United States Department of Labor
Employees' Compensation Appeals Board

W.W., Appellant	)	
and	)	**Docket No. 24-0940**
	)	**Issued: February 13, 2025**
DEPARTMENT OF VETERANS AFFAIRS, CAPTAIN JAMES A. LOVELL FEDERAL HEALTH CARE CENTER, North Chicago, IL, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On September 19, 2024 appellant, through counsel, filed a timely appeal from an August 20, 2024 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[3]

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id*. An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id*.; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq*.

[3] The Board notes that following the August 20, 2024 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id*.

ISSUE

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

FACTUAL HISTORY

On February 6, 2013 appellant, then a 59-year-old rehabilitation technician, filed an occupational disease claim (Form CA-2) alleging that he developed blastomycosis/fungus on his lungs due to factors of his federal employment, including exposure to dusts and chemicals from construction. He noted that he first became aware of his condition and realized that it was due to factors of his federal employment on January 21, 2013. On the reverse side of the claim form, the employing establishment indicated that appellant was last exposed to the conditions alleged to have caused the disease/illness on January 31, 2013. He did not stop work. OWCP accepted the claim for blastomycosis. It subsequently expanded its acceptance of the claim to include post-traumatic stress disorder (PTSD).[4]

On April 13, 2015 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In a development letter dated April 16, 2015, OWCP requested that appellant submit a detailed medical report from his physician addressing the permanent impairment due to his accepted employment injury in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[5] It afforded him 30 days to submit the requested information.

OWCP received an August 27, 2014 computerized tomography (CT) scan report, which indicated scattered emphysematous bullae in both lungs with chronic fibrosis in anterior aspect of left upper lobe.

In a September 17, 2015 report, Dr. Mamata Ravipati, a Board-certified internist, calculated one percent permanent impairment of the lungs based on appellant's radiographic findings. She indicated that due to his underlying emphysema, pulmonary lung function testing could not be used to assess the loss of lung function.

OWCP subsequently referred the case record and a statement of accepted facts (SOAF) to Dr. Albert A. Rizzo, a Board-certified internist and pulmonologist serving as a district medical adviser (DMA), for an opinion regarding appellant's permanent impairment.

In a February 6, 2016 report, Dr. Rizzo reviewed the medical records and SOAF, and found no impairment of the lungs based on the lack of pulmonary dysfunction in the absence of pulmonary functions testing, the lack of pulmonary symptoms, and appellant's continued ability to work. He noted that appellant had reached maximum medical improvement (MMI) on September 17, 2015, and that "the A.M.A., *Guides* does not acknowledge impairment based solely on radiographic findings or the history of pneumonia or other parenchymal diseases without supporting physiologic abnormalities that would be defined with pulmonary function testing."

[4] OWCP accepted the date of injury as November 6, 2012.

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

By decision dated February 10, 2016, OWCP denied appellant's schedule award claim, finding that the medical evidence was insufficient to establish permanent impairment of a scheduled member or function of the body due to his accepted pulmonary condition. It accorded the weight of the medical evidence to the opinion of the DMA.

On March 10, 2016 appellant requested a review of the written record by a representative of OWCP's Branch of Hearings and Review.

OWCP received progress notes dated December 3, 2013 through April 21, 2015, which discussed appellant's concurrent conditions and his blastomycosis, chest x-ray reports dated January 17, 2013 through January 21, 2016, which indicated findings similar to the previous study, and a May 3, 2015 CT report of the head.

By decision dated September 16, 2016, OWCP's hearing representative affirmed the February 10, 2016 schedule award decision, finding that the medical evidence failed to establish permanent impairment of the lungs under the A.M.A., *Guides*.

On October 21, 2020 appellant filed another Form CA-7 for a schedule award.

