



## **FACTUAL HISTORY**

Appellant, a 72-year-old retired supervisory quality assurance specialist -- shipbuilding, has an accepted claim for post-inflammatory pulmonary fibrosis, which arose on or about November 1, 2004.<sup>2</sup> On September 12, 2011 he filed a claim for a schedule award.

OWCP previously referred appellant for examination by Dr. Ganesh K. Akula, a Board-certified internist specializing in pulmonary disease, who examined appellant on April 14, 2011 and administered a pulmonary function study (PFS) that same day. The next day an arterial blood gas study was administered. An electrocardiogram and chest x-ray were administered on May 12, 2011. Dr. Akula also reviewed appellant's medical records. In a July 24, 2011 report, he noted that appellant was exposed to asbestos as a child while working in his father's auto shop. Dr. Akula also obtained a history of appellant's asbestos exposure while employed as a machinist at the shipyard from 1957 to 1974. Additionally, appellant was a smoker with a 47-year smoking history from age 18 to 65. Dr. Akula indicated that in 2004 appellant was diagnosed with chronic obstructive pulmonary disease (COPD)/emphysema and in January 2005 he had a large bleb surgically removed from his right lung. He interpreted the PFS as revealing moderate obstructive lung disease and probable underlying restrictive disease. The recent chest x-ray revealed hyperaerated lungs with bilateral partially calcified pleural plaques and left apical pleuroparenchymal fibrosis.<sup>3</sup> Dr. Akula diagnosed moderate COPD. He explained that appellant's PFS revealed moderate obstructive air flow due to previous tobacco abuse. Dr. Akula also diagnosed asbestos-related lung disease with pleural calcifications and interstitial pulmonary fibrosis. He indicated that appellant's main symptoms appeared related to his underlying COPD and to some extent due to asbestosis, but it was hard to tell what percentage was work related.

In a supplemental report dated August 11, 2011, Dr. Akula indicated that appellant had moderate COPD, secondary to his previous smoking and had also developed asbestos-related lung disease, including plural calcification and interstitial pulmonary fibrosis, as confirmed by CT scan and pulmonary function test. He reiterated that appellant's asbestos-related lung disease -- plural calcifications and interstitial pulmonary fibrosis (asbestosis) -- was due to his occupational exposure.

On October 3, 2011 Dr. A.E. Anderson, Jr., district medical adviser, reviewed the record, including Dr. Akula's reports and found that appellant had no impairment (zero percent) of the lungs. He applied the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (6<sup>th</sup> ed. 2008), referencing Table 5-4 (Pulmonary Dysfunction), A.M.A., *Guides* 88. Dr. Anderson calculated impairment based on a diagnosis of asbestosis and he relied on the forced vital capacity (FVC) result from appellant's April 14, 2011 PFS. The FVC (3.97) result was 94 percent of predicted normal.

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<sup>2</sup> Appellant voluntarily retired effective May 1, 1993.

<sup>3</sup> Dr. Akula also referenced a chest x-ray obtained on December 14, 2010. While he accurately described the findings, he incorrectly identified this multi-view chest x-ray as a December 14, 2011 "CT [computerized tomography] scan."

By decision dated October 5, 2011, OWCP denied appellant's claim for a schedule award.

On October 11, 2011 appellant's counsel requested reconsideration. He noted that, while appellant's FVC result did not demonstrate impairment, other findings of the April 14, 2011 PFS demonstrated impairment under Table 5-4, A.M.A., *Guides* 88. Specifically, counsel noted that the forced expiratory volume (FEV<sub>1</sub>) result (1.59) was 56 percent of predicted normal or a Class 2 impairment under Table 5-4.<sup>4</sup> Counsel requested that the case be remanded to the medical adviser to explain why appellant was not entitled to a rating based on his FEV<sub>1</sub> result.

In a report dated October 24, 2011, Dr. Anderson explained that, based on Dr. Akula's report, appellant had work-related asbestosis, which was a restrictive disorder. He further explained that, under the A.M.A., *Guides* (6<sup>th</sup> ed. 2008), FVC is the standard measure for restrictive lung disease.

