United States Department of Labor
Employees' Compensation Appeals Board

I.B., Appellant	)	
and	)	**Docket No. 14-388**
	)	**Issued: May 20, 2014**
DEPARTMENT OF THE NAVY, NAVAL FACILITIES ENGINEERING COMMAND -- STATIONS, San Diego, CA, 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 6, 2013 appellant filed a timely appeal from a November 25, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 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 has established permanent impairment due to his work-related injuries.

FACTUAL HISTORY

On May 31, 2012 appellant, then a 69-year-old retired boilermaker and boiler plant operator, filed an occupational disease claim (Form CA-2) alleging that he developed pleural

[1] 5 U.S.C. § 8101 *et seq.*

plaques in his lungs as a result of work-related exposure to asbestos. He first became aware of his condition and of its relationship to his employment on January 10, 2012.

In a November 16, 2012 statement of accepted facts, OWCP reported that appellant worked as a boilermaker from 1968 to 1974 and worked as a boiler plant operator from 1974 to 1995 when he retired from employment. The employing establishment confirmed that he participated in an asbestos medical surveillance program.

In a January 10, 2012 medical report, Dr. Herman Bruch, Board-certified in internal medicine and subspecialty in pulmonary disease, reported that appellant underwent a pulmonary function study on January 10, 2012. He noted that a computerized tomography (CT) scan of the chest revealed asbestos-related pleural disease and interstitial fibrosis indicative of pulmonary asbestosis. Dr. Bruch stated that appellant had no complaints of dyspnea and his lung function showed mild airway obstruction which was probably related to his history of smoking. He found no evidence of pulmonary emphysema. Upon review of the study and physical examination, Dr. Bruch diagnosed asbestos-related pleural disease and interstitial fibrosis as a result of appellant's federal employment duties.

OWCP referred appellant together with a statement of accepted facts and a series of questions, for a second opinion examination by Dr. Hsien Wen Hsu, Board-certified in internal medicine and subspecialty in pulmonary disease.

On January 10, 2013 appellant underwent a spirometry and pulmonary function analysis by Dr. Kristina Kramer, Board-certified in internal medicine and subspecialty in critical care medicine and pulmonary disease. The test revealed a forced vital capacity (FVC) of 3.76 liters (L) or 107 percent of predicted, a forced expiratory value in the first second (FEV_1) of 2.55 L or 93 percent of predicted and a diffusing capacity of carbon monoxide (DLco) of 22 millimeters (mm) per minute or 83 percent of predicted. The ratio of FEV_1 to FVC was 68 percent with no significant change with bronchodilators. Dr. Kramer found mild isolated obstruction with well-preserved lung volumes and gas exchange.

In a January 30, 2013 report, Dr. Hsu examined appellant and reviewed the case record and pulmonary function analysis. He opined that appellant had asbestos-related pleural disease and interstitial fibrosis due to work-related exposure based on findings of pleural thickening and mild interstitial infiltrate noted on both his chest CT and chest x-ray. Dr. Hsu diagnosed pleural plaque with presence of asbestos and pulmonary asbestosis. He reported that appellant continued to suffer from work-related exposure and his pleural disease and lung fibrotic changes would likely continue to worsen throughout his lifetime. In accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), Dr. Hsu opined that appellant's degree of impairment was class 0. An FVC equal or above 80 percent (107 percent predicted in his case), FEV_1 equal or greater than 80 percent (93 percent predicted) and a DLco above 75 percent (83 percent predicted) resulted in no ratable impairment despite appellant's subjective complaints.[2]

[2] A.M.A., *Guides* (2009).