In an October 20, 2020 impairment report, Dr. Sami E. Moufawad, a Board-certified physiatrist, noted the history of injury, reviewed the medical record, and presented examination findings. He opined that appellant had reached MMI on August 28, 2020 when Dr. Hassan Hashm, a pulmonologist, evaluated appellant and found him at MMI. Dr. Moufawad noted that a February 25, 2020 pulmonary function test (PFT) revealed normal total lung capacity (TLC) and forced vital capacity (FVC); however, the diffusing capacity of the lungs for carbon monoxide (DLCO) showed a 13.8 mL/mmHg/min or a 43.1 percent reduction from the reference (predictable) DLCO of 32.0 mL/mmHg/min. He utilized Table 5-4 on page 88 of the A.M.A., *Guides*, which provides criteria for rating permanent impairment due to pulmonary dysfunction, and indicated that appellant had a Class 4, grade C diagnosis. Dr. Moufawad provided impairment calculations and found 45 percent whole person permanent impairment.

On March 30, 2021 OWCP forwarded a March 29, 2021 SOAF and the medical record, including Dr. Moufawad's October 20, 2020 report, to Dr. David I. Krohn, a Board-certified internist serving as the DMA.

In a May 21, 2021 report, Dr. Krohn opined that under Table 5-4 of the A.M.A., *Guides*, appellant had 43 percent impairment due to pulmonary dysfunction. He disagreed with Dr. Moufawad's October 20, 2020 Class 4 impairment finding, noting that the key factor was objective tests, and the impairment was based on the most recent PFT of record dated February 25, 2020. Dr. Krohn found a Class 3 impairment and assigned a grade modifier for functional history (GMFH) of 3.

In a June 2, 2021 addendum impairment report, Dr. Moufawad reviewed Dr. Krohn's May 21, 2021 report, and explained that an additional 0.93 factor would decrease the normal predicted value, and negatively affect the impairment rating by bringing the predicted value down closer to the measured value, and falsely show that the measured value was closer to normal. He thus opined that the DMA's reasoning was incorrect. Dr. Moufawad opined that appellant had Class 4 or 50 percent whole person impairment as he had changed his GMFH of 1 to 3 to equal Dr. Krohn's score. He used the formula for converting whole person impairments to pulmonary impairments and obtained a value of 78 percent dysfunction of both lungs as both lungs were

equally affected, which resulted in a right lung impairment of 53 percent and a left lung impairment of 53 percent.

On August 13, 2021 Dr. Herbert White, Jr., a Board-certified orthopedic surgeon serving as the DMA, reviewed the evidence of record, including Dr. Moufawad's June 2, 2021 addendum report. He recommended that appellant undergo a repeat spirometry. Dr. White also disagreed with Dr. Moufawad that both lungs were equally affected as a review of the clinical studies revealed that only the left lung was affected.

In a September 3, 2021 second addendum report, Dr. Moufawad agreed to have repeat spirometry performed using more standardized results, but reiterated that his previous impairment calculation was correct. He also explained that while the chest x-rays showed damage on the left lung compared to the right lung, blastomycosis is an airborne pathogen which spreads to both lungs upon inhalation exposure. Dr. Moufawad indicated that while the upper lobe of the left lung was affected, appellant had "developed fibrotic tissue, a diffuse disease which affects both lungs." Thus, the changes described on x-ray did not eliminate the fact that both lungs were affected during the inhalation process which led to alveolar injury on both sides that were not severe enough to show on x-ray, but did affect the spirometry results.

In a September 16, 2021 amended report, Dr. White reviewed Dr. Moufawad's September 3, 2021 report, and opined that an impairment rating could not be performed with the information of record. He again recommended that appellant undergo a repeat spirometry. Dr. White further opined that Dr. Moufawad was correct in stating that both lungs should be rated.

On January 19, 2022 appellant underwent another PFT. The results were noted as within normal limits with no significant improvement after an inhaled bronchodilator device. Lung volumes were also noted to be within normal limits with mildly reduced DLCO of 78 percent of predicted not corrected for alveolar volume.