In a decision dated December 1, 2011, OWCP denied merit review.

### **LEGAL PRECEDENT**

Section 8107 of FECA sets 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.<sup>5</sup> FECA, 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 A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.<sup>6</sup> Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2008).<sup>7</sup>

No schedule award is payable for a member, function or organ of the body that is not specified in FECA or in the implementing regulations.<sup>8</sup> The list of scheduled members includes the eye, arm, hand, fingers, leg, foot and toes.<sup>9</sup> Additionally, FECA specifically provides for compensation for loss of hearing and loss of vision.<sup>10</sup> By authority granted under FECA, the Secretary of Labor expanded the list of scheduled members to include the breast, kidney, larynx,

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<sup>4</sup> The post-bronchodilator result (1.73) was 61 percent of predicted normal, which also represented Class 2 impairment under Table 5-4, A.M.A., *Guides* 88.

<sup>5</sup> 5 U.S.C. § 8107(c).

<sup>6</sup> 20 C.F.R. § 10.404.

<sup>7</sup> See Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6a (January 2010).

<sup>8</sup> *W.C.*, 59 ECAB 372, 374-75 (2008); *Anna V. Burke*, 57 ECAB 521, 523-24 (2006).

<sup>9</sup> 5 U.S.C. § 8107(c).

<sup>10</sup> *Id.*

lung, penis, testicle, tongue, ovary, uterus/cervix and vulva/vagina.<sup>11</sup> Neither FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back or the body as a whole.<sup>12</sup>

Not all impairments to a scheduled member need be employment related. Under certain circumstances, previous impairments may be included in calculating the percentage of loss.<sup>13</sup>

### ANALYSIS

The Board finds that the case is not in posture for decision. Dr. Akula diagnosed moderate COPD/emphysema due to smoking, as well as asbestos-related lung disease due to occupational exposure. Dr. Anderson rated appellant's pulmonary dysfunction based on his asbestos-related employment injury. He explained that asbestosis was a restrictive impairment and under the A.M.A., *Guides* (6<sup>th</sup> ed. 2008), the FVC result was the appropriate measure of impairment due to asbestosis. Dr. Anderson did not address the other findings from the pulmonary function studies. Example 5-4, page 94-95, for asbestos discussed clinical findings based on pulmonary function studies beyond the predicted FVC.

There are circumstances where prior impairments to a scheduled member may be included in calculating the overall percentage of loss.<sup>14</sup> Appellant had x-ray evidence of severe COPD dating back as early as August 2000, which predated his November 1, 2004 accepted employment injury. The case will be remanded to OWCP for further medical development. OWCP should ask Dr. Anderson to further address the extent of any pulmonary impairment based on pulmonary function studies or refer appellant for examination by a Board-certified pulmonary specialist. After such further medical development as OWCP deems necessary, a *de novo* decision shall be issued regarding appellant's entitlement to a schedule award.

### CONCLUSION

Appellant's claim for a schedule award is not in posture for decision.<sup>15</sup>

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<sup>11</sup> 5 U.S.C. § 8107(c)(22); 20 C.F.R. § 10.404(a).

<sup>12</sup> *Id.* at § 8107(c); *Id.* at § 10.404(a); *see Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

<sup>13</sup> Federal (FECA) Procedure Manual, *supra* note 8 at Chapter 2.808.7a(2); *see R.D.*, 59 ECAB 127, 130 (2007).

<sup>14</sup> Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.7a(2).

<sup>15</sup> Given the Board's disposition of the schedule award claim on the merits, OWCP's December 1, 2011 decision denying reconsideration is moot.

**ORDER**

**IT IS HEREBY ORDERED THAT** the December 1 and October 5, 2011 decisions of the Office of Workers' Compensation Programs are set aside and the case is remanded for further action consistent with this decision.

Issued: July 9, 2012  
Washington, DC

Richard J. Daschbach, Chief Judge  
Employees' Compensation Appeals Board

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

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