U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 02 June 2004

Case No. 2003-LHC-2660
2003-LHC-2661

OWCP No. 5-94290
5-112213

In the Matter of

BILLY J. PERRY,
Claimant
v.

NEWPORT NEWS SHIPBUILDING & DRY DOCK COMPANY,
Self-Insured Employer

Appearances:
Gregory E. Camden, Esq., for Claimant
Jonathan H. Walker, Esq., for Employer

Before:
RICHARD E. HUDDLESTON
Administrative Law Judge

DECISION AND ORDER

This proceeding involves a claim for permanent partial disability from an injury alleged to have been suffered by Claimant, Billy J. Perry, covered by the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. §901 *et seq*. (Hereinafter referred to as the "Act"). Claimant alleges that he was injured when he slipped and fell while employed by Employer; and that as a result he is suffering from an injury to his right knee.

The claim was referred by the Director, Office of Workers' Compensation Programs to the Office of Administrative Law Judges for a formal hearing in accordance with the Act and the regulations issued thereunder. A formal hearing was held on March 1, 2004. (TR).[1] Claimant submitted seven exhibits, identified as CX 1 through CX 7, which were admitted without objection. (TR. at 12). Employer submitted seventeen exhibits, EX 1 through EX 17, which

[1] EX - Employer's exhibit; CX - Claimant's exhibit; and TR - Transcript.

were admitted without objection. (TR. at 13). The parties submitted one joint exhibit, JX 1, which was admitted without objection. (TR. at 11). The record was held open until May 3, 2004, for the submission of post-hearing briefs. (TR. at 31). Employer submitted its brief on May 3, 2004. On May 4, 2004, counsel for Claimant submitted a motion for an extension of time to file his post-hearing brief, and on May 5, 2004, counsel for Claimant submitted his post-hearing brief. Following a telephone conference with the parties, Claimant's late post-hearing brief was accepted.

The findings and conclusions which follow are based on a complete review of the record in light of the argument of the parties, applicable statutory provisions, regulations, and pertinent precedent.

ISSUES

The following issues are disputed by the parties:

1. Whether Claimant's injury is a compensable consequence of his November 18, 1994, injury and therefore is entitled to permanent partial disability; and

2. The appropriate disability rating to be assigned if Claimant is entitled to permanent partial disability.

STIPULATIONS

At the hearing, Claimant and Employer stipulated:

1. That an employer/employee relationship existed at all relevant times;

2. That the parties are subject to the jurisdiction of the Longshore & Harbor Workers' Compensation Act[2];

3. That the claimant suffered an injury to both knees with a date of diagnosis of November 18, 1994;

4. That a timely notice of injury was given by the employee to the employer;

5. That a timely claim for compensation was filed by the employee;

6. That the employer filed a timely First Report of Injury with the Department of Labor and a timely Notice of Controversion;

[2] Counsel for Employer clarified on the record that the parties had stipulated only to coverage as to the first injury, that is, the injury that occurred on November 18, 1994. Employer's counsel further stated that its position was that situs did not exist for coverage of the second injury, which occurred on February 14, 2001. (TR. at 11).

7. That the claimant's average weekly wage at the time of his injury was $1,057.62 resulting in a compensation rate of $705.08;

8. That the employer has paid the claimant benefits as documented on the enclosed LS-208 dated May 24, 2000;[3]

9. That the Administrative Law Judge can enter an award for the benefits which have been paid as shown on the attached LS-208 dated May 24, 2000; and

10. That the claimant's treating physician is Dr. Earl D. White, II.

(JX 1).

DISCUSSION OF LAW AND FACTS

Testimony of Claimant

Claimant is sixty-one years old and began working for Employer in January, 1968. (TR. at 14-15). At the time that the injury occurred on November 18, 1994, Claimant was employed by Employer as an electrician supervisor. Claimant testified that this position was "taxing, physically" and required him to crawl, kneel, and climb. (TR. at 15). Claimant was injured when he was trying to get under a piece of electronic equipment and slipped and fell on a greasy floor. (TR. at 15-16). He stated that he fell onto both knees and that he "had to wait for a few minutes to straighten my feet out and then pull myself up." (TR. at 16).

Claimant saw Dr. Earl D. White, II, on December 5, 1994, for this injury. According to Claimant, Dr. White has been his treating physician since the injury. Initially, Dr. White treated Claimant's left knee, and recently, he performed a total knee replacement on that knee. (TR. at 14, 16). Dr. White originally assigned a 32% disability rating to Claimant's left knee, and Employer paid him based on a 30% disability rating. (TR. at 17).

Claimant began having problems with his right knee after the initial injury in 1994, but stated that the problems were not that bad, so no treatment was rendered on the right knee at that time. (TR. at 17). Claimant testified on cross-examination that he first reported his problems with his right knee when he told a shipyard doctor about the accident, that the left knee had already been treated, and that his right knee was also hurting. The doctor confirmed that they had been treating the left knee since 1992. (TR. at 21). According to Claimant, the doctor told him that the left knee was worse than the right knee, and so the shipyard sent him for treatment on the left knee. Claimant stated that the doctor told him that his right knee was hurting because he had been compensating for the pain in the left knee. Claimant said he was also told by the doctor that if the left knee were repaired, the right knee should improve. (TR. at 21-22). Claimant stated that he also told Dr. White that his right knee was hurting and that he had been shifting his weight to his right. (TR. at 23).

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[3] Counsel for Claimant clarified on the record that, as to Stipulations 8 and 9, which reference an attached form LS-208, that the form was actually submitted as Employer's Exhibit 6. (TR. at 10-11).

Claimant began going to the clinic in November, 1999, for right knee pain, and was taken out of work from December 27, 1999, until May 17, 2000, to have surgery performed on his right knee. This surgery occurred after he signed a stipulation as to the disability rating on his left knee. (TR. at 28).

Claimant injured the right knee again in February, 2001. Before that time, Claimant had had surgery performed on both knees. (TR. at 17-18). At the time of the February, 2001, injury Claimant was working as a planner in the Sears building. (TR. at 18). The Sears building is located outside of the shipyard's gate, on Huntington Avenue and 28th Street. (TR. at 20). According to Claimant, his position as a planner was "office work." (TR. at 18-19). Claimant had pain in his right knee prior to February, 2001, and Dr. White had given him medication, but Claimant stated that this medication "just worked for a while." When he was injured in February, 2001, Claimant stated that he "just kept working and walking and walking from the parking lot back and forth and back and forth, and pretty soon, it got to the point that it started burning, and it hurt, and I just couldn't stand on it." (TR. at 19).

At the time of the hearing, Claimant stated that his knee continued to "pop" and "slip," that it burned all night, and that many times he was unable to stand on it. (TR. at 19). According to Claimant, his doctor has told him that he might need to have a total knee replacement performed on the right knee just as was performed on his left knee because there was bone to bone contact in the right knee. (TR. at 19).