In an October 18, 2013 report, Dr. Emeka Eziri, an OWCP consultant Board-certified in pulmonary disease, reported that review of appellant's medical reports revealed asbestos-related pleural disease and interstitial fibrosis without pulmonary emphysema. Based on the sixth edition of the A.M.A., *Guides*, he noted no symptoms of dyspnea, no objective physical findings based on normal pulmonary function testing. Dr. Eziri agreed with Dr. Hsu's determination that appellant had a class 0 impairment rating for pulmonary dysfunction which did not represent a permanent impairment.[3]

By decision dated November 25, 2013, OWCP denied appellant's claim for a schedule award. It found that the medical evidence was not sufficient to establish that he sustained any permanent impairment to the lungs based on his asbestos exposure.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing regulations 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.[4] However, FECA 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.[5] For decisions after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[6]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[7] Chapter 5 of the A.M.A., *Guides* addresses the framework to be used for addressing the pulmonary system.[8] Table 5-4, Pulmonary Dysfunction, describes four classes of pulmonary dysfunction based on an assessment of history, physical findings and objective tests, including a comparison of observed values for certain ventilatory function measures and their respective predicted values.[9] The appropriate class of impairment is determined by the observed values for either the FVC, FEV_1 or DLco, measured by their respective predicted values. If one of the three ventilatory function measures, FVC, FEV_1 or DLco or the ratio of FEV_1 to FVC,

[3] *Id.* at 88, Table 5-4.

[4] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[5] *K.H.*, Docket No. 09-341 (issued December 30, 2011). For decisions issued after May 1, 2009, the sixth edition will be applied. *B.M.*, Docket No. 09-2231 (issued May 14, 2010).

[6] *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 and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

[7] *Supra* note 2 at 3, section 1.3, The ICF, Disability and Health: A Contemporary Model of Disablement.

[8] *Id*. at 77-99.

[9] *Id.* at 88.

stated in terms of the observed values, is abnormal to the degree described in classes 2 to 4, then the individual is deemed to have an impairment which would fall into that particular class of impairments, either class 2, 3 or 4, depending on the severity of the observed value.[10]

OWCP's procedures provide that 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 312 weeks (twice the award for loss of function of one lung) to obtain the number of weeks payable in the schedule award.[11] The procedures further provide that, after obtaining all necessary medical evidence, the file should be routed to the medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[12]

ANALYSIS

OWCP accepted appellant's claim for bilateral asbestosis. By decision dated November 25, 2013, it denied his claim for a schedule award as the medical evidence was not sufficient to establish that he sustained any permanent impairment to his lungs. The Board finds that appellant has not met his burden of proof to establish that he sustained a permanent impairment due to his work-related bilateral asbestosis.[13]

In a January 30, 2013 report, Dr. Hsu reviewed the January 10, 2013 pulmonary function analysis and opined that appellant had asbestos-related pleural disease and interstitial fibrosis due to his work-related exposure. Based on the sixth edition of the A.M.A., *Guides*, he determined that appellant's degree of impairment was class 0. An FVC equal or above 80 percent (107 percent predicted), FEV_1 equal or greater than 80 percent (93 percent predicted) and a DLco above 75 percent (83 percent predicted) resulted in no impairment despite appellant's subjective complaints.[14]

Dr. Eziri reviewed Dr. Hsu's report and the pulmonary function analysis. He agreed that appellant's asbestos-related pleural disease and interstitial fibrosis resulted in no permanent impairment under class 0. Dr. Eziri found no symptoms of dyspnea and no physical findings of current disease. Objective tests also established a class 0 impairment rating as appellant's 107 percent FVC was above 80 percent, the 93 percent FEV_1 was above 80 percent and the 83 percent DLco was above 75 percent resulting in objective findings of normal pulmonary function testing.[15] Dr. Eziri provided a well-reasoned report based on a proper factual and medical

[10] *Id.*

[11] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.4(d)(1) (January 2010).

[12] *Supra* note 6, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

[13] *J.P.*, Docket No. 06-683 (issued October 23, 2006).

[14] *Supra* note 9.

[15] *Id.*

history and included detailed findings and rationale supporting his opinion. Based on Table 5-4, he properly found that appellant had a class 0 impairment rating for pulmonary dysfunction which did not demonstrate a permanent impairment.[16] As the record does not provide any medical opinion finding that appellant sustained permanent impairment of his lung as a result of his employment injury, the Board finds that OWCP properly denied his claim for a schedule award.[17]

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish entitlement to a schedule award for permanent impairment.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decision dated November 25, 2013 is affirmed.

Issued: May 20, 2014
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

[16] *Id.*

[17] *James R. Bender*, Docket No. 04-997 (issued August 2, 2004).