United States Department of Labor
Employees' Compensation Appeals Board

D.W., Appellant	)	
	)	**Docket No. 17-0974**
and	)	**Issued: January 16, 2018**
DEPARTMENT OF AGRICULTURE, FOOD SAFETY & INSPECTION SERVICE, Minneapolis, MN, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On April 3, 2017 appellant filed a timely appeal from a November 17, 2016 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 to consider the merits of the case.

ISSUE

The issue is whether appellant has met his burden of proof to establish permanent impairment of his lungs, warranting a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been before the Board.[2] The facts and circumstances outlined in the Board's prior decisions are incorporated herein by reference. The relevant facts are as follows.

On March 29, 2006 appellant, then a 45-year-old inspector, filed an occupational disease claim (Form CA-2) alleging that he experienced dry mouth, coughing, headaches, upset stomach, chest pain, tightness of the chest, and nose and throat irritation due to a sharp and unusual smell in the air while working. He first became aware of his condition on March 7, 2006.

On March 14, 2006 appellant's supervisor noted that appellant reported symptoms that he attributed to high ozone levels at the employing establishment. He advised that the employing establishment had previously had a problem with the automated chlorine system which resulted in a strong chlorine smell and burning eyes for some employees. The supervisor reported that both ozone and chlorine were used to reduce the pathogens present in the slaughter environment.

In a report dated April 19, 2006, Dr. Tracy T. Phillips, an osteopath, indicated that appellant reported that he was exposed to ozone gases at work. Appellant listed his symptoms as headaches, chest tightness, shortness of breath, and thickened saliva. Dr. Phillips reported that appellant's chest x-ray was normal and referred him to a pulmonologist.

OWCP accepted appellant's claim on May 25, 2006 for exposure to unspecified gas, fume, or vapor with a toxic effect and unspecified asthma with acute exacerbation. It authorized wage-loss compensation benefits from March 15 through April 4, 2006. Appellant was transferred to another location at the employing establishment on July 9, 2006 and reported additional symptoms. OWCP authorized wage-loss compensation benefits from October 2 through November 25, 2006.

On September 10, 2013 appellant filed a claim for a schedule award (Form CA-7). In a letter dated September 18, 2013, OWCP requested that he provide additional medical evidence addressing his permanent impairment due to his accepted conditions in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment.*[3]

OWCP subsequently received a note from Dr. Ali Al-Nashif, a Board-certified sleep specialist, following an April 12, 2013 examination of appellant diagnosing occupational asthma. Dr. Al-Nashif indicated that appellant's symptoms worsened in the workplace. He opined that appellant's workplace exposure caused a permanent condition and permanent restrictions from exposure to chemicals.

OWCP referred appellant's medical records and his request for a schedule award to OWCP's medical adviser on November 4, 2013. In a report dated November 10, 2013, OWCP's

[2] Docket No. 16-1044 (issued October 20, 2016).

[3] A.M.A., *Guides* (6th ed. 2009).

medical adviser requested pulmonary function studies to determine whether appellant had any permanent impairment as a result of his accepted condition of asthma.

OWCP referred appellant for a second opinion examination with Dr. Robert Walter, a Board-certified pulmonologist, on June 6, 2014. Dr. Walter examined appellant on July 8, 2014 and noted his history of chemical exposure at work. He found that appellant's nose was normal and that his mouth and throat exhibited prominent turbinates with somewhat boggy, blue mucosa. Dr. Walter found that appellant used normal effort in his pulmonary examination with no stridor, respiratory distress, wheezes, rales or tenderness. He diagnosed occupational asthma and noted that appellant exhibited bronchial hyperresponsiveness while working at the employing establishment since 2006. Dr. Walter opined that appellant's condition was permanent and had reached maximum medical improvement (MMI). He reported that appellant had continued symptoms of runny nose, nasal congestion, facial pressure, and wheezing or dyspnea. Dr. Walter reported that appellant used a short-acting beta agnostic (SABA) inhaler twice a day and about one canister a month. Appellant explained that he awakened most nights wheezing and could climb only one flight of stairs without having to rest. Dr. Walter noted that asthma severity was rated on a multidimensional scale, including physiology, clinical and functional assessment. He found that appellant's asthma was not well controlled and his impairment rating would be class 3, 28 percent based on clinical parameters. Dr. Walter reported that appellant's spirometry was normal, but his prior monitoring suggested significant airflow variability. He provided appellant's pulmonary function testing. This demonstrated a forced expiratory volume within the first second (FEV_1) of 108 percent of reference and forced vital capacity (FVC) of 103 percent of reference with the FEV_1/FVC ratio of 104 percent which was normal. Spirometry and lung volumes were within normal limits, and diffusing capacity was normal. Dr. Walter did not provide post-bronchodilator studies.