Deposition Testimony of Dr. Earl D. White, II

Dr. White's deposition was taken on October 10, 2002, on behalf of the Claimant. (CX 3-1). Dr. White is a Board Certified orthopedic surgeon who has practiced in Hampton, Virginia, since 1973. (CX 3-5). Dr. White first saw Claimant on December 5, 1994, for an injury to Claimant's left knee. (CX 3-5, 3-6). At that time, Dr. White diagnosed Claimant with "a probable tear of the medial meniscus of the cartilage." (CX 3-6). According to Dr. White, Claimant had an MRI, which confirmed this diagnosis, and Claimant underwent an arthroscopic meniscectomy in December, 1994. Claimant's surgery was followed by physical therapy, and he was eventually released to light duty work. (CX 3-6).

Dr. White testified that Claimant began complaining about his right knee, particularly, pain behind the kneecap in the right knee, which Dr. White opined was probably from shifting weight from his left side to his right. (CX 3-6, 3-7, 3-8). To this extent, Dr. White testified that Claimant continued to complain about his left knee, and that Claimant never really got over this problem. According to Dr. White, work activity could have also contributed to the problem, such as squatting, crawling, kneeling, and climbing stairs. (CX 3-8). Dr. White formally diagnosed Claimant as having "some tearing of the cartilage of the right knee, and he had some degenerative changes beginning to develop in the right knee as well." This occurred in December, 1999. Claimant underwent an arthroscopic meniscectomy in late December, 1999, and had a full recovery. (CX 3-7, 3-8).

On March 9, 2000, Dr. White placed Claimant under permanent physical restrictions for both his left and right knees, which limited Claimant to walking no further than 1/4 mile; no

crawling, kneeling, or squatting; only incline stairs and ladders; no vertical ladders; and occasional use of foot controls. (CX 3-8, 3-9).

Dr. White provided a disability rating of 33% for Claimant's right knee on October 2, 2000, by using the Fourth Edition of the AMA Guides to the Evaluation of Permanent Impairment. (CX 3-9, 3-10). The rating was based upon the fact that Claimant had both a medial and lateral meniscectomy, that he had some cruciate ligament laxity, and some loss of joint space on weight-bearing X-rays. According to Dr. White, he utilized the combined values chart, which added two numbers from the guide and arrived at a sum that did not equal the actual sum of the two numbers. Dr. White stated that he has "tried to follow the methodology when I didn't think it made any sense." (CX 3-10). He stated that while this methodology was not the only one available but that it is a generally accepted way to calculate disability ratings, is probably most widely used, and was the method he typically used. (CX 3-11).

As to Dr. Luck's report, Dr. White opined that, "I think it's not accurate to say that only a single contributing factor needs to be – or condition needs to be considered in determination. I think there are other occasions where patients have a variety of things going on." (CX 3-12). To this extent, Dr. White explained that the loss of the meniscus was important not only because it would predispose a person to arthritic changes but also because it "mechanically deranges the knee and it doesn't move in a normal fashion." (CX 3-12). This also causes some individuals to experience discomfort. (CX 3-13). Dr. White testified that, "it's my opinion that combining both loss of joint space and the fact that the meniscus is no longer present is a valid way of estimating the abnormality and permanent impairment of the knee. Now, I recognize that Dr. Luck says . . . that that was not their intent, but I'm not sure I recall having ever seen that. . . . My logic and rationale for using more than one way of looking at the impairment and combining them is that independently each are a cause for impairment." (CX 3-14). Dr. White stated that he believed he was in the best position to evaluate Claimant since he was the physician who saw Claimant. (CX 3-15).

Dr. White stated on cross-examination that he would not consider it authoritative if Dr. Luck, the chairman of the AMA Guide chapter dealing with the lower extremity, said that the drafters' intent was only to use one form of rating for each anatomical part. While Dr. White stated he considered the methodology to be respected and generally well thought out, he did not consider that methodology to be more authoritative than any other single text. (CX 3-33). Therefore, Dr. White testified that, under certain circumstances, he would divert from the AMA Guides if the drafters sought to use only one form of rating for each anatomical part. (CX 3-33, CX 3-34).

Dr. White was also questioned as to the following statement by Dr. Luck:

> Patients with osteoarthritis have narrowing of their medial compartment, and the knee is then thrown into varus alignment, or a bowed configuration, which actually opens the lateral compartment. Nonetheless, their medial compartment symptoms are severe enough to warrant medical management in the early stages and surgical management, specifically total knee replacement in the advanced stages. In patients have [*sic*] a more symmetrical loss of joint space, the

> symptoms are not any more severe, nor is in need for medical and ultimately surgical management accelerated.

(CX 3-34). Dr. White's interpretation of this statement was that "the bulk of the symptoms would probably be attributable to the arthritic problem as opposed to the residuals following a meniscectomy." Dr. White stated that to a great extent, this was a true statement, but he did not believe this to be an exclusive statement. Instead, he believed that there was some residual that accounted for the meniscus, while the majority may account for the arthritis. (CX 3-35).

Upon cross-examination, Dr. White stated that two portions of his rating were "not based upon opinion based upon a unique ability to examine the patient that only I would possess." However, Dr. White's finding that Claimant had mild cruciate ligament laxity was based upon his personal examination of Claimant. Dr. White stated, though, that "any examiner should be able to take a look at the X ray and determine what the residual joint space is and things of that sort." (CX 3-17). Dr. White did state that he disagrees with the AMA Guides' methodology to the extent that it fails to take into account the differences between individuals, such as their height and weight, and explained that these characteristics can have a difference in areas such as the amount of joint space. (CX 3-17, 3-18).

Dr. White also discussed his office notes from March 9, 2000. According to Dr. White, he misspoke when doing his dictation in that when he stated that there was a loss of medial joint space on the right knee, he actually meant that the loss of medial joint space was in the left knee, and that his right knee was essentially normal with four millimeters of joint space. (CX 3-19). Dr. White repeated that his dictation was not clear and that whichever knee he was rating on that date had a residual joint space of two millimeters and that the opposite knee had a joint space of four millimeters. (CX 3-20).

As to his notes from March 9, 1998, Dr. White stated that his opinion was that Claimant's right knee problems were attributable to load-shifting from the left knee, which aggravated Claimant's right knee arthritic condition to the point where it became symptomatic. Dr. White opined that this aggravation was permanent in nature. (CX 3-21, 3-23, 3-24). To this extent, Dr. White testified that Claimant was having difficulty with his right leg, which would buckle and give way. (CX 3-40). Dr. White also opined that some activities such as climbing stairs could aggravate the right knee symptoms on a temporary basis as well. (CX 3-22, 3-24). Dr. White further clarified that he believed Claimant's symptoms indicated a "significant degenerative disease that's starting to occur in his opposite knee." (CX 3-23). Dr. White confirmed that there is no documentation in his notes that Claimant was told in March, 1998, that he would need surgery on his right knee, and that Claimant was not told he definitely needed surgery until December, 1999. (CX 3-38, 3-39).

Dr. White took weight-bearing X-rays on March 9, 1998, and at that time, Dr. White's impression was chondromalacia of Claimant's right knee, "status post industrial injury." (CX 3-26, 3-27). Dr. White explained that the latter phrase referred to the fact that Claimant originally came to his office on a workers' compensation claim from his left knee injury. (CX 3-27). Dr. White said that when he made the diagnosis of chondromalacia, he was unsure whether he made it clear to Claimant that this was a permanent problem, and testified that while this condition

tends to be chronic, the symptoms are not always chronic. (CX 3-27, 3-28). At this point, Dr. White did not believe that Claimant should climb stairs even on a limited basis, since this activity seemed to aggravate his right knee; this was intended as a permanent restrictions. (CX 3-28, 3-41).

