated December 19, 2006, Dr. Gary A. Agia, an osteopath, diagnosed mild obstructive lung disease, questionable asthma and asbestosis by history. He performed pulmonary function tests (PFT) on appellant, who was then 80 years old and 6 feet tall, which revealed "some mild obstructive impairments."

A PFT performed for Dr. Agia on December 27, 2007 revealed that appellant was 182.88 centimeters tall, had mild-to-moderate airway obstruction prebronchodilator with "excellent reversibility with bronchodilator" and normal diffusing capacity.[1] Appellant's forced vital capacity (FVC) result prebronchodilator was 3.59 liters, or 84 percent of predicted, and after bronchodilator was 4.47 or 105 percent of predicted. His forced expiratory value in the first second (FEV_1) was 2.18, or 66 percent of predicted prebronchodilator and 3.08, or 93 percent of predicted postbronchodilator. His ratio of FEV to FVC was 60.80, or 78 percent of predicted prebronchodilator and 68.77, or 88 percent of predicted postbronchodilator.

By decision dated March 4, 2008, the hearing representative affirmed the July 26, 2007 decision.

On April 21, 2008 appellant, through his attorney, requested reconsideration. He submitted an April 9, 2008 report from Dr. Agia in support of his request. Dr. Agia discussed appellant's work history, his 10-pack-a-year history of cigarette smoking and his history of "significant cardiac disease" with angioplasty and stinting. He related that x-rays confirmed pleural disease and that a CT scan showed "mild accentuation in the interstitial markings in both bases. This is consistent with early asbestos[-]related parenchymal disease." Dr. Agia interpreted PFTs as showing reversible obstructive airways disease without a restrictive component or an impairment in diffusing capacity. He diagnosed asbestos-related pleural

[1] A computerized tomography (CT) scan of the chest dated December 26, 2007 revealed chronic interstitial markings without infiltrates or effusions and pleural thickening with calcifications "likely suggesting asbestos exposure."

disease and early asbestos-related parenchymal disease with a Class 2, or 15 to 20 percent, impairment. Dr. Agia also diagnosed early interstitial findings on CT scan likely due to asbestosis and asthma with normal diffusing capacity and lung volume testing. He noted that appellant's respiratory impairment would likely increase and concluded, "Overall impairments due to asbestos[-]related lung disease are estimated to be 20 percent (Class 2)."

By decision dated July 23, 2008, the Office denied modification of its March 4, 2008 decision. It found that Dr. Agia did not explain how he determined that appellant had a Class 2 impairment or discuss the effect of his cardiac disease on his pulmonary function. The Office further noted that, as Dr. Agia found that the PFT showed a reversible obstructive airways disease, appellant was not at maximum medical improvement.

On appeal, appellant's attorney contends that Dr. Agia's report establishes that he has permanent impairment of the lungs. He alternatively argued that the medical evidence warranted further development by the Office.

LEGAL PRECEDENT

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 diffusion of carbon dioxide (Dco). The values for predicted and observed normal values for FEV_1, FVC and Dco are found in Table 5-2a through Table 5-7b.[2] 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.[3] For Class 2 through Class 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.[4] 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.[5] 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.[6]

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

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

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

[4] The predicted normal values and the predicted lower limits of normal values for the FVC, FEV_1 and DLCO tests are delineated in Table 5-2a through 5-7b.

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

[6] *Id*. at 107.

312 weeks (twice the award for loss of function of one lung) to obtain the number of weeks payable in the schedule award.[7]

Office procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the Office medical adviser providing rationale of the percentage of impairment specified.[8]

ANALYSIS

The Office accepted that appellant sustained pleural thickening due to asbestos exposure in the course of his federal employment. On March 27, 2007 he filed a claim for a schedule award. In an April 9, 2008 impairment evaluation, Dr. Agia diagnosed asbestos-related pleural disease and parenchymal disease and found that a CT scan revealed early interstitial findings likely caused by asthma and asbestosis. He noted that appellant had a history of cardiac disease treated with angioplasty and a stint. Dr. Agia interpreted a PFT performed on December 27, 2007 as showing normal diffusing capacity and volume testing but reversible obstructive airway disease. He asserted that appellant had a Class 2 pulmonary impairment due to his lung disease resulting from his asbestos exposure.

While Dr. Agia did not explain how he calculated the Class 2 impairment under the A.M.A., *Guides*, the Office may rely on the opinion of the Office medical adviser to apply the A.M.A., *Guides* to the findings reported by the attending physician.[9] In this case, however, the Office did not refer either the December 27, 2007 PFT or Dr. Agia's impairment evaluation to an Office medical adviser for review to determine whether it revealed a ratable pulmonary impairment. As noted, Office procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an Office medical adviser for an opinion concerning the nature and percentage of any impairment, and the Office medical adviser should provide rationale for the percentage of impairment specified.[10] The Office found that as appellant's PFT results improved postbronchodilator, he was not at maximum medical improvement. The degree of improvement postbronchodilator, however, does not determine whether or not a claimant has reached maximum medical improvement. The A.M.A., *Guides* instructs the evaluator to "[u]se the spirogram indicating the best effort, before or after administration of a bronchodilator, to determine FVC and FEV_1 for impairment assessment."[11]

The Office further found that Dr. Agia did not discuss the effect of appellant's cardiac condition on his pulmonary impairment.[12] The Board notes, however, that impairments due to

[7] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.4.(c)(1) (March 2005).

[8] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002); *Tommy R. Martin*, 56 ECAB 273 (2005).

[9] *See Linda Beale*, 57 ECAB 429 (2006).

[10] *Id*.

[11] A.M.A., *Guides* 93, section 5.4d.

[12] The Office further found that Dr. Agia did not explain how he calculated the extent of appellant's lung impairment.

preexisting conditions are included in determining the extent the lung impairment, as long as the impairment is due at least in part to the employment injury.[13] On remand, the Office should refer the evidence to the Office medical adviser for a determination of whether the medical evidence is sufficient to establish whether appellant has reached maximum medical improvement, and if so, whether appellant has a pulmonary impairment causally related to his accepted work injury and, if so, the extent of any impairment. Following this and any further development deemed necessary, the Office should issue a *de novo* decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated July 23, 2008 is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: April 7, 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

[13] *Beatrice L. High*, 57 ECAB 329 (2006) (in determining the amount of a schedule award for a member of the body that sustained an employment-related impairment, preexisting impairments are to be included); *Thomas P. Lavin*, 57 ECAB 353 (2006) (where the claimant did not demonstrate any permanent impairment caused by the accepted occupational exposure, the claim was not ripe for consideration of any preexisting impairment).