In an April 20, 2022 amended report, Dr. White, serving as DMA, reviewed the January 19, 2022 PFT and Dr. Moufawad's September 3, 2021 report. He indicated that the January 19, 2022 PFT was normal except for mildly reduced DLCO. Dr. White opined that appellant had reached MMI on January 19, 2022. He indicated that the key impairment factor, the January 19, 2022 PFT, resulted in a Class 0 or pulmonary impairment rating of 0 percent. Dr. White noted that the FVC was 80 percent or greater than predicted; the FEV_1 was 80 percent or greater than predicted; the FEV_1/FVC was 75 percent or greater than predicted; and the DLCO was 75 percent or greater than predicted, which yielded no impairment under Table 5-4.

In a May 27, 2022 report, Dr. Moufawad reviewed the January 19, 2022 PFT and Dr. White's April 20, 2022 amended report. He opined that his impairment calculation from his October 20, 2022 report was accurate.

In a June 22, 2022 amended report, Dr. White, serving as DMA, reviewed Dr. Moufawad's May 27, 2022 report and opined it did not change that the date of MMI of January 19, 2022 or that there was 0 percent impairment based on the January 19, 2022 PFT.

On June 29, 2022 OWCP found a conflict in medical opinion existed between Dr. Moufawad and Dr. White, the DMA, regarding permanent impairment, if any, of appellant's lungs.

On January 11, 2024 OWCP referred appellant along with the medical record, a series of questions, and a March 30, 2021 SOAF to Dr. Jeffrey Parker, a Board-certified pulmonologist, for an impartial medical examination to resolve the conflict in medical opinion regarding whether he had permanent impairment due to his accepted pulmonary condition. The March 30, 2021 SOAF did not indicate that appellant had undergone the January 19, 2022 PFT.

In a February 24, 2024 report, Dr. Parker, serving as the impartial medical examiner (IME), reviewed a March 30, 2021 SOAF and appellant's medical record. He related appellant's physical examination findings and his review of record, which included multiple CT scans, x-rays, and the pulmonary function testing of February 25, 2020 and January 19, 2022. Dr. Parker noted that the February 25, 2020 PFT showed normal flow tests and normal lung volumes with decreased diffusion capacity. The January 19, 2022 PFT showed normal flow test, normal lung volumes, and normal diffusion capacity. Dr. Parker indicated that the pulmonary functions tests were almost completely identical, except for the diffusion abnormality noted on the February 25, 2020 test. He noted that the A.M.A., *Guides* provided that diffusion capacity was primarily used in the presence of parenchymal lung disease, and thus did not apply in this case. Dr. Parker explained that as the diffusion values were normal in the second study, appellant never had a diffusion abnormality or alveolar capillary dysfunction abnormality. He indicated that PFTs were the most accurate way of assessing potential pulmonary disability, and in appellant's case, there was no pulmonary disability as the differences in the PFTs were minimal and the second test showed the lungs could provide normal gas transport. Dr. Parker further indicated that if one PFT is totally normal, one cannot refer to an earlier PFT to make a disability calculation. He asserted that it was axiomatic in pulmonary medicine that only the best results could be used, and that whether diffusion capacity was normal or abnormal did not apply in this case. Dr. Parker considered Dr. Moufawad's reports, and related that the fact that the attending physician would not accept the second PFT, but reverted back to the first PFT for disability purposes. He further noted that many of the doctors of record seemed to disagree with the "facts" claimed by the attending physician. Dr. Parker advised that the numbers on the PFTs, as well as the pulmonary imaging, proved that there was no interstitial component and no pulmonary disability. Thus, he concluded that as appellant had no permanent pulmonary dysfunction based on objective pulmonary function testing, impairment ratings for each lung were moot. Dr. Parker further opined that appellant had reached MMI on February 25, 2020, the date of the first PFT.