After changing his opinion as to Claimant's ability to climb stairs, Dr. White said that he felt Claimant could perform sedentary work, so long as he could move around, as it could be uncomfortable to Claimant to sit for long periods of time. (CX 3-29, 3-30). However, Dr. White qualified his answer by stating that Claimant could experience episodes where he could be in too much pain to work at all. In general though, Dr. White opined that Claimant should have been able to perform a sedentary job so long as he did not have to walk an excessive distance or climb any stairs. (CX 3-22).

Medical Evidence

A note from the shipyard clinic dated November 9, 1993, states "Brings from Dr. Nevins Rx for Tylenol #3, [illegible], & OWCP-5 form for light duty 3370 updated in computer sent to dept. screen print given. Pt to take to supervisor. F/U appt 11/15/93 @ 9 am Has MRI scheduled for 3:45 p.m." The entry is signed by C. Shoemaker, RN. (EX 3-2).

A note from the shipyard clinic dated November 15, 1993, states, "Brings from Dr. Nevins OWCP-5 form for permanent restrictions. No F/U appt schedules @ this time 3370 updated in computer sent to dept. + screen print given pt to take to dept." The entry is signed by C. Shoemaker, RN. (EX 3-2).

An entry in the shipyard clinic notes dated November 23, 1994, reads, "L knee hurt 'all the time.' On 11-18 94 @ 1900 on H2317J while squatting down L knee gave way." This part is signed by C. Lauria, RN. (EX 3-2). The second part of this entry uses the SOAP method of evaluation. Under "S," the notes state, "Hx as above L knee gives out all the time now. Pain is worse when bending all the way back or when twisting. Using Flexall, heat." For "O," the following is written: "T medial joint [illegible] tenderness McMurray – T pain, T click Drawers -, swell -." Under "A": Knee sprain R/O meniscal tear. Finally, under "P": Ace, heat. Refer to ortho of choice. No working in tight spaces. No kneeling or squatting until [illegible]." The signature on this portion of the entry is illegible. (EX 3-2, 3-3).

On November 29, 1994, a "Report of Occupational Injury" was completed. The form stated that the injury occurred on November 18, 1994, and that the injury was reported on November 23, 1994. In the section labeled "Employee's Statement," the form reads "Instructing worker on how to test precipitators and I tried to kneel down and my left knee turned to the side." The form appears to be signed by Mr. Perry, as well as by a witness. In the section labeled "Diagnosis," Dr. Matt Jardiniano wrote, "Knee Sprain Left R/O Meniscal Tear Ace Heat Refer to Ortho of Choice 3370 until 12/1/94." Also written in that section is the following: "L Medial Meniscal Tear 9/15/95 Dr. White 12.16.94 L Partial Med. Meniscectomy Dr. White 9/15/95 arthroscopy. 11/29/99 Rt knee pain [illegible] & Dr. Tornberg." The expected return to work date on the form is noted as November 23, 1994. (EX 1).

Claimant returned to the shipyard clinic on November 29, 1994, "for 2954 and appt. ortho." The notes from this visit state "Code of Jurisdiction explained; panel of physicians offered to patient. Patient chose Dr. Earl White. Appt. scheduled for Monday, 12/5/94 @ 10:00 a.m. Patient informed of appt. and to pick up authorization papers." This entry is initialed, but the initials are illegible. (EX 3-3).

An "Insurer's First Report of Injury" was completed on November 30, 1994. The form states that the accident occurred on November 18, 1994. The nature of injury is noted as "Knee Sprains." The description of the accident is listed as "Instructing worker on how to test precipitators and I tried to Knee down and my left knee turned to the side." (EX 2).

Claimant was seen by Dr. White on December 5, 1994, because his knee was "go[ing] out" and would "slip, catch[], pop[] and is very painful when this occurs." Dr. White noted that Claimant did not describe true locking. Claimant was shifting his weight to the right leg, which was also giving him problems. Dr. White notes "That is primarily just aching discomfort and general discomfort." Upon examination, Dr. White found that Claimant had full range of motion in his left knee, that he was tender over the medial joint line, particularly posteriorly medially. The X-rays of the left knee were unremarkable. Dr. White's impression was "probable tear of the medial meniscus." Dr. White scheduled Claimant for an MR study and gave Claimant Ibuprofen for his discomfort. Claimant related to Dr. White that he did not like to be in tight spaces for long periods of time. Dr. White also prescribed Claimant Valium, 5 mg. Claimant was to return when the MR study was complete. (CX 1-33; EX 4-16).

Dr. John D. O'Neil of Advanced Medical Imaging Institute conducted an MRI of Claimant's left knee on December 6, 1994, upon referral from Dr. White. Dr. O'Neil found edema in the prepatellar soft tissues and around the medial collateral ligament. He found no disruption of the extensor tendons or retinacula. Claimant had a small fluid collection in the semimembranosus gastrocnemius bursa, the gastrocnemius muscle sheath, around the medial and lateral heads of the inferior sections, and around the medial head of the cephalad sections. Dr. O'Neil found no intramuscular fluid collection or hematoma. Dr. O'Neil also noted an "extensive horizontal cleavage tear involving the posterior horn of the medial meniscus." There was no significant displacement of the meniscal fragments. Dr. O'Neil wrote that the "tear also involves the body of the meniscus but leaves the anterior horn unaffected. The lateral meniscus is intact, as are the cruciate ligaments." Dr. O'Neil found the fibular collateral ligament to also be intact. Claimant had a small joint effusion. (CX 4-1). Dr. O'Neil's impressions were: "Extensive horizontal cleavage tear involving the body and posterior horn of the medial meniscus;" "Medial prepatellar soft tissue edema but no apparent disruption of any of the supporting structure of the knee. Fluid also seen in the semimembranosus gastrocnemius bursa as well as within the gastrocnemius muscle sheath. Please see above comments. The significance of this finding is uncertain;" and "small joint effusion." (CX 4-1, 4-3).

Claimant saw Dr. White on December 12, 1994. He was still symptomatic in his knee, and his MR study showed a tear of his cartilage. Dr. White wrote that they would proceed with arthroscopic meniscectomy of the left knee. (CX 1-31; EX 4-15).

On December 15, 1994, the shipyard clinic received a call from Claimant, at which time he stated that Dr. White would be performing surgery on his knee the next day. The entry is initialed, and the initials appear to read BMC. (EX 3-3).

On December 16, 1994, Dr. White performed an arthroscopy, partial medial menisectomy upon Claimant at Sentara Hampton General Hospital. In addition to the notes regarding the mechanics of the surgical procedure, Dr. White noted that Claimant tolerated the procedure well and was returned to the recovery area in satisfactory condition. (CX 1-32).

Claimant telephoned the shipyard clinic again on December 19, 1994, and stated that he had an appointment with Dr. White on December 23, 1994. The initials on this entry appear to read DX. (EX 3-3).

