U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of JOHNNY M. MEADORS and DEPARTMENT OF JUSTICE,
U.S. BORDER PATROL, San Diego, CA

Docket No. 99-271; Submitted on the Record;
Issued April 11, 2000

DECISION and ORDER

Before MICHAEL J. WALSH, GEORGE E. RIVERS,
MICHAEL E. GROOM

The issue is whether appellant has greater than an eight percent permanent impairment of his right lower extremity, for which he has received a schedule award.

The Office of Workers' Compensation Programs accepted that on January 14, 1997 appellant, then a 32-year-old border patrol agent, slipped on a hillside and struck his knee on the ground while pursuing a group of illegal aliens, sustaining right knee strain and traumatic chondromalacia of the right knee. The Office also accepted that appellant required right knee arthroscopic surgery on April 3, 1997.[1]

On June 27, 1997 appellant filed a claim for a schedule award for permanent impairment of his right lower extremity.

By report dated June 27, 1997, Dr. Thomas W. Harris, a Board-certified orthopedic surgeon and appellant's treating physician, provided a final assessment of appellant's condition and his limitations with stated reference to the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, Fourth Edition (1993).[2] Dr. Harris reviewed appellant's complaints, reported his muscular strength testing and deep tendon reflex results and measured his range of motion restrictions. He noted that appellant had "atrophy of the VMO muscle group," which caused an ongoing patellofemoral pain syndrome, crepitus of the right knee and five degrees loss in range of right knee motion. He indicated that appellant underwent an arthroscopy with a partial lateral meniscectomy and opined that he was permanent and stationary in relation to his employment injury. Dr. Harris opined that, considering appellant's crepitation

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[1] Appellant's lateral meniscus was resected back to viable tissue where there was a parrot-beak tear posteriorly. Post operative diagnoses were noted as "Partial lateral meniscectomy, right knee, [and] chondroplasty using laser and microfracture technique."

[2] A.M.A., *Guides.*

in the patellofemoral joint and the traumatic chondromalacia, he had an arthritis impairment based upon the surgical procedure utilizing Table 62, page 83 of the A.M.A., *Guides*. In addition Dr. Harris considered the Grade II -- III chondromalacia of the patellofemoral joint and opined that it resulted in a 6 percent whole person impairment and a 15 percent lower extremity impairment. He also noted that impairment factors additionally included constant knee pain and chronic weakness.

On August 14, 1997 the Office referred appellant's record to an Office medical adviser for a determination of appellant's percentage of permanent impairment. By report dated August 21, 1997, the Office medical adviser, Dr. Leonard A. Simpson, reviewed the record and Dr. Harris' June 27, 1997 report and noted that appellant's pain and weakness would be graded a maximal Grade II as per the grading scheme found in Chapter Three of the A.M.A., *Guides*, Fourth Edition, or a 25 percent grade of a maximal 7 percent (femoral nerve), equivalent to a 2 percent impairment. Dr. Simpson noted that appellant's loss of five degrees range of motion, which was equivalent to a zero percent impairment as per Table 41. Quadriceps strength described as 4+/5 would be rated as a mean between 4 and 5 weakness, or, according to Table 39, between a 0 and 12 percent impairment, or thus a 6 percent impairment of the lower extremity for weakness. Dr. Simpson then used the Combined Values Chart and combined a two percent impairment for pain and a six percent impairment for weakness to obtain an eight percent impairment of the right lower extremity.

Dr. Simpson calculated appellant's impairment by a second method for comparison, based upon the footnote found in Table 62, which allows an award for patellofemoral chondromalacia with crepitus on examination but without x-ray evidence of narrowing, which would be applicable in this case. Dr. Simpson opined that a five percent impairment would be assigned, as when a value from Table 62 is selected, no additional value for loss of function due to pain, loss of function due to atrophy/weakness or a loss with limited range of motion would be combined with the value from Table 62.[3] Dr. Simpson opined that since the first method resulted in the higher award it should be adopted and that consequently appellant had an eight percent permanent impairment of his right lower extremity.

On October 1, 1997 the Office granted appellant a schedule award for an eight percent permanent impairment of his right lower extremity for the period June 27 to December 5, 1997.

