

**United States Department of Labor  
Employees' Compensation Appeals Board**

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D.A., Appellant )

and )

DEPARTMENT OF VETERANS AFFAIRS, )  
VETERANS ADMINISTRATION MEDICAL )  
CENTER, Dallas, TX, Employer )

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**Docket No. 17-1753  
Issued: February 13, 2018**

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

*Case Submitted on the Record*

**DECISION AND ORDER**

Before:

CHRISTOPHER J. GODFREY, Chief Judge  
ALEC J. KOROMILAS, Alternate Judge  
VALERIE D. EVANS-HARRELL, Alternate Judge

**JURISDICTION**

On August 8, 2017 appellant filed a timely appeal from June 29 and July 7, 2017 merit decisions of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act<sup>1</sup> (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 more than six percent permanent impairment of the lungs for which she previously received schedule awards.

**FACTUAL HISTORY**

On February 9, 2009 appellant, then a 50-year-old vocational nurse, filed an occupational disease claim (Form CA-2) alleging that she developed difficulty breathing, shortness of breath,

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<sup>1</sup> 5 U.S.C. § 8101 *et seq.*

nasal and sinus congestion, asthma, eye irritation, and mouth ulcers due to mold and toxin exposure at work. She became aware of her condition on June 2, 2008 and its relationship to her federal employment on July 2, 2008. The employing establishment indicated that appellant worked in a different building after the date of injury. OWCP accepted the claim for an aggravation of allergic rhinitis and an aggravation of asthma due to mold exposure.<sup>2</sup>

In a March 7, 2012 impairment evaluation, Dr. Gregory Powell, a Board-certified physiatrist, discussed appellant's symptoms of shortness of breath and diagnosed occupational asthma. He identified the diagnosis as class 1 asthma using Table 5-5 on page 90 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).<sup>3</sup> Dr. Powell indicated that appellant's daily use of a bronchodilator constituted a class 2 impairment but found that her forced expiratory volume in one second (FEV<sub>1</sub>) was 79 percent of predicted, for a class 1 impairment. He advised that he used the class 1 impairment as it was based on objective testing, but modified her impairment rating upward due to her daily bronchodilator use, for eight percent whole person permanent impairment.

Dr. H. Mobley, an internist and OWCP district medical adviser (DMA) reviewed the evidence on July 31, 2012 and noted that Dr. Powell had not included a copy of the pulmonary function study (PFS) he relied upon in reaching his impairment determination.<sup>4</sup> He recommended referring appellant for a second opinion examination.

On August 21, 2012 OWCP referred appellant to Dr. Javed Ashiq, a Board-certified internist and pulmonologist, for a second opinion examination regarding the extent of appellant's permanent impairment of the lungs. In a report dated September 11, 2012, Dr. Ashiq interpreted a PFS as showing a normal, large airway with no bronchodilator response, mildly reduced diffusing capacity of the lungs for carbon monoxide (DLCO), and normal lung volume. He diagnosed allergic rhinitis and asthma. Dr. Ashiq advised that appellant's postbronchodilator FEV<sub>1</sub> was 88 percent of predicted for a class 0 impairment. He further found a class zero impairment for pulmonary dysfunction under Table 5-4 on page 88 based on objective tests, history, and examination findings.

Dr. Mobley reviewed the evidence and concurred with Dr. Ashiq's finding of no lung impairment. He noted, however, that Dr. Ashiq should submit a copy of the PFS relied upon in reaching his impairment rating.

In an impairment evaluation dated April 6, 2015, Dr. Louise Lamarre, a family practitioner, discussed appellant's history of injury. She reviewed a November 21, 2012 PFS

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<sup>2</sup> By decision dated March 6, 2009, OWCP denied appellant's claim as the medical evidence was insufficient to establish a diagnosed condition as a result of the accepted work factors. On September 8, 2009 it vacated its March 6, 2009 decision and accepted the claim for an aggravation of allergic rhinitis and asthma.

<sup>3</sup> A.M.A., *Guides* (6<sup>th</sup> ed. 2009).

<sup>4</sup> By decision dated May 15, 2012, OWCP denied appellant's claim for wage-loss compensation on February 13 and 21, March 7, and April 24, 2012. On September 7, 2012 it vacated the May 15, 2012 decision and found that she was entitled to compensation for four hours per day on those dates for time lost due to doctor's appointments.

showing an FEV<sub>1</sub> of 59 percent of predicted and a study two years later showing an FEV<sub>1</sub> of 70 percent of predicted. Dr. Lamarre noted that a July 28, 2008 computerized tomography (CT) scan revealed nodules in the right upper lobe of appellant's lung. She identified the diagnosis as class 1 asthma using Table 5-5 on page 90 of the A.M.A., *Guides* based on the PFS showing an FEV<sub>1</sub> of 70 percent of the predicted value, which yielded a default value of six percent. Dr. Lamarre moved the value to grade D due to appellant's periodic exacerbations of her condition, frequent use of medication, the lung nodule on the CT scan, and the prior PFS showing an FEV<sub>1</sub> of 59 percent of predicted, for a final impairment rating of eight percent of the whole person.