Claimant returned to Dr. White's office on December 23, 1994, approximately one week after his arthroscopic meniscectomy. According to Dr. White's notes, Claimant had a "very large complex posterior medial horn tear of the medial meniscus. He had an uneventful scope with the remainder of his joint being in good shape." Dr. White noted that Claimant had not recovered well, that he was reluctant to put weight on the knee, and that he had excessive pain. Dr. White stated that he would start Claimant on a vigorous physical therapy rehabilitation program and would allow him to bear weight on his knee as tolerated. (CX 1-31).

Upon referral from Dr. White, physical therapist Patty Pelen of Peninsula Physical Therapy & Associates, Inc. evaluated and treated Claimant on January 4, 1995 for "s/p (L) meniscectomy." She found "AROM (L) knee flexion = 90°, extension = -6°;" "Fair plus VMO and rectus femoris isometric ms contractility;" "Abnormal gait sequence with (B) axillary crutches PWB (L) LE;" and "Moderate joint effusion (L) anterior knee joint." Ms. Pelen treatment recommendations were A/PROM; gait training; and therapeutic exercise. Under the "Goals" section, Ms. Pelen listed the following: increase AROM (L) knee to 90°, extension to 0°; Good to good plus (L) LE strength; Normal gait pattern without device FWB (L) LE; Resolve joint effusion; and independent home exercise program. (CX 6-1).

Ms. Pelen completed a status summary to Dr. White on January 12, 1995. In the summary, Ms. Pelen noted that Claimant began treatment on January 4, 1995, and received gait training, PROM, and therapeutic exercises. Ms. Pelen noted that Claimant was progressing in the following categories: Increase R.O.M.; Increase Strength; Improve Function; Increased Mobility; and Improve Ambulation. Claimant's status was unchanged as to a decrease in his pain. In the comments section of the status summary, Ms. Pelen noted that a reassessment revealed improve gait, but that his gait remains antalgic and "decreased TKE noted." Ms. Pelen wrote that Claimant had a minimal decrease in anterior knee joint fusion; that his 'AROM (L) knee flexion = 110°, extension = -2°. Isometric VMO and rectus femoris contractility is fair plus [illegible] effusion and pain [illegible] TKE resulting in decreased contraction. Progressing as expected. Please advise." Under the section labeled "Physician's Request," Dr. White signed the section and noted that Claimant should continue therapy for three weeks at three days per week. He also noted "Good progress. Keep it up." (CX 6-2).

An Attending Physician's Report was completed by Dr. James M. Reid at the shipyard clinic on January 12, 1995. The date of the injury is listed as November 18, 1994, and the date of the first visit (presumably to the shipyard clinic) is listed as November 23, 1994. In the "Dates of Your Treatment" section, "11-23-94 Thru " is written. In the section labeled "Employee's Account of how Injury or Exposure to Occupational Disease Occurred," the following is written: "Instructing worker on how to test precipitators and I tried to kneel down and my left knee turned to the side." In the section labeled "Findings Upon Examination," "Knee Sprain Left R/O Meniscal Tear Ace Heat Refer to Ortho of choice 3370 until 12/1/94" is written. (EX 3-1).

Claimant saw Dr. White on January 13, 1995, approximately one month after his arthroscopic meniscectomy. Claimant related that he was doing better after his physical therapy. Claimant's range of motion was from slight flexion contracture to 110-115 degrees. Claimant still had a slight antalgic limp, but this had improved. Claimant was to return in three weeks. (CX 1-30; EX 4-14).

Claimant returned to Dr. White's office on February 8, 1995, still moderately symptomatic. Claimant's range of motion had improved, and he was able to walk without crutches. Claimant still had some crepitation with retropatella range of motion. Dr. White returned Claimant to light duty status, and was to be seen again three weeks later. Dr. White also noted "He is going to be very restricted in his activities." (CX 1-30).

Claimant was seen at the shipyard clinic on February 13, 1995. He was attempting to return to work and had light duty restrictions per Dr. White's note of February 8, 1995, according to the clinic notes. Under "P" in the SOAP method, C. Lauria, RN, wrote "1 / 3370." (EX 3-3).

On March 1, 1995, Dr. White found that Claimant's joint remained inflamed and that he had some relative osteoporosis radiographically. Dr. White administered an injection of Lidocaine and Celestone and instructed Claimant to stay on restricted activity. Claimant was to return in one month for re-evaluation. (CX 1-29; EX 4-13).

According to an entry made in the shipyard clinic notes on March 1, 1995, Claimant had an appointment scheduled with Dr. White on April 3, 1995. The number "3370" is also listed. The signature is illegible. (EX 3-4).

Claimant was seen by Dr. White on April 12, 1995, at which point he was still symptomatic with his knee. Claimant had poor quadricep strength and was sent to physical therapy on a daily basis for the next month. Claimant was to return in six weeks. (CX 1-29; EX 4-13).

According to the shipyard clinic notes, Claimant saw Dr. White on April 13, 1995, and his next appointment with Dr. White was scheduled for May 31, 1995. Claimant brought to the shipyard clinic papers for a prescription for DCN-100 and physical therapy. Claimant's prescription was authorized, and his physical therapy was arranged to start on April 17, 1995. The signature on this entry is illegible. (EX 3-4).

Claimant's appointment with Dr. White for May 30, 1995, was rescheduled. (CX 1-28).

Claimant was examined by Dr. White on June 9, 1995, at which time he was still symptomatic. Claimant complained that his knee "goes out" and described a slipping sensation, which Dr. White wrote was consistent with meniscal dislocation. Claimant was diffusely tender with significant quad weakness and crepitation on range of motion. Dr. White's impression was "Residuals status post arthroscopic meniscectomy." Dr. White wrote that he would have Claimant "work vigorously on his rehab program" and that he would see Claimant again in six weeks. Claimant was kept on light duty status. (CX 1-28; EX 4-11).

The shipyard clinic notes indicate that Claimant had an appointment scheduled with Dr. White for July 21, 1995, for a follow up. Claimant brought with him a light duty note dated June 6, 1995. The entry also indicated "1 / 3370." The entry was signed by C. Lauria. (EX 3-4).

At his July 21, 1995, appointment with Dr. White, Claimant was still symptomatic and continued to have pain on the medial aspect, with his knee catching and popping. Claimant told Dr. White that he had not been doing his exercises on a regular basis because he was apprehensive to do so. Dr. White found crepitation upon examination, as well as a retropatellar pop. Claimant had medial joint line tenderness as well. (CX 1-28; EX 4-11). Claimant was encouraged to resume his exercises, and Dr. White gave him Daypro 1,200 mg. He was given samples for a week and a prescription for a month. Dr. White noted that if Claimant did not improve significantly in the following month, he would consider re-exploration through arthroscopy. Claimant was to return in one month for re-evaluation. (EX 4-12).