OWCP's medical adviser reviewed the medical record as well as Dr. Walter's report on September 30, 2014 and determined that appellant had reached MMI. He reported that the record before OWCP did not support that appellant had been treated for pulmonary mediated symptoms after 2006. OWCP's medical adviser applied the A.M.A., *Guides*,[4] to the pulmonary function test results and found no ratable permanent impairment of either lung. He concluded that appellant's pulmonary conditions had resolved.

By decision dated September 30, 2014, OWCP denied appellant's claim for a schedule award as he had not met his burden of proof to establish a ratable impairment to a scheduled member.

On October 30, 2014 appellant requested a review of the written record from OWCP's Branch of Hearings and Review. He argued that OWCP's medical adviser had improperly applied Table 5-4 Pulmonary Dysfunction,[5] rather than Table 5-5 of the A.M.A., *Guides*, which addresses impairments due to asthma.[6] Appellant argued that he required medication to treat his

[4] A.M.A., *Guides* 90, Table 5-5, Criteria for Rating Permanent Impairment due to Asthma.

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

[6] *Supra* note 4.

condition and that he had frequent attacks as documented by Drs. Al-Nashif and Walter. In support of this request, he submitted notes dated June 19, 2007, November 2, 2010, and April 15, 2013 from Dr. Mohammad Zakiullah, a general practitioner, diagnosing bronchial asthma. Appellant resubmitted Dr. Al-Nashif's January 23, 2012 note and a note dated April 12, 2013.

By decision dated April 17, 2015, an OWCP hearing representative affirmed OWCP's September 30, 2014 decision. She found that the weight of the medical evidence did not establish a ratable pulmonary impairment for schedule award purposes.

On June 12, 2015 appellant requested reconsideration. He asserted that he had a class 3 impairment for 28 percent for occupational asthma and that he required further medical treatment. Appellant resubmitted Dr. Walter's July 8, 2014 report. He also submitted additional medical records addressing his left ankle injury in 2014.

By decision dated August 24, 2015, OWCP denied appellant's request for reconsideration of the merits of his claim, finding that the evidence he submitted was repetitious or irrelevant.

Appellant again requested reconsideration on October 23, 2015. He provided his interpretation of Dr. Walter's second opinion report. Appellant also submitted a note dated May 29, 2015 from Dr. Walter and an October 13, 2015 letter. Dr. Walter reviewed OWCP's decision with appellant on May 29, 2015 and contended that normal spirometry did not exclude the diagnosis of asthma. He also opined that OWCP used only a single dimension of the A.M.A., *Guides* rating scale to determine appellant's disability.

Dr. Walter completed a report on October 13, 2015. He noted that asthma was characterized by episodic increased in airflow obstruction, which may be fully normalized between exacerbations. Dr. Walter found that measuring asthma required multidimensional tools and that reliance on a single metric such as FEV_1 did not appropriately capture disease severity. He noted that the current A.M.A., *Guides* recognized that spirometry/FEV_1 was variable and depended on adequacy of therapy. Dr. Walter contended that FEV_1 could be entirely normal after a dose of SABA. He reported that the A.M.A., *Guides* provide for both bronchial hyperresponsiveness and FEV_1 in quantifying disease severity. Dr. Walter opined that a disability determination using solely FEV_1 would not comport with these standards. He noted that appellant had documented bronchial hyperresponsiveness evidenced by his serial pulmonary function tests and peak flow measures. Dr. Walter contended that the degree of appellant's bronchial hyperresponsiveness had not been quantified. He noted, "It is notable that he, at our last encounter, was on daily inhaled steroids as well as leukotriene inhibitors and was still using daily inhaled bronchodilators. This would suggest, using [the A.M.A., *Guides*], at least a mild/moderate (*i.e.*, class 2 or 3) disability."

By decision dated January 12, 2016, OWCP denied appellant's request for reconsideration of the merits of his claim. It found that Dr. Walter's notes were cumulative. Appellant appealed to the Board and by its October 20, 2016 decision, the Board remanded the case for consideration of the merits of his claim.[7] Following remand from the Board, OWCP referred the medical evidence to a different medical adviser. In his November 8, 2016 report, the

[7] *Supra* note 2.

medical adviser reviewed the A.M.A., *Guides* and found that the appropriate provision for rating permanent impairment was Table 5-4, page 88. He again reviewed appellant's pulmonary function numbers, the key factors under the A.M.A., *Guides*, to determine appellant's pulmonary dysfunction for schedule award purposes. The medical adviser ascertained that the objective pulmonary function tests were all consistent with class 0 indicating zero percent impairment. He noted, "So, although airway hyperresponsiveness may exist and warrant chronic medications, no impairment is found and job disability is based on the exposures that the specific job may entail." The medical adviser concluded, "Based on the A.M.A., *Guides* 6th edition, I feel that the level of overall respiratory impairment for this claimant is class 0, zero percent based on my above explanation of factors using the A.M.A., *Guides* 6th edition, page 88, Table 5-4 and the provided texts from page 89."

By decision dated November 17, 2016, OWCP denied modification of the prior schedule award decision.