OWCP determined that a conflict in medical opinion existed between Dr. Lamarre and Dr. Powell, appellant's physicians, and Dr. Ashiq, who had provided a second opinion examination, regarding whether appellant sustained a permanent impairment of the lungs. On May 16, 2016 it referred her to Dr. Dennis M. Parker, a Board-certified internist and pulmonologist, for an impartial medical examination.

In a report dated August 8, 2016, Dr. Parker discussed appellant's history of injury. He obtained a PFS demonstrating a forced vital capacity (FVC) of 72 percent of normal and an FEV<sub>1</sub> of 73 percent of normal before bronchodilators and an FVC of 77 percent of normal and an FEV<sub>1</sub> of 76 percent of normal after bronchodilators. Using Table 5-4 on page 88 of the A.M.A., *Guides*, Dr. Parker found that appellant had class 1 impairment due to allergic asthma based on her intermittent use of albuterol. He determined that she had no physical findings and did not use optimal effort on PFS, for a class zero permanent impairment based on testing. Dr. Parker related, "Therefore, I would characterize [appellant's] impairment as class 1, grade 1 because her history of still requiring intermittent treatment would preclude her from being entirely in class 0 with zero impairment. I would assign to her at best [two percent] impairment." He opined that appellant had reached maximum medical improvement.

Dr. Albert A. Rizzo, a Board-certified internist and pulmonologist acting as a DMA, reviewed the evidence on October 3, 2016 and found that an FVC of 77 percent and an FEV<sub>1</sub> of 76 percent postbronchodilator constituted class 1 impairment with a default value of six percent under Table 5-4 on page 88. He further found class 1 impairment due to dyspnea requiring medication and class 0 impairment based on physical findings, which adjusted the impairment down to four percent. In a supplemental report dated December 14, 2016, Dr. Rizzo related that Dr. Parker found that appellant had class 0 impairment and then adjusted the impairment upward to two percent based on history even though it was a non-key factor. He used the FVC and FEV<sub>1</sub> results to find class 1 impairment under Table 5-4, and adjusted the impairment rating downward to four percent from the default value of six percent.

By decision dated January 24, 2017, OWCP granted appellant a schedule award for four percent permanent impairment of a lung. The period of the award ran for 6.24 weeks from August 8 to September 20, 2016.

Appellant, on April 7, 2017, requested reconsideration. By decision dated June 29, 2017, OWCP modified in part and affirmed in part the January 24, 2017 decision. It found that Dr. Parker's report constituted the special weight of the evidence and established that appellant had six percent permanent impairment of the lungs. OWCP determined that its medical adviser

should not have adjusted the report of the impartial medical examiner (IME), and modified its January 24, 2017 decision to show that appellant had six percent permanent impairment.

By decision dated July 7, 2017, OWCP granted appellant a schedule award for an additional two percent permanent impairment of a lung. The period of the award ran for 3.12 weeks from September 21 to October 12, 2016.

On appeal appellant questions the period of the award and why it did not begin on the date of injury. She notes that she still experiences problems due to her accepted condition.

### **LEGAL PRECEDENT**

The schedule award provision of FECA,<sup>5</sup> and its implementing federal regulation,<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, 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.<sup>7</sup> As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.<sup>8</sup>

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based impairment (DBI) method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).<sup>9</sup> Chapter 5 of the A.M.A., *Guides* addresses the framework to be used for addressing the pulmonary system.<sup>10</sup> 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.<sup>11</sup> The appropriate class of impairment is determined by the observed values for the FVC, FEV<sub>1</sub>, or DLCO, measured by their respective predicted values. If one of the three ventilatory function measures, FVC, FEV<sub>1</sub>, or DLCO or the ratio of FEV<sub>1</sub> to FVC, 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.<sup>12</sup> Table 5-5, relevant to rating impairments due to asthma,

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<sup>5</sup> 5 U.S.C. § 8107.

<sup>6</sup> 20 C.F.R. § 10.404.

<sup>7</sup> *Id.* at § 10.404(a).

<sup>8</sup> Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (February 2013); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

<sup>9</sup> A.M.A., *Guides* 3 (2009), section 1.3, The ICF, Disability and Health: A Contemporary Model of Disablement.

<sup>10</sup> *Id.* at 77-99.

<sup>11</sup> *Id.* at 88.

<sup>12</sup> *Id.*

provides whole person permanent impairment ratings based on a designated class (0-4) of impairment.<sup>13</sup> Depending on the assigned class, the range of whole person permanent impairment due to asthma is 0 to 65 percent.

