United States Department of Labor
Employees' Compensation Appeals Board

K.M., Appellant	)	
and	)	**Docket No. 08-612**
	)	**Issued: July 15, 2008**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, St. Petersburg, FL, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On December 26, 2007 appellant filed a timely appeal of the Office of Workers' Compensation Programs' schedule award decision dated October 26, 2007. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has met his burden of proof to establish that he has more than a two percent impairment of his right lower extremity, for which he received a schedule award.

FACTUAL HISTORY

On November 28, 2005 appellant, then a 51-year-old carpenter, was injured in the performance of duty when he fell while exiting a vehicle. The Office accepted appellant's traumatic injury claim for right meniscus tear and old disruption of right anterior cruciate ligament (ACL). On March 2, 2006 appellant underwent a partial medial meniscectomy and allograft (prosthetic) reconstruction of the right anterior cruciate ligament.

Appellant submitted a report dated August 14, 2006 from Dr. Philip A. Davidson, a Board-certified orthopedic surgeon, who performed the March 2, 2006 surgery. Dr. Davidson's examination of the right knee revealed range of motion of 0 to 140 degrees. Testing reflected a 1+ Lachman, with a firm and distinct endpoint. Dr. Davidson found no joint line pain and no effusion. He opined that appellant had reached maximum medical improvement, and that he had a five percent whole body impairment rating pursuant to the relevant guidelines.

In order to determine whether to authorize payment for appellant's prosthetic implant procedure, the Office referred appellant to Dr. Jeffrey M. Oettinger, a Board-certified orthopedic surgeon, for an opinion as to whether the procedure was appropriate and was causally related to the accepted November 28, 2005 injury. On June 28, 2007 Dr. Oettinger diagnosed right knee status post ACL reconstruction, partial medial meniscectomy, with minimal residual pain. Examination of the right lower extremity revealed 1+ laxity of the knee, with firm endpoint; range of motion from 0 to 135 degrees; and slight medial joint line pain. Appellant was stable to varus-valgus testing, and there was no active effusion or swelling. His quadriceps were similar in size, within a centimeter. Distally, he had normal sensation to light touch. The left knee exhibited a 1+ laxity with a firm endpoint. Otherwise, the left knee was completely asymptomatic. Dr. Oettinger opined that the prosthetic implant procedure was appropriate and causally related to the accepted injury.[1]

Appellant filed a claim for a schedule award on July 27, 2007. The Office referred the medical record to the Office medical adviser for review and an opinion as to the degree of permanent impairment to appellant's right lower extremity and the date of maximum medical improvement.

On September 19, 2007 the medical adviser stated that Dr. Davidson found 1+ laxity bilaterally, which indicated no instability in the reconstructed right knee. Referring to Table 17-33 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001), he determined that appellant was entitled to a two percent impairment rating for his March 2, 2006 partial meniscectomy. The medical adviser noted that Dr. Davidson had failed to provide a basis for his five percent impairment rating. He concluded that appellant reached maximum medical improvement on December 2, 2006, which was nine months after his March 2, 2006 surgery.

On October 26, 2007 the Office granted appellant a schedule award for a two percent impairment of his right lower extremity. The period of the award was from June 27 through August 8, 2007, for a total of 5.76 weeks. The Office found that appellant reached maximum medical improvement on December 2, 2006.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[2] The Act, however, does not specify the manner by which the

[1] The Board notes that the Office authorized payment for the prosthetic implant on September 20, 2007.

[2] 5 U.S.C. §§ 8101-8193.

percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[3] The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[4]

For lower extremity impairments due to meniscectomies or ligament injuries involving the knees, Table 17-1, page 525 of the A.M.A., *Guides* directs the clinician to utilize section 17.2j, beginning at page 545,[5] as the appropriate method of impairment assessment. Section 17.2j, entitled Diagnosis-Based Estimates, instructs the clinician to assess the impairment using the criteria in Table 17-33 at page 546, entitled Impairment Estimates for Certain Lower Extremity Impairments.[6] According to Table 17-33, a partial medial meniscectomy is equivalent to a two percent impairment of the lower extremity.[7] Additional percentages of impairment are awarded for laxity of the cruciate or collateral ligaments.[8]

It is well established that the period covered by a schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of the employment injury. The Board has defined maximum medical improvement as meaning that the physical condition of the injured member of the body has stabilized and will not improve further. The Board has also noted a reluctance to find a date of maximum medical improvement, which is retroactive to the award, as retroactive awards often result in payment of less compensation benefits. The Board, therefore, requires persuasive proof of maximum medical improvement in the selection of a retroactive date of maximum medical improvement.[9] The determination of whether maximum medical improvement has been reached is based on the probative medical evidence of record and is usually considered to be the date of the evaluation by the attending physician which is accepted as definitive by the Office.[10]

ANALYSIS

The Office granted appellant a schedule award for a two percent permanent impairment of his right lower extremity, based upon the recommendation of the Office medical adviser. However, the Board finds this case is not in posture for a decision, as the report of the medical adviser requires clarification.