LEGAL PRECEDENT

The schedule award provisions of FECA[8] and its implementing regulations[9] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss of use of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[10]

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).[11] Chapter 5 of the A.M.A., *Guides* addresses the framework to be used for evaluating the pulmonary system.[12]

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

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

[10] For new decisions issued after May 1, 2009 OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, 6th ed. (2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[11] A.M.A., *Guides* 3, Section 1.3, The [ICF,] Disability, and Health: A Contemporary Model of Disablement.

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

the award for loss of function of one lung) to obtain the number of weeks payable in the schedule award.[13] 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.[14]

ANALYSIS

The Board finds that appellant has failed to meet his burden of proof to establish permanent impairment of his lungs, warranting a schedule award.

OWCP accepted appellant's claim for exposure to unspecified gas, fume, or vapor with a toxic effect and unspecified asthma with acute exacerbation. Dr. Walter, OWCP's second opinion physician, diagnosed occupational asthma and noted that appellant exhibited bronchial hyperresponsiveness while working at the employing establishment since 2006. He noted that appellant used his SABA inhaler twice a day and about one canister a month. Dr. Walter found that appellant's asthma was not well controlled and his impairment rating would be class 3, 28 percent based on clinical perimeters.[15] He also provided appellant's spirometry results which resulted in FEV_1 of 108 percent of reference. In his supplemental report of October 13, 2015, Dr. Walter noted that asthma was characterized by episodic increased in airflow obstruction, which may be fully normalized between exacerbations. He found that measuring asthma required multidimensional tools and that reliance on a single metric such as FEV_1 did not appropriately capture disease severity. Dr. Walter noted that the current A.M.A., *Guides* recognizes that spirometry/FEV_1 was variable and depended on adequacy of therapy and contended that FEV_1 could be entirely normal after a dose of SABA. He reported that the A.M.A., *Guides* provides for both bronchial hyperresponsiveness and FEV_1 in quantifying disease severity. Dr. Walter opined that a disability determination using solely FEV_1 would not comport with these standards. He noted that appellant had documented bronchial hyperresponsiveness evidenced by his serial pulmonary function tests and peak flow measures. Dr. Walter contended that the degree of appellant's bronchial hyperresponsiveness had not been quantified. He noted, "It is notable that he, at our last encounter, was on daily inhaled steroids as well as leukotriene inhibitors and was still using daily inhaled bronchodilators. This would suggests, using [the A.M.A., *Guides*], at least a mild/moderate (*i.e.*, class 2 or 3) disability.

The A.M.A., *Guides* provides for evaluation of asthma under Table 5-5 for asthma.[14] The objective tests for asthma impairment are not the same as for the pulmonary function impairment under Table 5-4.[16] However, both tables begin rating impairment with FEV_1 at 80 percent or less of predicted. There is no medical evidence of record supporting that appellant's FEV_1 was 80 percent or less than predicted. Dr. Walter's pulmonary function testing demonstrated FEV_1 of 108 percent of predicted. Furthermore, OWCP's medical adviser

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

[14] *Id.* at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

[15] *Supra* note 4.

[16] *W.C.*, Docket No. 16-1357 (issued March 9, 2017).

disagreed with Dr. Walter's interpretation of the A.M.A., *Guides* noting that Table 5-5 was not used to determine impairment for airway hyperresponsiveness when there was an absence of airflow limitation with asthma treatment. Table 5-5 of the A.M.A., *Guides* begins with a maximum postbrochodilator FEV_1 of 80 percent of predicted and then descends to 50 percent. As appellant's FEV_1 percentage was 108 percent of reference, Table 5-5 is not applicable.[17] The A.M.A., *Guides* note that the individual with airway hyperresponsiveness may have no measurable impairment (solely determined by lung function test values).[18]

OWCP's medical adviser properly determined that Table 5-5 was not applicable and then proceeded to evaluate appellant's lung impairment in accordance with Table 5-4 of the A.M.A., *Guides*. Under Table 5-4 for Pulmonary Dysfunction, appellant's pulmonary function testing also did not comport with any of the objective test standards listed in Table 5-4.[19] For example an FVC value of 103 percent would not result in a ratable impairment. The FEV_1 of 108 is not a ratable test result, nor is FEV_1/FVC of 104 percent. As appellant's airway hyperresponsiveness is not ratable by the A.M.A., *Guides*, he is not entitled to a schedule award for his accepted lung conditions.[20]

Appellant may request a schedule award or increased schedule award at any time 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 permanent impairment of his lungs warranting a schedule award.

[17] A.M.A., *Guides* 89. "Note that in the absence of airflow limitation with asthma treatment, Table 5-5 may not be used to determine impairment for airway hyperresponsiveness…."

[18] *Id.*

[19] *Supra* note 5.

[20] *D.B.*, Docket No. 16-1050 (issued October 5, 2016).

ORDER

IT IS HEREBY ORDERED THAT the November 17, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 16, 2018
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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