U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of FRANK MONTEMAYOR, JR. and U.S. POSTAL SERVICE, POST OFFICE, Kansas City, OH

Docket No. 99-2083; Submitted on the Record;
Issued October 10, 2000

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
A. PETER KANJORSKI

The issue is whether appellant has more than a seven percent permanent impairment to his left lower extremity for which he received a schedule award.

The Office of Workers' Compensation Programs accepted appellant's claim for a left knee strain, left medial meniscal tear and arthroscopy of the left knee on August 30, 1993. He did not work from August 30, 1993 through February 15, 1994.

On January 9, 1996 appellant filed a claim for a schedule award.

In a progress note dated April 25, 1994, appellant's treating physician, Dr. Cris Barnthouse, a Board-certified orthopedic surgeon, opined that appellant's July 1, 1993 employment injury resulted in a 15 percent permanent impairment of the left lower extremity.

In a report dated February 19, 1996, the district medical Director stated that Dr. Barnthouse's impairment rating of appellant's left lower extremity in his April 25, 1994 progress note was unacceptable because he did not use the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed. 1994), in making his rating.

The Office therefore referred appellant to Dr. James S. Zarr, a Board-certified physiatrist, for another evaluation. In his report dated May 14, 1996, Dr. Zarr considered appellant's history of injury, performed a physical examination and diagnosed persistent left knee pain and status post left knee partial medial meniscectomy with medial femoral condyle chondroplasty and patellar chondroplasty. He opined that, based on a left knee x-ray which showed a space cartilage interval of 3 millimeters, using Table 62, page 83, presumably of the A.M.A., *Guides* (4th ed. 1994), appellant had a 7 percent impairment to his left lower extremity.

By decision dated June 18, 1996, the Office granted appellant an award for a seven percent impairment to his left lower extremity.

By letter dated July 9, 1996, appellant requested an oral hearing before an Office hearing representative which was held on April 16, 1997. At the hearing, he gave many reasons why he thought the impairment rating of seven percent was too low including that his knees were wearing out, that he could not climb steps, walk up and down hills, stand for long periods of time, hunt, go on long boat rides, run or waterski. Appellant stated that he also required special supports in his shoe. The Office hearing representative granted appellant 30 days to obtain additional documentation from Dr. Barnthouse of his impairment and informed him that Dr. Barnthouse must use the A.M.A., *Guides* (4th ed. 1994) in explaining his impairment rating.

Appellant subsequently submitted a report from Dr. Barnthouse dated May 5, 1997. In his report, Dr. Barnthouse stated that, contrary to the Office's assertion that he did not report appellant's range of motion and residuals of chronic pain, in his December 6, 1995 progress note, he described appellant's symptoms and in the second paragraph, he stated that appellant's range of motion was from 0 to 130 degrees. He stated that he did not report any sensory deficits as typically in a knee injury such as appellant's, he would not expect one. Dr. Barnthouse stated that he based his impairment rating on the fact that appellant had significant articular surface injury as well as significant meniscal injury.

Dr. Barnthouse stated that he typically used the A.M.A., *Guides* (4th ed. 1994) to make his determination. He stated that, using the A.M.A., *Guides*, Table 36 where it indicates torn meniscus and/or mensicectomy, and then under No. 5 where it lists arthritis due to any etiology, there was a range of 0 to 10 percent for one meniscus and 0 to 20 percent according to the deformity. Dr. Barnthouse stated that, based on his evaluation of appellant, his persistent symptoms and the guidelines, appellant had a 15 percent impairment of the left lower extremity.

The Office referred the case to a district medical adviser and noted that, although Dr. Barnthouse stated that he used the A.M.A., *Guides* (4th ed. 1994), he actually used the third edition. There is no Table 36 in the fourth edition which refers specifically to the knee but there is such a table in the third edition on page 61.

In a report dated June 16, 1997, the district medical adviser stated that, using the A.M.A., *Guides* (4th ed. 1994), under Table 64, page 85, appellant had a 2 percent impairment for a partial meniscectomy and under Table 62, page 83, appellant had a 5 impairment for complaints of patellofemoral pain even without radiographic documentation of arthritic changes. He stated that, using the Combined Values Chart, page 322, the values totaled a 7 percent impairment to the left lower extremity. The district medical adviser stated that he was "not sure" how Dr. Barnthouse obtained his impairment percentage of the A.M.A., *Guides* (4th ed. 1994).

By decision dated June 18, 1997, the Office hearing representative affirmed the Office's June 18, 1996 award.