Dr. O'Neil performed a second MRI on Claimant's left knee on August 22, 1995, upon referral from Dr. White. Dr. O'Neil noted that since the initial MRI, Claimant had undergone a partial medial meniscectomy involving the body and posterior horn. Dr. O'Neil found residual irregularities in the undersurface of the meniscal remnant, which Dr. O'Neil opined were likely post-operative in nature. Dr. O'Neil found a minimal residual tear in the periphery of the posterior horn, as well as moderate thinning of the articular cartilage in the medial compartment. Dr. O'Neil opined that the latter could be "mildly accelerated relative to the previous scan." Dr. O'Neil found that the lateral meniscus and compartment were unremarkable; the cruciate and collateral ligaments and the extensor tendons were intact. Claimant's prepatellar edema and fluid in the gastrocnemius-semimembranosus bursa and gastrocnemius muscle were all resolved. (CX 4-2). Dr. O'Neil's impressions were: "substantial partial medial meniscectomy involving the body and posterior horn with post operative changes in the meniscal remnant. Suspect very small residual peripheral undersurface tear in the posterior horn;" and "interval resolution of prepatellar edema, gastrocnemius-semimembranosus bursa fluid, and fluid in/around the gastrocnemius muscle." (CX 4-2).

On August 28, 1995, Dr. White found that Claimant's symptoms were essentially unchanged. His exam showed medial joint line tenderness and pain on McMurray's maneuver. Dr. White opined that he needed to repeat Claimant's arthroscopy to attempt to determine the etiology of Claimant's symptoms and to determine if there was an additional tear in the meniscus. (CX 1-27; EX 4-10).

Claimant was seen by Dr. White on September 5, 1995. Dr. White noted that Claimant had a "meniscal abnormality in the remnant" and would "need to be taken back to surgery to do another scope on him." (CX 1-25; EX 4-9).

An entry in the shipyard clinic notes dated September 14, 1995, notes that Claimant was scheduled to have surgery on his left knee on September 15, 1995, "Office to fax note. P.P.O in computer." The signature on this entry is illegible. (EX 3-4).

On September 15, 1995, Dr. White performed surgery on Claimant's left knee after diagnosing a tear of the remaining posterior horn of the medial meniscus. In addition to the notes regarding the mechanics of the surgical procedure, Dr. White noted that he also found degenerative joint disease of the mediofemoral compartment. Claimant was returned to the recovery area in satisfactory condition. (CX 1-26).

Claimant was seen on September 25, 1995, ten days after his operation. Dr. White noted that his wound had healed well, that he had excellent motion, and that he was walking better. Dr. White also found "a residual tear present and a posterior horn along with some mild degenerative changes. The posterior horn tear was completely resected." Claimant was instructed to return in two weeks, and to return to physical therapy. (CX 1-25; Ex 4-9).

Claimant saw Dr. White again on October 10, 1995, at which time he was mildly to moderately symptomatic. Claimant continued to have trouble with deep knee bends and squats; climbing and descending stairs; and being on his feet for long periods of time. Dr. White recommended continued exercising, but did not send him back to work, as his job required walking long distances and climbing stairs. Dr. White wrote that he would leave Claimant out of work for an additional three weeks. (CX 1-25; EX 4-9).

Claimant was examined by Dr. White on October 26, 1995, at which time Claimant was "moderately symptomatic but slowly improving." Dr. White observed better function, but Claimant still complained of fatigue and aching with overuse. Claimant was returned to light duty status and instructed to return in one month for another clinical evaluation. (CX 1-24; EX 4-7).

Claimant returned to the shipyard clinic on October 30, 1995. The notes indicate, using the SOAP method, that Claimant "RTW after knee surgery per Dr. White." Claimant brought a note for "L.D. Rest" and "Note for P.T. F.U. on 11-27-95." Under "P," the notes indicate "3370 L.D. Rest P.T. to be Schld. P.B. to work in A [illegible]." The signature appears to be S.C. Barger. (EX 3-4).

A second entry in the shipyard clinic notes dated October 30, 1995, is also signed by S.C. Barger. The second entry states, "Pat. P.B. to work Per M. Lassiter (R.C.). Given 3370 & Inquired about where to go for work. He could not use stairs to get to ship. Telephoned M. Lassiter, Pat. Talked with him & was told Rest. Need to be clarified by Dr. White. Per M. Lassiter Pat. Will be P.O. until seen by Dr. White. Will RTC after appt. Pat. P.O. again per M. Lassiter." (EX 3-5).

By letter dated November 22, 1995, Patty McMahan, P.T., of Peninsula Physical Therapy & Associates, Inc., informed Dr. White that Claimant had been seen there between September 28, 1995, and November 22, 1995, for 29 treatments, for evaluation and treatment of his left knee meniscectomy. Claimant was discharged due to lack of progress from physical therapy. Ms. McMahan noted that the initial findings were as follows: (L) knee joint pain with WBing greater than 1 hour, knee, and descending ramps; Decreased function with WB activities; Decreased A/PROM (L) Knee; Weakness (L) LE; Swelling (L) knee; and Gait abnormalities. Claimant was treated with therapeutic exercise. At discharge, the following findings were made as to Claimant's condition: (L) knee lacks 25° active XT and -2° passive EXT and 105° active flexion; Ambulation of more than 2 blocks causes pain; Muscle strength for (L) quads and hamstrings 3+/5; Pt knows home exercise program well and has been instructed to continue his program. (EX 4-8).

When he saw Claimant on November 27, 1995, Dr. White noted that Claimant was slowly improving but had not made the gains that he expected him to make. Claimant had a "fairly weak VMO" but Dr. White sensed "that he is not effectively exercising in a consistent fashion." Dr. White wrote that the discomfort Claimant was experiencing caused a fair amount of pain as well. Dr. White kept Claimant on the same restrictions and told him to continue exercising on a regular basis. Claimant was told to return in six weeks for a follow up evaluation. (CX 1-24; EX 4-7).

Claimant returned to the shipyard clinic on November 28, 1995. The notes indicate that Claimant had a scheduled appointment with Dr. White and was to call for a follow up appointment on or for January 2, 1996. Claimant brought with him a light duty note dated November 27, 1995. Under "P" in the SOAP method, C. Lauria wrote "1 / 3370 seq 006. No work per dept. RTC 12-12-95 @ 0700." (EX 3-5).

On December 12, 1995, Claimant returned to the clinic to see if any work was available. The notes state "Form 3370 updated. No work avail. Per B. Meekins. P.O. record updated. RTC 1/3/96 after appt. Dr. White." The signature on this entry is illegible. (EX 3-5).

Claimant was seen by Dr. White on January 3, 1996, still symptomatic in his knee. Claimant stated he was uncomfortable when trying to fully extend his knee, and had pain on weightbearing. Claimant's physical examination showed "slight flexion contracture which he can pull out by maximum contraction of his quad." He also had pain on manipulation with range of motion. Claimant's weightbearing X-rays of his left knee showed some slight loss of medial joint space, approximately one millimeter, as compared to the opposite knee. Dr. White's impression was "Status post partial medial meniscectomy with early DJD." Claimant was instructed to continue with his quad and hamstring strengthening exercises, to take Ibuprofen for discomfort, and to return to Dr. White's office in one month. Dr. White returned Claimant to light duty work. (CX 1-23, 1-24; EX 4-6, 4-7).

An entry in the shipyard clinic notes on January 4, 1996, stated that Claimant had an appointment with Dr. White on January 8, 1996, and a follow up appointment on February 5, 1996. Claimant brought with him a note "to cont. L.D. rest." Claimant was "currently OOW No

Work avail. Per dept." Claimant's 3370 form was updated. The entry is signed by S.C. Barger. (EX 3-5).

