

Appellant submitted an x-ray of the left knee dated March 15, 2005, which revealed evidence of prior left knee surgery, medial compartment narrowing bilaterally and classical subluxation of the left patella.¹ An April 1, 2005 magnetic resonance imaging (MRI) scan of the left knee revealed postoperative changes involving the lateral tibial plateau, avulsion injury, prominent degenerative changes involving the mid and posterior aspect of the lateral meniscus, torn anterior cruciate ligament (ACL) and early osteoarthritis. In a February 27, 2006 report, Dr. Richard S. Janey, a Board-certified orthopedist, diagnosed left knee ACL tear, left knee lateral meniscus tear and left knee retained hardware. He noted that appellant had a prior left knee surgery over the lateral compartment of the knee with a well-healed incision and recommended an ACL reconstruction for stabilization. On March 23, 2006 Dr. Janey performed a left knee ACL patellar tendon reconstruction, left knee arthroscopic partial medial meniscectomy and lateral meniscectomy with hardware removal. He diagnosed left knee ACL tear, left knee lateral meniscus tear, retained hardware of the left knee and medial meniscus tear of the anterior horn.

Thereafter, appellant was treated by Dr. Mathew S. Shapiro, a Board-certified orthopedist, for significant left knee stiffness, pain, dysfunction and severe postsurgical limp. Dr. Shapiro advised that physical therapy was ineffective in restoring normal range of motion and diagnosed postoperative arthrofibrosis of the left knee. On October 9, 2006 he performed a left arthroscopic excision of arthrofibrosis, multicompartamental synovectomy, lateral retinacular release and manipulation. Appellant submitted reports dated October 17, 2006 to April 4, 2007 from Dr. Shapiro, who noted that appellant was progressing slowly postsurgery and diagnosed status post arthrofibrosis surgery, persistent stiffness and a large effusion. Dr. Shapiro recommended additional surgery and on April 9, 2007 performed an open excision of arthrofibrosis with medial and lateral patellar retinacular releases of the left knee and diagnosed arthrofibrosis of the left knee. In subsequent reports, he noted that appellant was recovering from surgery without complications but range of motion was suboptimal.² On November 6, 2007 Dr. Shapiro noted that appellant reached maximum medical improvement and advised that no further treatment was necessary.

On November 26, 2007 appellant filed a claim for a schedule award. On December 7, 2007 the Office advised him of the need for additional medical evidence. Specifically, it requested that appellant submit a physician's opinion regarding the extent of any permanent impairment due to the accepted condition. The Office advised that the impairment rating should be prepared in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.³

Appellant submitted a December 5, 2007 report from Dr. Stanley L. James, a Board-certified orthopedist and an associate of Dr. Shapiro, who noted a history of injury and subsequent medical treatment and surgeries. Dr. James diagnosed post ACL reconstruction with

¹ The record indicates that appellant had a left knee meniscal repair in 1983.

² On January 8, 2007 the Office denied appellant's claim for six hours of compensation on October 4, 2006. On June 12, 2007 a hearing representative affirmed the Office's decision. Appellant has not appealed the June 12, 2007 decision.

³ A.M.A., *Guides* (5th ed. 2001).

partial medial and lateral meniscectomy and residuals of arthrofibrosis secondary to the work incident of March 2005. He opined that, in accordance with the A.M.A., *Guides*, appellant had 22 percent impairment of the left leg. Dr. James based his impairment rating on mild ACL laxity, mild medial collateral ligament laxity and partial medial and later meniscectomies. He noted findings upon physical examination for ligament testing of “1+ valgus laxity” at three degrees of flexion and a flexion drawer test indicative of mild ACL instability. Dr. James noted that impairment for partial medial and lateral meniscectomy of the left knee was 10 percent,⁴ impairment for mild ACL laxity was 7 percent⁵ and impairment for mild medial collateral ligament laxity was 7 percent,⁶ for a 22 percent impairment of the left lower extremity using the Combined Values Chart.⁷

In a report dated January 23, 2008, an Office medical adviser determined in accordance with the A.M.A., *Guides* that appellant sustained 23 percent impairment of the left lower extremity. He noted maximum medical improvement occurred on September 18, 2007. The medical adviser concurred with Dr. James’ findings that impairment for partial medial and lateral meniscectomy of the left knee was 10 percent, impairment for mild ACL laxity was 7 percent and impairment for mild medial collateral ligament laxity was 7 percent. He noted that the final left lower extremity impairment secondary to diagnosis-based impairments was equal to the combination of impairment for the left partial medial and lateral meniscectomies and instability of the left knee measured by ligament laxity, for a 23 percent impairment of the left lower extremity using the Combined Values Chart.⁸

In a decision dated January 24, 2008, the Office granted appellant a schedule award for 23 percent impairment of the left lower extremity. The period of the schedule award was from September 18, 2007 to December 24, 2008.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees’ Compensation Act⁹ and its implementing regulations¹⁰ 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, the Act 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 to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be

⁴ *Id.* at 546, Table 17-33.

