United States Department of Labor
Employees' Compensation Appeals Board

W.C., Appellant	)	
	)	
and	)	**Docket No. 16-1357**
	)	**Issued: March 9, 2017**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Manchester, NH, 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
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On June 22, 2016 appellant filed a timely appeal from a June 1, 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 this case.

ISSUE

The issue is whether appellant has established more than 17 percent permanent bilateral impairment of the lungs for which he had received a schedule award.

On appeal appellant argues that he should receive 312 weeks of compensation, not 52 weeks.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On November 2, 1984 appellant, then a 34-year-old incinerator operator, filed an occupational disease claim (Form CA-2) alleging a pulmonary disorder causally related to factors of his federal employment. He did not stop work. OWCP accepted the claim for hypersensitivity pneumonitis and extrinsic asthma.

On December 7, 1988 appellant filed a claim for a schedule award (Form CA-7), which was denied by OWCP in a November 13, 1990 decision. OWCP found the medical evidence of record insufficient to establish any permanent lung impairment.

In a letter dated December 12, 1990, appellant's then counsel, requested an oral hearing before an OWCP hearing representative, which was held on July 25, 1991.

By decision dated November 25, 1991, an OWCP hearing representative affirmed the denial of appellant's claim for a schedule award.

In a letter dated November 10, 1992, appellant requested reconsideration of the denial of his schedule award claim.

By decision dated October 28, 1993, OWCP denied modification. It found the evidence submitted by appellant failed to establish a permanent impairment to his lungs. As there was no permanent impairment OWCP found he was not entitled to a schedule award.

In a letter dated September 3, 2013, appellant requested reconsideration of the denial of his claim for a schedule award for his accepted lung condition. He alleged that his condition had worsened over the years resulting in permanent lung impairment.

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

By letter dated May 5, 2015, appellant was referred for a second opinion evaluation with Dr. Leonard Y. Cosmo, Board-certified in pulmonary disease, for a permanent impairment evaluation.

In a report dated June 1, 2015, Dr. Cosmo, based on a physical examination and review of the statement of accepted facts, pulmonary function tests, and medical records and physical examination, diagnosed occupational asthma. He reviewed results from a pulmonary function test, which showed 2.66 liters for forced vital capacity (FVC) or 54 percent of predicted and 2.39 liters for forced expiratory volume in one second (FEV_1) or 65 percent of predicted. The FEV_1/FVC ratio was 117 percent and a ratio of 0.9. Dr. Cosmo reported a variable degree of impairment based on both abnormal and normal pulmonary functions studies, which he reported was consistent with an asthmatic condition. A review of recent pulmonary function tests showed a moderate restricted pattern. Using the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), Dr. Cosmo determined that appellant had 17 percent bilateral permanent impairment of the lungs. In reaching this determination, he assigned a class 2 impairment using Table 5-4, page 88 with a default value of C or 17 percent.

On June 22, 2015 an OWCP medical adviser reviewed Dr. Cosmo's report and requested that OWCP obtain the pulmonary function tests performed by Dr. Cosmo.

In a memorandum dated June 23, 2015, OWCP requested that Dr. Cosmo provide clarification regarding the testing he performed. Specifically, it asked if he performed tests for both pre- and post-bronchodilators. If the answer was yes, OWCP asked Dr. Cosmo to provide the test results.

In a July 20, 2015 addendum, Dr. Cosmo reported findings from a pulmonary function test which included a rate flow of 0.9, FVC of 2.66 liters, and FEV of 2.39 liters resulting in a FEV_1/FEC of 117 percent. He noted that appellant was tested before and after using bronchodilators.

On July 27, 2015 an OWCP medical adviser reviewed Dr. Cosmo's addendum and noted that he had not provided all the results from the pulmonary function test.

On July 29, 2015 OWCP requested further clarification from Dr. Cosmo regarding question 5. Specifically, it requested all the testing performed on May 26, 2015.

In a second addendum dated November 3, 2015, Dr. Cosmo reported that he was unable to provide a copy of the diagnostic study based on the software used in accordance with new state requirements on being paper free. He noted that the results from the diagnostic tests had been recorded in his report.

On December 12, 2015 an OWCP medical adviser reviewed Dr. Cosmo's reports and the medical record. He noted that it was very unclear from the reports whether Dr. Cosmo used the post- or pre-bronchodilator value in his impairment determination. The medical adviser noted that Dr. Cosmo assigned 17 percent whole person impairment rating using the 65 percent FEV_1 value. Using Table 5-5, page 90, he used an organ impairment conversion to find 17 percent whole person respiratory impairment. The medical adviser noted that whole person impairment ratings were allowed for organs such as the lungs. In calculating the impairment rating, he assigned a class 2 impairment with a default C grade for 65 percent FEV_1 value. The record contained no objective tests for degree of airway so the final class was 2 and grade was C resulting in 17 percent whole person impairment. Using the procedure manual for determining loss of internal organs, the medical adviser multiplied the 17 percent whole person impairment by 65 percent, the maximum whole person impairment of the table used, to find 26 percent permanent respiratory impairment.[2]

By decision dated January 15, 2016, OWCP granted appellant 17 percent permanent impairment of the right lung and 17 percent impairment of the left lung, for a total permanent impairment of 34 percent. The award covered 53.04 weeks and ran from May 26, 2015 to May 31, 2016. OWCP determined the date of maximum medical improvement to be May 26, 2015.

---

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

In a form dated February 2, 2016, appellant requested a review of the written record by an OWCP hearing representative.