On February 13, 1996, Claimant's symptoms were unchanged when he saw Dr. White. He continued to experience pain in the medial aspect of his knee and could not fully extend it. Claimant had crepitation when he put his knee through a full range of motion. Dr. White administered an injection of Lidocaine and Celestone. He also noted that Claimant continued to have significant quad weakness, which Claimant was instructed to work on. Dr. White kept Claimant's restrictions in place and was told to return in six weeks for another evaluation. (CX 1-23; EX 4-6).

When Claimant was examined by Dr. White on April 2, 1996, his symptoms were unchanged, as he continued to complain of medial knee pain. He was tender upon palpation of the medial aspect of the joint and had pain on McMurray's maneuver. Claimant could extend his leg slightly better and could do a leg raise. Claimant was placed on Daypro and was instructed to return in six weeks. (CX 1-23; EX 4-6).

Dr. White saw Claimant on May 13, 1996, at which time Claimant was still moderately symptomatic with his knee. This was aggravated by activities such as squatting, crawling, and kneeling. Claimant related to Dr. White that his building was evacuated today and walking down the steps from the eighth floor increased the aggravation. Claimant had no effusion, and his weightbearing X-rays were unchanged. However, Dr. White did note medial joint space narrowing when compared to the opposite normal knee. Dr. White's impression was "DJD following meniscal tear." Dr. White continued Claimant's restrictions, and stated that he would do a final impairment rating upon Claimant's next visit in three months. (CX 1-22; EX 4-3).

Claimant was seen by Dr. White on August 14, 1996, for a final evaluation. He remained symptomatic in his knee, and had a limited range of motion from 5 to 110 degrees. Dr. White found Claimant's joint space was narrowing upon examining the weightbearing X-ray. Dr. White noted that he would use the AMA Guide to do a final impairment rating, and noted that he had given Claimant permanent restrictions. (CX 1-22; EX 4-3).

A "Physical Abilities Form" was completed on August 14, 1996. The signature appears to be that of Dr. White. The form notes that the restrictions listed therein are permanent, and are as follows: Occasional lifting between 11 and 25 pounds; Occasional carrying of 11 to 24 pounds at a distance of no more than 100 feet; Continuous pushing or pulling (seating); Occasional pushing or pulling (standing); Occasional bending; No squatting, kneeling, crawling, or climbing; Continuous ability to reach above shoulder level; and occasional alternation of sitting and standing. The form notes that there are no restrictions on the use of Claimant's hands. Claimant was permitted to "frequently" use his right foot for movement to operate foot controls. Claimant was not permitted to operate a truck, crane, tractor, or other vehicle, nor was he allowed to be around moving machinery. Claimant was permitted to be exposed to dust, fumes, and gases. (EX 4-4, 4-5).

Claimant returned to the shipyard clinic on August 15, 1996, after a scheduled appointment with Dr. White. The notes as to a follow up appointment are illegible. The entry

indicates "8-14-96 perm restrictions" and "1 / 3370 - seq. 012. States when hurt L knee in 1994, also hurt R knee and told by P.A. not to use it." This entry is signed by C. Lauria, R.N. (EX 3-5).

By letter dated January 9, 1997, Dr. White informed Mr. Scott Caldwell at Newport News Shipbuilding that Claimant had reached maximum medical improvement and was impaired under the AMA Guide to Evaluation of Permanent Impairment. Dr. White found the following:

> [The Guide] shows impairment based on limited range of motion of 6% of the whole person and 14% of the lower extremity. Additionally, he has loss of medial joint space of 2 mm, giving him 8% of the whole person and 20% of the lower extremity. Using the combined values chart, it is 14% of the whole person and 31% of the left lower extremity. The above measurements are permanent. The MMI has been reached.

Dr. White indicated that Claimant would remain under his care for his ongoing symptoms with his knee. Dr. White anticipated deterioration in the future that might require surgery and perhaps would result in some increase in impairment. (CX 1-21; EX 4-2).

On January 31, 1997, an appointment was made for Claimant to see Dr. Baddar for evaluation. Claimant was notified of this appointment and told to take any MRI's and X-rays with him. This entry is initialed BMC. (EX 3-6).

On February 3, 1997, Claimant's records were copied and mailed by registered mail. The recipient of these copies is not noted, and the entry is initialed by BMC. (EX 3-6).

Claimant returned to see Dr. White on March 9, 1998, to have his left knee reevaluated. Claimant related that he was experiencing some difficulty with his left knee with increased activity, and that he had been required to climb some stairs. Claimant stated that his right knee, which he was using as a "climbing leg," had now begun to buckle and give way. Dr. White found flexion contracture of his left knee. Claimant had pain upon full extension and quadricep weakness on the left side. Claimant's right knee showed mild retropatellar crepitation, and Claimant also had painful patellofemoral compression. Weightbearing X-rays showed that Claimant's left knee had some mild medial joint space narrowing of approximately 1 to 1 1/2 millimeters, while the right knee was unremarkable. Dr. White's impression was "DJD, left knee, status post industrial injury" and "Chondromalacia patellae, right knee, status post industrial injury." Dr. White opined that Claimant should not climb stairs even on a limited basis because this could pose a risk of potential reinjury, and that he should use an elevator. Claimant did relate to Dr. White that this could pose a problem from an administrative viewpoint because the elevator was accessible by using an emergency exit. (CX 1-19; EX 4-1).

By letter dated March 11, 1998, Dr. White wrote to Kelly Edwards, Case Manager for Workers' Compensation, that he was enclosing a copy of Claimant's medical records. Dr. White wrote that Claimant was not likely to have any significant improvement over time and that the

restrictions were permanent. Dr. White expected Claimant's condition could deteriorate to the point that he would need surgery in the future. (CX 1-20).

Claimant returned to the shipyard clinic on March 12, 1998, and brought permanent restrictions from Dr. White. Claimant stated that this was a re-evaluation, and there had been no new injury or aggravation. Claimant's Form 3370 was updated. The entry also notes "RTW." The signature is illegible. (EX 3-6).

An entry in the shipyard clinic notes dated September 14, 1998, reads as follows: "No show for Asbestos – [illegible] schedule [illegible] 9/9/94." The initials on this entry appear to read PCK. (EX 3-6).

On October 23, 1998, Dr. White noted that Claimant was still symptomatic in both knees. The left knee was unchanged, but he was shifting his weight to his left side, where he was having problems in the retropateller and infrapatellar areas. Upon examination, Claimant was found to have "flexion contracture of the left knee with diffuse tenderness." Claimant's right knee showed infrapatellar tenderness and little joint line tenderness. He also had "some crepitus on range of motion and some mild discomfort on patellofemoral compression." Claimant's X-rays were unremarkable as to the right knee. The weightbearing X-rays revealed "some slight approximately 1 mm or more of medial joint space narrowing on the left knee as compared to the right." (CX 1-18, 1-19).

An entry in the shipyard clinic notes dated April 12, 1999, discusses Claimant's permanent partial disability rating. The first portion states, "Compromised an additional 8% PPD to the LLE. For a total of 30% PPD to the LLE." The second portion reads, "Additional 8% P.P.D. rating per order dated 4/8/99. To be paid in a lump sum per MLM (PES). Total of 30% to (LLE)." This entry is initialed, "MLM-T." (EX 3-7).