By decision dated March 25, 2024, OWCP denied appellant's schedule award claim, finding that he had not established permanent impairment of a scheduled member or function of the body. It accorded the special weight of the medical evidence to the opinion of Dr. Parker, the IME.

On April 2, 2024 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. A hearing was held on July 10, 2024.

In a July 11, 2024 report, Dr. Moufawad noted his disagreement with Dr. Parker's opinion. He argued that Dr. Parker's opinion denied the objective findings shown by the June 16, 2014 CT scan, which show permanent changes in the parenchyma of the lungs and the diffusion membrane. Dr. Moufawad asserted that the accepted blastomycosis infection affected the membrane, and therefore, resulted in the diffusion abnormality. He further explained why he chose the February 25, 2020 PFT over the January 19, 2022 PFT test.

By decision dated August 20, 2024, an OWCP hearing representative affirmed OWCP's March 25, 2024 decision.

LEGAL PRECEDENT

The schedule award provision of FECA,[6] and its implementing federal regulation,[7] 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.[8] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[9]

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.[10] The list of schedule members includes the eye, arm, hand, fingers, leg, foot, and toes. Additionally, FECA specifically provides for compensation for loss of hearing and loss of vision.[11] By authority granted under FECA, the Secretary of Labor expanded the list of schedule members to include the breast, kidney, larynx, lung, penis, testicle, tongue, ovary, uterus/cervix and vulva/vagina, and skin.[12] 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.[13] Compensation for total loss of use of a single lung is 156 weeks.[14]

Although FECA does not specifically provide for compensation for whole person impairment, the measurement of lung function warrants special consideration. Table 5-4, Pulmonary Dysfunction, A.M.A., *Guides* page 88, provides whole person impairment ratings based on a designated Class (0-4) of impairment. Depending on the assigned class, the range of whole person impairment due to pulmonary dysfunction is 0 to 65 percent. OWCP procedures provide that lung impairment should be evaluated in accordance with the A.M.A., *Guides* insofar as possible. It further provides that schedule awards are based on the loss of use of both lungs and the percentage for the particular 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.[15]

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[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id*. at § 10.404(a).

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[10] *J.G.*, Docket No. 16-1533 (issued March 15, 2018); *W.C.*, 59 ECAB 372, 374-75 (2008); *Anna V. Burke*, 57 ECAB 521, 523-24 (2006).

[11] *Supra* note 8 at § 8107(c)(13) and (14).

[12] *Id*. at § 8107(c)(22); 20 C.F.R. § 10.404(b).

[13] *Id*. at § 8107(c); *id*. at § 10.404(a); *see Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

[14] *Id*. at § 10.404(b).

[15] *Supra* note 11 at Chapter 2.808.5c(1); *id*. at Chapter 3.700.4d(1)(c).

The A.M.A., *Guides* provide that most pulmonary impairments should be rated using Table 5-4, Pulmonary Dysfunction. It provides:

> "The examiner should note that throughout this chapter the objective test results are used as the primary or 'key' factor in the impairment rating for the condition, or range of conditions. Well-validated organ-specific functional test measures exist for the pulmonary system that correlate well with levels of impairment. It is therefore appropriate to choose 'objective test results' as the primary determinant of impairment class rating in this chapter."[16]

The A.M.A., *Guides* specifies that in rating pulmonary impairment the examiner should assign an impairment class using the key impairment factor, objective test results, and that "only the key factor can be used to assign the impairment class." It further provides that "[w]hen non-key factors such as history and physical exam[ination] are relevant to the rating, they are each assigned a relative class value, which in turn is used to move the impairment rating up or down in the same class.... Regardless of the discrepancy of impairment classes between the key factor and non-key factors, the impairment rating should never move out of the class to which it was initially assigned, using only the key factor."[17]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[18]

Section 8123(a) of FECA provides in pertinent part: "If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."[19] In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an IME for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[20]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish permanent impairment of the lungs, warranting a schedule award.