By letter dated December 15, 1997, appellant requested reconsideration of the Office's decision and submitted a medical report from Dr. Barnthouse dated October 31, 1997. In his report, Dr. Barnthouse noted appellant's surgery in August 1993 and stated that his last evaluation showed both medial compartment and patellofemoral compartment arthrosis and there was radiographic evidence to suggest narrowing of both those compartments as well. He stated that he used Tables 62 and 64 of the A.M.A., *Guides* (4th ed. 1994) to make the following

determinations that, based on the narrowing of appellant's knee compartments, appellant had a 7 percent impairment of the left lower extremity, that appellant's significant patellofemoral symptoms warranted a 5 percent lower extremity impairment, and based on the extent of the removed meniscus, appellant had a 3 percent impairment. Dr. Barnthouse stated that the figures resulted in an impairment of 15 percent to appellant's left lower extremity.

In a report dated February 23, 1998, the district medical adviser found that Dr. Barnthouse's October 31, 1997 report was unacceptable. He stated that Dr. Barnthouse did not report x-ray findings which allowed him to consider using Table 62, that his finding of a 3 percent impairment based on the removed meniscus was not a rating that derived from Table 64 and Dr. Barnthouse's assigning a 5 percent impairment to appellant's significant patellofemoral symptoms was not supported by his report which "was completely deficient regarding a history of physical examination which would validate any considerations, particularly using Table 62." Dr. Barnthouse stated that the report provided no basis to agree or disagree that appellant had patellofemoral symptoms.

By decision dated March 3, 1998, the Office denied appellant's request for modification.

By letter dated November 29, 1998, appellant requested reconsideration of the Office's decision and submitted a report from Dr. Barnthouse dated October 20, 1998. In his report, Dr. Barnthouse noted on physical examination that standing alignment showed appellant to have evidence of bilateral genu varum, that he walked with a slight antalgic gait, that the range of motion of the left knee was approximately 5 degrees flexion contracture and further flexion to 120 degrees. He stated that appellant had 2+ retropatellar crepitus and 2+ medical compartment crepitus. Dr. Barnthouse stated that the x-ray films of the left knee standing "PA" flexion showed a medial compartment narrowing to around one millimeter and his patellofemoral joint space had approximately three to four millimeters joint space remaining. He concluded that, based on Table 62, page 83, of the A.M.A., *Guides* (4th ed. 1994), the joint space narrowing of his left knee medial compartment indicated a 25 percent impairment of the lower extremity at the level of the left knee.

In a report dated February 4, 1999, the district medical adviser reviewed Dr. Barnthouse's November 29, 1998 report, and stated that the measurements of joint space interval narrowing must be measured, not just "eyeballed" as appeared to be the case. He stated that, because Dr. Barnthouse stated that the PA flexion films showed a medial compartment narrowing to "around" one millimeter, "the impreciseness indicated that no measurement using a measuring device graded in millimeters was done."

The district medical adviser further noted that Table 62 (presumably of the A.M.A., *Guides* (4th ed. 1994), according to section 3.2g, "Arthritis," [page 82], requires that the x-ray view be based on "standard roentgenograms taken with the patient standing, if possible, and 36 inches from the machine." Further, he noted that the preamble to section 3.2g [page 82], stated that "[i]f there is doubt or controversy about the suitability of a specific patient for this rating method, range of motion techniques may be used."

The district medical adviser concluded that the x-ray Dr. Barnthouse referenced was not positioned appropriately and the measurements of range of motion were not performed with a

goniometer in that the "flexion contracture" was *about* five degrees [as emphasized]. He noted that goniometric measurements were made precisely to the degree. The district medical adviser stated that, because severe doubt existed about Dr. Barnthouse's impairment rating, it could not be accepted.

By decision dated February 10, 1999, the Office denied appellant's request for modification.

The Board finds that appellant has no greater than a seven percent impairment to his left lower extremity.

The schedule award provision of the Federal Employees' Compensation Act[1] provides for compensation to employees sustaining permanent impairment from loss or loss of use of specified members of the body. The Act's compensation schedule specifies the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body. The Act does not, however, specify the manner by which the percentage loss of a member, function or organ shall be determined. The method used in making such a determination is a matter that rests in the sound discretion of the Office.[2] For consistent results and to ensure equal justice under the law to 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.[3]

It is well settled that, when an attending physician's report gives an estimate of permanent impairment but does not indicate that the estimate is based on the application of the A.M.A., *Guides*, the Office may follow the advice of its medical adviser or consultant where he or she has properly utilized the A.M.A., *Guides*. Board cases are clear that, if an attending physician does not utilize the A.M.A., *Guides*, his opinion is of diminished probative value in establishing the degree of any permanent impairment.[4] Moreover, Office procedures direct the use of the third edition, revised, for schedule awards determined between September 1, 1991 and October 31, 1993 and the fourth edition, issued in 1993, for schedule awards determined on and after November 1, 1993.[5]

In the present case, Dr. Barnthouse's April 25, 1994 report in which he stated that appellant's July 1, 1993 employment injury resulted in a 15 percent impairment to the left lower extremity is not probative because he did not refer to the A.M.A., *Guides*.[6] Dr. Barnthouse's May 5, 1997 report is also not probative because although he claimed to use the A.M.A., *Guides*

[1] 5 U.S.C. § 8107 *et seq.*

[2] *Arthur E. Anderson*, 43 ECAB 691, 697 (1992); *Danniel C. Goings*, 37 ECAB 781, 783 (1986).