Claimant came in to Dr. White's office on June 24, 1999, complaining of gradual increased discomfort in his knee. Claimant had been working in an administrative job, but related that that job required him walk around a fair amount. Claimant also told Dr. White that he had a lot of pain when he initially got up and began to walk, but that the pain improved somewhat as he continued moving. At the end of the day, Claimant stated that he experienced great discomfort and that the pain worsened when he began working longer periods of time, which occurred due to a strike at the shipyard. On examination, Dr. White found that Claimant had "slight flexion contracture on the left knee." Dr. White found no effusion, but did find some diffuse gonarthritic change and diffuse thickness of the synovial area as well as medial joint line tenderness. McMurray's maneuver was uncomfortable, Dr. White wrote. Dr. White found no significant change upon review of the weightbearing X-rays. The doctor's impression was "residual from previous industrial injury with permanent impairment." Claimant was kept on permanent restrictions. Dr. White opined that Claimant also needed to be limited to a forty-hour work week. Claimant was prescribed Daypro and was told to follow up on an annual basis. (CX 1-18).

Claimant returned to the shipyard clinic on June 25, 1999, stated that he saw Dr. White on June 24, 1999, and brought in permanent restrictions. The note states "M. Massenburg-

Tucker called & made aware & said to proceed [illegible]." The Form 3370 was signed, and Claimant stated that there was work available for him. Claimant was given two copies of the form and returned to work. The signature on this entry is illegible. (EX 3-6).

Dr. Scott A. Kellermeyer of HealthSouth Diagnostic Center performed an MRI on Claimant's right knee on November 12, 1999, upon referral from Dr. David N. Tornberg. Dr. Kellermeyer found a small suprapatellar joint effusion, as well as edema in the subcutaneous tissues overlying the patella inferiorly. Dr. Kellermeyer did not observe any posterior fluid collection. Claimant's extensor mechanism was intact. Dr. Kellermeyer found a small enthesophyte involving the insertion of the quadriceps tendon. Claimant's anterior and posterior cruciate ligaments were intact, and his medial and lateral collateral ligaments were unremarkable in appearance. Dr. Kellermeyer noted that the posterior horn of the medial meniscus was mildly atrophic, particularly along the inferior peripheral aspect. Dr. Kellermeyer also noted "a band of increased T1 and T2 weighted signal running through the body and posterior horn of the medial meniscus. This horizontal band is best appreciated on the coronal sequences." He observed mild increased signal in the posterior horn of the lateral meniscus, but did not see any intra-articular extension in the lateral joint compartment. Finally, Dr. Kellermeyer wrote that Claimant had a "mild increased signal seen within the apex of the fibular head compatible with degenerative change." (CX 5-1). Dr. Kellermeyer's impressions were as follows: "Small horizontal full thickness tear of the posterior horn of the medial meniscus is seen. There is atrophic change seen in this region as described" and "Mild myxoid degenerative change seen involving the posterior horn of the lateral meniscus." (CX 5-1).

Claimant was seen on December 9, 1999, for continuing pain of his right knee. He was tender over the medial joint line and had pain on a "McMurray's maneuver without a click." Dr. White reviewed an MR study on Claimant and found a tear in the medial meniscus with some increased signal in the lateral meniscus without evidence of a frank tear. Dr. White found mild degenerative changes present. Dr. White's impression was tear of the medial meniscus, right knee, and mild osteoarthritis with degenerative changes, right knee. Dr. White scheduled Claimant for an arthroscopy and partial medial meniscectomy as an outpatient. (CX 1-17).

Dr. White performed an arthroscopy, partial medial meniscectomy, and debridement of the lateral meniscus upon Claimant on December 27, 1999, after finding a tear of the right medial meniscus. In addition to the notes regarding the mechanics of the surgical procedure, Dr. White noted that "The lateral compartment was inspected and found to have some minor inner rim fraying which was debrided. The ACL showed laxity, although fibers were intact." Dr. White wrote that Claimant was returned to the recovery area in satisfactory condition. (CX 1-16).

Claimant was seen on January 17, 2000, by Dr. White, approximately three weeks after his arthroscopic meniscectomy. Claimant related to Dr. White that he had been getting along well but had some discomfort over the weekend. Upon examination, Dr. White found "no significant effusion. Motion from zero to 100 degrees. Good distal circulation." Dr. White's impression was "resolving symptoms right knee, status post arthroscopic meniscectomy." Dr. White instructed Claimant to continue with his therapy and limited activity. Dr. White felt that Claimant could return to light duty status, with a limitation of walking no more than 200 yards to

his place of employment. Claimant was to return in three weeks for another evaluation. (CX 1-15).

A form from Tidewater Physical Therapy, Inc., contains several entries. The first entry is dated January 21, 2000, and notes that this is Claimant's seventh visit to Tidewater Physical Therapy. The corresponding section notes the following: "O: TE 4 CP Rx; A: Able to tolerate [upwards arrow] IL weight; P: will perform progress per tolerance." The signature is illegible. (CX 7-1).

The second entry on the form from Tidewater Physical Therapy notes this is Claimant's eighth visit and is dated January 24, 2000. The following notes are contained in the corresponding section: "O: TE x 5 CP Rx Added new [illegible]; A: Improving; P: con't to progress." Again, the signature is illegible. (CX 7-1).

The third entry on the Tidewater Physical Therapy form noted that Claimant's ninth visit occurred on January 26, 2000. The following is noted: "O TE x 5 Cp; A: doing well in program; P: Take ROM next visit." The signature is illegible. (CX 7-1).

According to the form from Tidewater Physical Therapy, Claimant's tenth visit there occurred on January 27, 2000. The form notes: "O: TE x 6 Cp Rx; A: working hard; P: con't strength program per plan." The signature is illegible. (CX 7-1).

Claimant's eleventh visit to Tidewater Physical Therapy occurred on January 31, 2000. The notes read as follows: "O: TE x 6; A: Doing great – need to get objective biodex strength test; P: Do biodex test next visit. Girth SP 43; IP 38 1/2. 0 edema." The signature is illegible. (CX 7-1).

Claimant was seen by Dr. White on February 8, 2000, approximately six weeks after his operation and after Claimant had completed his physical therapy. Claimant had full range of motion and minimal tenderness. Dr. White noted that Claimant had "some quad atrophy, which needs to be worked on." Dr. White instructed Claimant to continue exercises on his own and sent Claimant back to his limited duty job. Claimant was to return in one month for a final evaluation. (CX 1-14).

When Claimant was seen by Dr. White on March 9, 2000, he told the doctor that he was having moderate problems with his knee. This was approximately three months after his operation. Claimant was not back at work because his employer did not bring him in for limited duty. Claimant had "some mild retropatellar crepitation and some medial joint line tenderness." Claimant had no instability. The weightbearing X-rays taken that day showed "significant loss of medial joint space on the right with a space of about 2 mm medially compared to the right, where it is 4 mm." Dr. White's impression was "Post-op arthroscopic meniscectomy with secondary degenerative changes." Dr. White opined that Claimant was "rateable at this point because these are going to be diagnosis based and radiographic based, as opposed to functional impairment ratings." Dr. White planned to apply ratings in the near future and gave Claimant a permanent limited duty status slip. (CX 1-14).