OWCP found a conflict in the medical opinion evidence between Dr. Moufawad, an attending physician, and Dr. White, the DMA, concerning whether appellant had permanent impairment to the left and right lungs. Based on a February 25, 2020 PFT, Dr. Moufawad opined that appellant had 53 percent left lung impairment and 53 percent right lung impairment. Based on a January 19, 2022 PFT, Dr. White, the DMA, opined that there was zero percent impairment

[16] A.M.A., *Guides* 87.

[17] *Id*.

[18] *See supra* note 11 at Chapter 2.808.6f (March 2017).

[19] 5 U.S.C. § 8123(a).

[20] *See J.P.*, Docket No. 23-0075 (issued March 26, 2023); *C.M.*, Docket No. 20-1647 (issued October 5, 2021); *James P. Roberts*, 31 ECAB 1010 (1980).

to either lung. In order to resolve the conflict, OWCP properly referred appellant to Dr. Parker, pursuant to 5 U.S.C. § 8123(a), for an impartial medical examination.

Where a case is referred to an IME for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently rationalized and based on a proper factual and medical background, must be given special weight.[21]

In a February 24, 2024 report, Dr. Parker reviewed the medical record and SOAF and performed a physical examination. He provided a detailed discussion of the results of the two PFTs of record dated February 25, 2020, and January 19, 2022, indicating that they were essentially identical, except for the diffusion abnormality noted on the February 25, 2020 test. Dr. Parker explained that as the diffusion values were normal in the second study, there was never any diffusion abnormality or any alveolar capillary dysfunction abnormality. Additionally, the fact that appellant had the ability to perform a normal diffusion test, at any time, proved that there was never any diffusion abnormality or alveolar capillary block problem. Dr. Parker further asserted that it was axiomatic in pulmonary medicine to use the best results. He noted that diffusion capacity was relevant in cases of parenchymal abnormality, which was not applicable in this case. Dr. Parker indicated that PFTs were the most accurate way of assessing potential pulmonary disability, and in appellant's case, showed that he had no pulmonary disability. He further indicated that if one PFT was totally normal, it was not possible to refer back to an earlier PFT to make a disability calculation. Dr. Parker advised that the numbers on the PFTs as well as the pulmonary imaging proved that there was no interstitial component and no pulmonary disability. He thus found no permanent impairment of the lungs based on appellant's lack of pulmonary dysfunction on objective pulmonary function testing.

The Board finds that the special weight of the medical opinion evidence is represented by the thorough, well-rationalized opinion of Dr. Parker. As Dr. Parker's report is detailed, well rationalized, and based on a proper factual background, his opinion represents the special weight of the medical evidence.[22] Consequently, appellant has not met his burden of proof.

The Board further finds that Dr. Moufawad's July 11, 2024 report is not sufficient to overcome the special weight accorded to the report of Dr. Parker as the IME, or create a new conflict in medical opinion. The Board notes that Dr. Moufawad was on one side of the conflict which was resolved pursuant to 5 U.S.C. § 8123(a). Thus, his additional report is insufficient to overcome the special weight accorded the IME's report or to create a new conflict.[23]

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 permanent impairment.

[21] *J.K.*, Docket No. 20-0907 (issued February 12, 2021); *B.T.*, Docket No. 24-0736 (issued August 23, 2024); *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001); *James P. Roberts*, *id*.

[22] *See L.M.*, Docket No. 24-0620 (issued September 9, 2024); *K.M.*, Docket No. 23-1103 (issued February 6, 2024).

[23] *See M.S.*, Docket No. 24-0625 (issued September 17, 2024); *E.B.*, Docket No. 23-1021 (issued February 16, 2024); *T.B.*, Docket No. 12-0866 (issued September 25, 2012); *Harrison Combs, Jr.*, 45 ECAB 716 (1994); *Dorothy Sidwell*, 41 ECAB 857 (1990).

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish permanent impairment of the lungs, warranting a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the August 20, 2024 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 13, 2025
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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