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[3] 5 U.S.C. § 8107.

[4] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999); 20 C.F.R. § 10.404.

[5] A.M.A., *Guides* 525, Table 17-1.

[6] *Id.* at 545.

[7] *Id.* at 546, Table 17-33.

[8] *Id.*

[9] *J.C.*, 58 ECAB ___ (Docket No. 06-1018, issued January 10, 2007); *D.R.*, 57 ECAB 720 (Docket No. 06-668, issued August 22, 2006); *James E. Earle*, 51 ECAB 567 (2000).

[10] *Mark A. Holloway*, 55 ECAB 321, 325 (2004).

On August 14, 2006 appellant's treating physician, Dr. Davidson, opined that appellant had a five percent whole body impairment rating pursuant to the relevant guidelines. His examination of the right knee revealed range of motion of 0 to 140 degrees. Testing reflected a 1+ Lachman, with a firm and distinct endpoint. He found no joint line pain and no effusion. Dr. Davidson opined that appellant had reached maximum medical improvement at that time.

On June 28, 2007 Dr. Oettinger, the second opinion physician, diagnosed right knee status post ACL reconstruction, partial medial meniscectomy, with minimal residual pain. Examination of the right lower extremity revealed 1+ laxity of the knee, with firm endpoint; range of motion from 0 to 135 degrees; and slight medial joint line pain. Appellant was stable to varus-valgus testing, and there was no active effusion or swelling. His quadriceps were similar in size, within a centimeter. Distally, he had normal sensation to light touch. Appellant denied any sense of instability. The left knee exhibited a 1+ laxity with a firm endpoint. Otherwise, the left knee was completely asymptomatic.

On September 19, 2007 the medical adviser stated that Dr. Davidson found 1+ laxity bilaterally, which indicated no instability in the reconstructed right knee. Referring to Table 17-33 of the fifth edition of the A.M.A., *Guides*, he found that appellant was entitled to a two percent impairment rating for his March 2, 2006 partial meniscectomy.[11] The medical adviser correctly noted that Dr. Davidson had failed to provide a basis for his five percent impairment rating.[12] However, in light of findings of 1+ laxity in the right knee by both Dr. Davidson and Dr. Oettinger, he did not adequately explain his conclusion that appellant had no instability in his right knee, which would permit an additional impairment rating pursuant to Table 17-33.[13] The fact that appellant had ligament laxity in both lower extremities does not negate a finding of laxity. Moreover, Table 17-2, the cross usage chart, does not appear to prohibit the diagnosis-based rating for the partial meniscectomy with a rating for cruciate ligament laxity. The Board finds that the Office medical adviser's opinion is not sufficient to establish the degree of appellant's permanent impairment.

The medical adviser concluded that appellant reached maximum medical improvement on December 2, 2006, which was nine months after his March 2, 2006 surgery. However, he did not offer any medical explanation for selecting that date. The determination of whether maximum medical improvement has been reached is based on the probative medical evidence of record and is usually considered to be the date of the evaluation by the attending physician which is accepted as definitive by the Office.[14] In this instance, the medical adviser did not identify the report upon which he based his impairment rating. He referred to both Dr. Davidson's

[11] A.M.A., *Guides* 546, Table 17-33.

[12] The Board notes that, while the A.M.A., *Guides* provides for impairment to the individual member and to the whole person, neither the Act nor its regulations allows schedule awards for impairment to the whole person. 5 U.S.C. § 8107; *see also Richard R. Lemay*, 56 ECAB 341 (2005); *Phyllis F. Cundiff*, 52 ECAB 439 (2001); *Jay K. Tomokiyo*, 51 ECAB 361 (2000).

[13] Table 17-33 provides for a 7 percent impairment rating for mild cruciate or collateral ligament laxity; 17 percent for a moderate laxity; and 25 percent for severe laxity. A.M.A., *Guides* 546, Table 17-33.

[14] *Mark A. Holloway*, 55 ECAB 321, 325 (2004).

August 14, 2006 report, and to Dr. Oettinger's June 28, 2007 report. Ultimately, he selected, a date which did not correspond to the date of either report. The Board will set aside the Office's October 26, 2007 decision and remand the case for further development of the medical evidence, as appropriate, to determine the impairment of appellant's right lower extremity, and the date of maximum medical improvement.

CONCLUSION

The Board finds that the case is not in posture for decision. The case will be remanded to the Office for clarification from its medical adviser regarding the degree of appellant's permanent impairment and the date of maximum medical improvement, and for such other further development of the medical evidence as is deemed necessary by the Office.

ORDER

IT IS HEREBY ORDERED THAT the October 26, 2007 decision is set aside for further development consistent with this decision of the Board.

Issued: July 15, 2008
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board