By letter dated April 8, 1998, appellant requested reconsideration of the schedule award and in support he submitted an additional medical report. He claimed that he had at least a 15 percent permanent impairment as Dr. Harris had found.

By report dated February 13, 1998, Dr. Steven Tradonsky, an orthopedic surgeon, presented appellant's current complaints of pain, crepitus and stiffness, lateral tilting of the patella and a slightly increased Q-angle in his knees bilaterally. He also noted significant cartilage damage to the under surface of the right knee and he diagnosed early degenerative arthritis of the right patellofemoral joint.

[3] *See* FECA Procedure Manual, Part -- 3, Medical, *Schedule Awards*, Chapter 3.700 (October 1995).

On May 5, 1998 the Office referred Dr. Tradonsky's report to the Office medical adviser, Dr. Simpson and asked whether appellant was entitled to an additional schedule award.

By report dated May 11, 1998, Dr. Simpson reviewed Dr. Tradonsky's report and opined as follows:

> "[I] would recommend grading these pain complaints a maximal grade III as per the grading scheme found in Chapter Three, Fourth Edition of the A.M.A., *Guides* or pain and/or altered sensation that may interfere with activities, which would be equivalent to a 60 percent grade. The maximum would be 7 percent (femoral nerve) and this thus would equate to a 4.2 or rounded off to 4 percent impairment for pain factors. The report offered [by] Dr. Tradonsky does not give an actual range of motion of the knee and thus no value can be assigned for this. Utilizing this particular method and the information given the updated medical reports would indicate a four percent for pain factors but no value can be given for loss of motion to be combined with this and no value for atrophy or weakness can be given to combine with this.
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> "The report does indicate a significant chondromalacia patella with crepitation on exam[ination] and this can be rated utilizing Table 62,…. There is no [x-ray] narrowing and noting the footnote attached to Table 62, a five percent impairment would be assigned for this. In addition, there was [a] partial lateral meniscectomy and according to Table 64, this would be assigned a two percent impairment. Utilizing the Combined Values Chart, the five combined with the two would be equivalent to a seven percent impairment of the right lower extremity or leg.
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> "This award is lower than the previously assigned eight percent impairment of the right lower extremity or leg. The review of these additional medical records does not document any award higher than the previously calculated eight percent."

By decision dated June 1, 1998, the Office denied modification of the October 1, 1997 schedule award. The Office noted that Dr. Tradonsky's report was reviewed by Dr. Simpson, who calculated that, according to Dr. Tradonsky's findings, appellant had only a seven percent permanent impairment of his right lower extremity. As this was lower than the schedule award previously granted appellant, the Office found that no additional award was indicated.

The Board finds that appellant has no greater than an eight percent permanent impairment of his right lower extremity for which he has received a schedule award.

The schedule award provision of the Federal Employees' Compensation Act[4] and its implementing regulation[5] set forth the number of weeks of compensation to be paid for permanent loss, or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent the amount of compensation is paid in proportion to the

[4] 5 U.S.C § 8101 *et seq.*; *see* 5 U.S.C. § 8107(c).

[5] 20 C.F.R. § 10.304.

percentage loss of use.[6] However, neither the Act nor its regulations specify the manner in which the percentage of loss of a member is to be determined. For consistent results and to ensure equal justice under the law to all claimants, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants seeking schedule awards. The A.M.A., *Guides* (Fourth Edition) have been adopted by the Office for evaluating schedule losses and the Board has concurred in such adoption.[7]

The standards for evaluating the percentage of impairment of extremities under the A.M.A., *Guides* are based primarily on loss of range of motion. In determining the extent of loss of motion, the specific functional impairments such as loss of flexion or extension, should be itemized and stated in terms of percentage loss of use of the member in accordance with the tables in the A.M.A., *Guides*.[8] All factors that prevent a limb from functioning normally should be considered, together with the loss of motion in evaluating the degree of permanent impairment. Chapter 15 of the A.M.A., *Guides* (Fourth Edition) provides a grading scheme and procedure for determining impairment of an affected body part due to pain, discomfort, or loss of sensation.[9] The element of pain may serve as the sole basis for determining the degree of impairment for schedule compensation purposes.[10]