By decision dated June 1, 2016, an OWCP hearing representative affirmed the January 15, 2016 schedule award determination.

LEGAL PRECEDENT

Under section 8107 of FECA[3] and section 10.404 of the implementing federal regulations,[4] schedule awards are payable for permanent impairment of specified body members, functions or organs. FECA, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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 schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition.[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 the FVC, $FEV_{1,}$ or diffusing capacity of the lungs for carbon monoxide (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, 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] Table 5-5, Asthma provides whole person

---

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] *D.J.*, 59 ECAB 620 2008); *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[6] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (February 2013); Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[7] A.M.A., *Guides* 3 (2009), section 1.3, The ICF, Disability and Health: A Contemporary Model of Disablement.

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

[9] *Id.* at 88.

[10] *Id.*

impairment ratings based on a designated class (0-4) of impairment. Depending on the assigned class, the range of whole person impairment due to asthma is 0 to 65 percent.

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 the claim for hypersensitivity pneumonitis and extrinsic asthma. By decision dated January 15, 2016, it granted appellant a schedule award for 17 percent permanent impairment of each lung, for a total permanent impairment of 34 percent. An OWCP hearing representative affirmed the schedule award determination in a June 1, 2016 decision.

In a June 1, 2015 report, Dr. Cosmo determined that appellant had 17 percent whole person permanent impairment. In reaching this determination, he rated appellant's pulmonary dysfunction and assigned appellant's lung impairment a class 2 impairment using Table 5-4, page 88 with a default value of C or 17 percent. A review of a pulmonary function test showed 2.66 liters for FVC of 54 percent of predicted, 2.39 liters for FEV_1 or 65 percent of predicted, and an FEV_1/FVC ratio of 117 percent. Dr. Cosmo, in a July 20, 2015 addendum, reiterated the pulmonary findings from his initial report and noted that appellant had been tested before and after using bronchodilators. In a second addendum, dated November 3, 2015, Dr. Cosmo explained that he was unable to provide the actual pulmonary function test results due to new state rules and software.

An OWCP medical adviser reviewed Dr. Cosmo's June 1, 2015 report and his July 20, 2015 addendum and requested additional clarification and a copy of the pulmonary function tests. On December 12, 2015 OWCP's medical adviser reviewed Dr. Cosmo's second addendum in addition to the prior reports. He reported that it was unclear from the reports whether Dr. Cosmo used the post- or pre-bronchodilator value in his impairment determination. Using Table 5-5 for Asthma, the medical adviser assigned a class 2 impairment with a default C grade for 65 percent FEV_1 value. He also noted that as the record contained no objective tests for degree of airway impairment, the class would be rated as a 2 and grade was C resulting in 17 percent whole person impairment. Using the procedure manual for determining loss of internal organs, the medical adviser multiplied the 17 percent whole person impairment by 65 percent,

[11] *Supra* note 2.

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

the maximum whole person impairment of the table used, to find 26 percent respiratory impairment.

The Board finds that this case is not in posture for a decision. Once OWCP undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[13]

The Board finds that the reports from Dr. Cosmo and the December 12, 2015 report of OWCP's medical adviser fail to provide sufficient medical rationale as to the extent of appellant's permanent impairment. Dr. Cosmo failed to provide either the pulmonary function test report or the test results for pre- and post-bronchodilator as requested by OWCP for review by the medical adviser. As the medical adviser noted, it was unclear from the report which bronchodilator value was used by Dr. Cosmo in his impairment determination. The record also does not contain objective test results to determine the degree of airway impairment.

Moreover, OWCP has accepted the conditions of hypersensitivity pneumonitis and extrinsic asthma, conditions which are evaluated under different Tables. The A.M.A., *Guides* provides for evaluation of hypersensitivity pneumonitis under Table 5-4 and Table 5-5 for asthma impairment calculations.[14] The objective tests for asthma impairment are not the same as for the pulmonary function impairment under Table 5-4.[15] Under Table 5-4 for Pulmonary Dysfunction, an FVC value of 54 percent could place appellant in a class 3, rather than class 2, with a default value of 32 percent permanent impairment. Neither physician provided any explanation as to why appellant's permanent impairment determination was rated under either Table 5-4 for Pulmonary Dysfunction or Table 5-5 for Asthma.[16] Accordingly, the case will be remanded to OWCP for further development of the medical evidence as to the extent of appellant's lung impairment. On remand, OWCP should refer appellant's case file to another second opinion physician for examination and evaluation. After further development as deemed necessary, it should issue an appropriate merit decision on appellant's schedule award claim.[17]

On appeal appellant argues that he is entitled to be paid for 312 weeks and not the 52 weeks he was paid and that the date of maximum medical improvement was incorrect. As explained above, further development of the claim is necessary.

CONCLUSION

The Board finds that the case is not in posture for decision and is remanded to OWCP for further development of the evidence.

---

[13] *See P.S.*, Docket No. 14-1395 (issued July 6, 2015).

[14] *Supra* note 7 at 88, Table 5-4 and 90, Table 5-5.

[15] *See L.B.,* Docket No. 13-1088 (issued September 13, 2013).

[16] *Id*.

[17] *See P.K.*, Docket No. 08-2551 (issued June 2, 2009); *see also Horace Langhorne*, 29 ECAB 820 (1978).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated June 1, 2016 is set aside and the case remanded for further action consistent with this decision of the Board.

Issued: March 9, 2017
Washington, DC

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

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board