OWCP's procedures provide that all claims involving permanent 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.<sup>14</sup>

FECA provides that, if there is disagreement between an OWCP-designated physician and the employee's physician, OWCP shall appoint a third physician who shall make an examination.<sup>15</sup> For a conflict to arise the opposing physicians' viewpoints must be of "virtually equal weight and rationale."<sup>16</sup> Where OWCP has referred the case to an impartial medical examiner to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well-reasoned and based upon a proper factual background, must be given special weight.<sup>17</sup>

When a case has been referred for a referee evaluation to resolve the issue of permanent impairment, it is appropriate for the DMA to review the calculations to ensure the referee physician appropriately used the A.M.A., *Guides*.<sup>18</sup>

### ANALYSIS

OWCP accepted that appellant sustained an aggravation of allergic rhinitis and an aggravation of asthma due to exposure to mold at work. It properly determined that a conflict in medical opinion arose between her attending physicians, Dr. Powell and Dr. Lamarre, and the OWCP referral physician, Dr. Ashiq, regarding whether she sustained a permanent impairment of the lungs due to her accepted employment injury. OWCP properly referred appellant to Dr. Parker, a Board-certified internist and pulmonologist, for an impartial medical examination.

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<sup>13</sup> *Id.* at 90.

<sup>14</sup> Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(c)(1) (February 2013).

<sup>15</sup> 5 U.S.C. § 8123(a); *see* 20 C.F.R. § 10.321; *Shirley L. Steib*, 46 ECAB 309, 317 (1994). The DMA, acting on behalf of OWCP, may create a conflict in medical opinion. 20 C.F.R. § 10.321(b).

<sup>16</sup> *Darlene R. Kennedy*, 57 ECAB 414, 416 (2006).

<sup>17</sup> *Gary R. Sieber*, 46 ECAB 215, 225 (1994).

<sup>18</sup> Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.8k (September 2010). Although the DMA may review the opinion of a referee specialist in a schedule award case, the resolution of the conflict is the specialist's responsibility. *Id.* The DMA cannot resolve a conflict in medical opinion. *Id.*

When a case is referred to an impartial medical examiner for the purpose of resolving a conflict, the opinion of such specialist, is sufficiently well rationalized and based on a complete factual and medical background, must be given special weight.<sup>19</sup>

The Board finds that the case is not in posture for decision as the impartial medical examiner did not provide an impairment rating in accordance with the provisions of the A.M.A., *Guides*. In a report dated August 8, 2016, Dr. Parker identified the diagnosis as asthma. He used Table 5-4 on page 89 of the A.M.A., *Guides* to find class 1 impairment based on appellant's use of albuterol. Dr. Parker noted that a PFS demonstrated an FVC of 72 percent of normal and an FEV<sub>1</sub> of 73 percent of normal before bronchodilators and an FVC of 77 percent of normal and an FEV<sub>1</sub> of 76 percent of normal after bronchodilators. Dr. Parker indicated that appellant used suboptimal effort on the PFS and had no physical findings, for a class zero impairment, but opined that she had class 1 impairment as she still required treatment. He found two percent permanent impairment of the lungs. The A.M.A., *Guides*, however, provides a separate table, Table 5-5, for calculating impairments due to asthma.<sup>20</sup> The objective tests for asthma impairment are not the same as for rating other pulmonary function impairments under Table 5-4.<sup>21</sup>

As Dr. Parker did not provide an impairment rating in accordance with the A.M.A., *Guides*, his opinion is insufficient to resolve the conflict in medical opinion. OWCP procedures note:

“If the referee specialist submits an opinion which is equivocal, lacks rationale, or fails to address the specified medical issues or conflict, the CE [claims examiner] should seek clarification or further rationale from that physician. When OWCP undertakes to develop the evidence by referring the case to an [OWCP]-selected physician, it has an obligation to seek clarification from that physician upon receiving a report that did not adequately address the issues that [OWCP] sought to develop.

“Only if the referee physician does not respond, or does not provide a sufficient response after being asked, should the CE request a new referee examination.”<sup>22</sup>

On remand OWCP shall obtain a supplemental report from Dr. Parker addressing the extent of any permanent impairment of the lungs in accordance with the A.M.A., *Guides*. The Board further notes that, in its January 24 and July 7, 2017 decisions, OWCP issued schedule awards for impairment to a single lung. However, as noted, OWCP procedures provide that 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

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<sup>19</sup> See A.S., Docket No. 17-1033 (issued October 23, 2017); M.P., Docket No. 16-0551 (issued May 19, 2017).

<sup>20</sup> A.M.A., *Guides* 90, Table 5-5; see also M.H., Docket No. 14-0013 (issued April 2, 2014).

<sup>21</sup> See L.B., Docket No. 13-1088 (issued September 13, 2013).

<sup>22</sup> Federal (FECA) Procedure Manual, *supra* note 18 at Chapter 2.810.11(e) (September 2010); K.E., Docket No. 16-1494 (September 19, 2017).

of function of one lung) to obtain the number of weeks payable in the schedule award.<sup>23</sup> Upon remand, OWCP shall determine if its procedures were properly followed. Following this and such further development as deemed necessary, OWCP shall issue a *de novo* decision regarding appellant's entitlement to schedule award compensation.

**CONCLUSION**

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

**ORDER**

**IT IS HEREBY ORDERED THAT** the July 7 and June 29, 2017 decisions of the Office of Workers' Compensation Programs are set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: February 13, 2018  
Washington, DC

Christopher J. Godfrey, Chief Judge  
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge  
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge  
Employees' Compensation Appeals Board

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<sup>23</sup> See *supra* note 13.