⁵ *Id.*

⁶ *Id.*

⁷ *Id.* at 604.

⁸ *Id.*

⁹ 5 U.S.C. § 8107.

¹⁰ 20 C.F.R. § 10.404 (1999).

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.

ANALYSIS

On appeal, appellant contends that he has more than 23 percent impairment of his left lower extremity.

Appellant submitted a December 5, 2007 report from Dr. James who based his impairment rating on mild ACL laxity, mild medial collateral ligament laxity and partial medial and lateral meniscectomies. Dr. James opined that this was a more thorough assessment of impairment than utilizing thigh atrophy or range of motion. He noted that, since partial meniscectomies and ligament laxities were part of the diagnosed-based estimates, neither the thigh atrophy nor the range of motion could be combined. Dr. James noted that impairment for partial medial and lateral meniscectomy of the left knee was 10 percent,¹¹ mild ACL laxity was 7 percent¹² and mild medial collateral ligament laxity was 7 percent.¹³ However, he incorrectly noted that appellant sustained a 22 percent impairment of the left lower extremity using the Combined Values Chart.¹⁴ Instead, the A.M.A., *Guides*, Combined Values Chart, provides for a 23 percent impairment rating when combining 10 percent medial and lateral meniscectomy of the left knee, 7 percent for mild ACL laxity and 7 percent for mild medial collateral ligament laxity.¹⁵

The Office's medical adviser generally concurred with Dr. James's findings and also correlated them to provisions in the A.M.A., *Guides*. In a report dated January 23, 2008, he determined that appellant sustained 23 percent impairment of the left lower extremity. The medical adviser noted that impairment for partial medial and lateral meniscectomy of the left knee was 10 percent,¹⁶ mild ACL laxity was 7 percent¹⁷ and mild medial collateral ligament laxity was 7 percent.¹⁸ He properly combined these diagnosis-based impairments to equal 23 percent impairment of the left leg.¹⁹ The medical adviser further noted that appellant's impairment was the largest allowable impairment secondary to the combination of impairment methods which may be combined under Table 17-2, page 526 of the A.M.A., *Guides*. He noted that impairment for loss of left knee range of motion and left thigh atrophy were not able to be

¹¹ A.M.A., *Guides* 546, Table 17-33.

¹² *Id.*

¹³ *Id.*

¹⁴ *Id.* at 604.

¹⁵ *Id.*

¹⁶ *Id.* at 546, Table 17-33.

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.* at 604.

combined with diagnosis-based impairments, pursuant to Table 17-2 of the A.M.A., *Guides*, so that the greatest applicable impairment rating was obtained by using diagnosis-based estimates.²⁰

The Board notes that under the A.M.A., *Guides* appellant has no more than 23 percent impairment of the left lower extremity.

On appeal, appellant asserts that the amount of the schedule award is insufficient as his work injury caused a change in his lifestyle including an inability to work, difficulty in completing normal and usual day to day tasks, inability to enjoy recreational activities and an inability to enjoy his hobbies. However, the Board has held that the amount payable pursuant to a schedule award does not take into account the effect that the impairment has on employment opportunities, wage-earning capacity, sports, hobbies or other lifestyle activities.²¹

CONCLUSION

The Board finds that appellant has no more than 23 percent permanent impairment of the left lower extremity.

ORDER

IT IS HEREBY ORDERED THAT the January 24, 2008 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 6, 2009
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

²⁰ Table 17-2 specifically provides that impairment due to lost range of motion or atrophy not be combined with impairment derived from diagnosis-based estimates. As noted, Dr. James, appellant's examining physician, opined that the diagnosis-based estimates provided a more thorough estimate of appellant's impairment.

²¹ *Ruben Franco*, 54 ECAB 496 (2003).