[3] *Arthur E. Anderson*, *supra* note 2 at 697; *Henry L. King*, 25 ECAB 39, 44 (1973).

[4] *See Paul R. Evans*, 44 ECAB 646, 651 (1993); *Thomas P. Gauthier*, 34 ECAB 1060, 1063 (1983).

[5] *See John Yera*, 48 ECAB 243, 247 (1996).

[6] *See Paul R. Evans*, *supra* note 4 at 651.

(4th ed. 1994) in making his impairment rating of 15 percent, his references to Table 36 corresponded to the third edition of the A.M.A., *Guides* and therefore he did not use the most recent A.M.A., *Guides* edition, *i.e.*, the fourth edition, which was appropriate for appellant's June 18, 1996 award.[7]

In his October 31, 1997 report, Dr. Barnthouse referred generally to Tables 62 and 64 of the A.M.A., *Guides* (4th ed. 1994), and stated that, based on the narrowing of appellant's knee compartments, appellant had a 7 percent impairment of the left lower extremity, that appellant's significant patellofemoral symptoms warranted a 5 percent lower extremity impairment, and that, based on the extent of the removed meniscus, appellant had a 3 percent impairment. He therefore concluded that appellant had a total 15 percent impairment to his left lower extremity.

The district medical adviser noted in his February 23, 1998 report, however, that, in his October 31, 1997 report, Dr. Barnthouse did not report x-ray findings which allowed him to consider using Table 62, the 3 percent impairment rating based on the extent of the removed meniscus did not derive from Table 64 and he did not provide a history of his physical examination to support a 5 percent impairment under Table 62 for patellofemoral symptoms.

Appellant subsequently submitted Dr. Barnthouse's October 20, 1998 report in which he assessed a 25 percent impairment rating. In making that rating, he particularly relied on left knee standing PA flexion x-rays which he stated showed a medial compartment narrowing to around one millimeter and that appellant's patellofemoral joint space had approximately three to four millimeters joint space remaining. Using Table 62, page 83, of the A.M.A., *Guides* (4th ed. 1994), he determined that the joint space narrowing of appellant's left knee medial compartment indicated a 25 percent impairment of the left lower extremity.

In his February 4, 1999 report, the district medical adviser noted, however, that, in Dr. Barnthouse's October 20, 1998 report, he used flexion x-rays which were not consistent with section 3.2g (page 82) of the A.M.A., *Guides* (4th ed. 1994), and did not use a goniometer to obtain precise measurements of appellant's flexion contracture or joint space as indicated by his words "around," "about" or "approximately" when describing the amount of millimeters for range of motion and joint space. Due to the defects the district medical adviser noted in Dr. Barnthouse's October 31, 1997 and October 20, 1998 reports which show they were not in conformance with the A.M.A., *Guides* (4th ed. 1994), Dr. Barnthouse's reports are not probative. Moreover, in his May 14, 1996 report, the referral physician, Dr. Zarr, used an x-ray showing a space cartilage of 3 millimeters to determine that in using Table 62, page 83, that appellant had a 7 percent impairment.[8] This rating was confirmed by the district medical adviser in his June 16, 1997 report in which using Table 64, page 85 and Table 62, page 83, of the A.M.A., *Guides* (4th ed. 1994), he determined that appellant had a 2 percent impairment for a partial meniscectomy and a 5 percent impairment for complaints of patellofemoral pain. Using the Combined Values Chart, page 322, he determined appellant's total impairment rating to his left lower extremity

[7] *See John Yera*, *supra* note 5.

[8] In contrast, Dr. Barnthouse's reference in his October 20, 1998 report to the x-ray showing "approximately three to four millimeters" of joint space removing was not as precise.

was 7 percent. Therefore, based on Dr. Zarr's impairment rating which conformed to the A.M.A., *Guides* (4th ed. 1994), and was confirmed by the district medical adviser, appellant has no more than a 7 percent impairment rating to his left lower extremity.[9]

The decision of the Office of Workers' Compensation Programs dated February 10, 1999 is hereby affirmed.

Dated, Washington, DC
October 10, 2000

David S. Gerson
Member

Willie T.C. Thomas
Member

A. Peter Kanjorski
Alternate Member

[9] *See Paul R. Evans, supra* note 4.