In the present case, Dr. Harris stated that he used Table 62, page 83, "arthritis impairments based on roentgenographically determined cartilage intervals," in determining that appellant had a 15 percent permanent impairment of his right lower extremity, yet the record is devoid of any postoperative radiographic evidence determining such cartilage intervals.[11] Therefore, the contents of Table 62 are not applicable in this case.[12] Dr. Harris also stated that he considered the Grade II -- III chondromalacia of the patellofemoral joint in determining that appellant had a 15 percent permanent impairment but he did not cite any Table or Figure in the A.M.A., *Guides*, upon which he relied in making this determination.[13] Therefore this degree of impairment due to chondromalacia is not supported by the A.M.A., *Guides*.[14] Consequently,

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[6] 5 U.S.C. § 8107(c)(19).

[7] *Thomas D. Gauthier*, 34 ECAB 1060 (1983).

[8] *William F. Simmons*, 31 ECAB 1448 (1980); *Richard A. Ehrlich*, 20 ECAB 246 (1969) and cases cited therein.

[9] A.M.A., *Guides* (Fourth Edition 1993).

[10] *Paul A. Toms*, 38 ECAB 403 (1987); *Robin L. McClain*, 38 ECAB 398 (1987).

[11] A preoperative MRI performed on March 10, 1997 was reported as revealing "degeneration of the articular cartilage overlying the patellar facets with a chondral fracture overlying the median patellar ridge." No cartilage interval measurements were reported.

[12] However, a footnote to Table 62 does allow a 5 percent impairment for complaints of patellofemoral pain and crepitation but without joint space narrowing as demonstrated on x-ray. Therefore, reference to this table would support a 5 percent impairment of the lower extremity. In basing the impairment rating on the footnote, no percentage for loss of function due to pain, atrophy/weakness or loss of motion may be added; *see* FECA Procedure Manual, Part -- 3, Medical, *Schedule Awards*, Chapter 3.700. (October 1995)

[13] Table 62, page 83, does not address graded chondromalacia.

[14] Board precedent is well settled, however, that when an attending physician's report gives an estimate of

Dr. Harris' determination of appellant's right lower extremity permanent impairment is not in accordance with the A.M.A., *Guides* and is, therefore, of reduced probative value in establishing the degree of appellant's permanent impairment.

Dr. Simpson, however, reviewed Dr. Harris' findings of indices of impairment, which included pain, weakness and loss in range of motion and, using the A.M.A., *Guides* with the specific applicable tables and grading schemes identified, properly calculated that appellant had an eight percent permanent impairment of his right lower extremity. As Dr. Simpson's opinion was based upon the proper application of the A.M.A., *Guides*, it constitutes the weight of the medical evidence of record in establishing appellant's degree of permanent impairment.[15]

Following the award, appellant obtained a new report from Dr. Tradonsky, who did not refer to the A.M.A., *Guides* and who did not give any numerical percentage for appellant's permanent impairment. As this report did not refer to the A.M.A., *Guides* and did not offer an opinion on the degree of appellant's permanent it is of reduced probative value in proving that appellant had greater than an eight percent permanent impairment of his right lower extremity.[16] Therefore, appellant has not established that he has greater than an eight percent permanent impairment of his right lower extremity.

permanent impairment and mentions the A.M.A., *Guides*, but does not base that estimate upon correct application of specifically identifiable sections, grading schemes, tables or figures, the Office is correct to follow the advice of its medical adviser or consultant where he or she has properly utilized the *Guides*. *See Ronald J. Pavlik*, 33 ECAB 1596 (1982); *Robert R. Snow*, 33 ECAB 656 (1982); *Quincy E. Malone*, 31 ECAB 846 (1980). Board cases are clear that if the attending physician does not properly utilize the A.M.A., *Guides*, his or her opinion is of diminished probative value in establishing the degree of any permanent impairment; *see Thomas P. Gauthier*, 34 ECAB 1060 (1983); *Raymond Montanez*, 31 ECAB 1475 (1980).

[15] *Id.*

[16] *See supra* note 14.

Accordingly, the decision of the Office of Workers' Compensation Programs dated June 1, 1998 is hereby affirmed.

Dated, Washington, D.C.
April 11, 2000

Michael J. Walsh
Chairman

George E. Rivers
Member

Michael E. Groom
Alternate Member