Claimant saw Dr. White on September 19, 2000, complaining of increasing difficulty with pain in both of his knees, and the pain in the right knee greater than the left. Dr. White found crepitation on range of motion and tenderness upon examining Claimant's right knee. Claimant's left knee was unchanged and showed some crepitation and tenderness. Dr. White noted that he was sending Claimant back to the shipyard to get weightbearing X-rays for both of his knees. Dr. White wrote that he would review the impairment rating on Claimant's left knee and assign an impairment rating to the right knee based on his arthroscopy with meniscectomy and probable degenerative disease. (CX 1-13).

On October 2, 2000, Dr. White determined that Claimant had reached maximum medical improvement. According to Dr. White, Claimant had continued right knee pain and "limited activity with a tendency toward buckling and giving away." Dr. White wrote that he used the AMA Guides to the Evaluation of Permanent Impairment, Fourth Edition, to find that Claimant qualified under a diagnosis for partial medial and lateral meniscectomy and ACL laxity. Dr. White also noted that "weight bearing radiographs of the knees show loss of joint space of 2 millimeters. Dr. White found the following with regard to Claimant's impairment:

> Medial and lateral meniscectomy constitutes a 4% whole person and 10% knee impairment. ACL laxity which is mild is 3% whole person, 7% of the knee, and arthritis based impairment with 2 mm of joint space loss is 8% whole person and 20% knee. Using the combined values chart, this constitutes a summing of the values 4 and 3 for a combined value of 7 and 7 and 8 for a combined value of 14 for the whole person and summing the values of 10 and 7 for a combined value of 16 with 20 using the combined values table for a total of 33%.
>
> Therefore, the final permanent impairment rating is 14% of the whole person and 33% of the right knee.

(CX 1-12; CX 3-47; EX 13).

By letter dated November 3, 2000, Dr. James V. Luck, orthopedic surgeon, responded to Employer's counsel's inquiry as to the use of Table 62 in the AMA Guides.[4] According to Dr. Luck's letter, counsel inquired as to patients with multiple degenerative changes involving more than one compartment in the knee. Dr. Luck wrote that "It was our intention that these patients be rated based on the most severely involved compartment that would give the highest rating." Dr. Luck went on to say that "Patients with meniscal pathology who have had partial or total meniscectomies as well as narrowing of the joint space of the knee would be rated for one or the other, but not both . . . whichever gave the higher rating, which would most probably be the medial compartment narrowing." (CX 3-49; EX 10-1).

Dr. Luck explained that the rationale for this method "relates to the fact that patients' symptoms and need for medical and surgical intervention relate to the narrowest compartment, principally medial or lateral, and are not worsened by having another compartment narrowed as well." Dr. Luck further stated that "Most patients with osteoarthritis have narrowing of their

[4] Dr. Luck's letter is accompanied by eight photocopied pages from the AMA Guides to the Evaluation of Permanent Impairment, Fourth Edition. (EX 10-3 through 10-10).

medial compartment, and the knee is then thrown into varus alignment, or a bowed configuration, which actually opens the lateral compartment. Nonetheless, their medial compartment symptoms are severe enough to warrant medical management in the early stages and surgical management, specifically total knee replacement, in the advanced stages." Dr. Luck concluded by stating that "in patients who have a more symmetrical loss of joint space, the symptoms are not any more severe, nor is the need for medical and ultimately surgical management accelerated." (CX 3-49, 3-50; EX 10-1, 10-2).

By letter dated May 7, 2001, Dr. David N. Tornberg, Medical Director for Employer, notified Employer's counsel that he had reviewed the impairment rating of 33% that Dr. White had assigned to Claimant for his right knee injury. Dr. Tornberg stated that he "strongly disagree[d] with the methodology used by Dr. White to establish this level of impairment." Citing the AMA Guides, Dr. Tornberg noted that "'In general, only one evaluation method shall be used to evaluate a specific impairment.'" Dr. Tornberg wrote that, "In this case, there is one impairment of the lower extremity; that of post traumatic degenerative arthritis of the right knee. It is appropriate, therefore, to evaluate this impairment in its global context and not by securing impairments for each individual finding." (EX 9-1).

Dr. Tornberg assigned a level of 10% permanent impairment to Claimant's right lower extremity, based on post traumatic degenerative arthritis of the right knee. (EX 9-2). Dr. Tornberg arrived at this rating by evaluating Claimant's X-rays, which, according to Dr. Tornberg showed that 3 mm of residual joint space remained in the degenerative knee. Dr. Tornberg compared this to Dr. White's findings, who found that 2 mm of joint space was lost. Dr. Tornberg asserts that the standard is not the amount of joint space that is lost, but rather, the amount of joint space that remains. Using Table 62 in the AMA Guides, Dr. Tornberg found that 7% impairment existed in the right knee based upon the remaining 3 mm of joint space. Alternatively, Dr. Tornberg noted that Table 64 could also be used to arrive at an impairment rating, but examining the impairment due to arthritis associated with partial loss of the medial and lateral, which would result in 10% impairment. According to Dr. Tornberg, "The assignment of disability for anterior cruciate laxity is not considered because the rating for this condition is significantly less than that associated with either of the other two options for rating the degenerative arthritis in the knee." (EX 9-1).

Dr. White examined Claimant on December 4, 2001, at which time he found that Claimant was "significantly symptomatic with both of his knees, now his right greater than his left." Claimant stated that he had no aggravating incident but that he was progressively more uncomfortable and had difficulty walking. Dr. White found that the right knee was slightly warm and had crepitation. Claimant had difficulty extending his leg and had discomfort on medial and lateral stress. Claimant's left knee also showed crepitation but was not quite as inflamed. Claimant's X-rays showed no change from the films taken in May except for slight medial joint space loss in the left knee. Dr. White placed Claimant on Naproxen and planned to see Claimant in six months. (CX 1-11; CX 3-48; EX 14).

Claimant was seen by Dr. White on July 2, 2002, complaining of pain in both knees. Claimant had tenderness to palpation and crepitation on range of motion. Claimant was X-rayed, and Dr. White found medial compartment disease with narrowing at about 2 1/2 millimeters in

width of the joint in the weight bearing view. Dr. White opined that Claimant was a candidate for unicondylar total knee replacement. (CX 1-10).

Claimant was examined by Dr. White on September 17, 2002, in anticipation of his unicondylar knee replacement surgery on September 19, 2002. Dr. White noted that Claimant had two previous knee arthroscopies, and a history of problems with his neck and back, hypertension and hypercholesterolemia. Dr. White found that Claimant was generally healthy and his physical exam was unremarkable except for tenderness over the medial aspect of his right lower extremity. Claimant had a +1 posterior tibial and dorsalis pedis pulse. Dr. White's impression was that Claimant had osteoarthritis in his right knee, hypertension, hypercholesterolemia, and maturity onset diabetes type 2, diet controlled. (CX 1-9).

On September 19, 2002, Dr. White performed left unicondylar knee replacement on Claimant after finding a loss of medial joint space in the left knee and Claimant's complaints of progressively increasing pain. The surgery was performed at Sentara Hampton General Hospital. In addition to the notes regarding the mechanics of the surgical procedure, Dr. White noted that "Range of motion was excellent with no apparent impingement of the patella on the implant. The patella had only mild chondromalacic changes and the lateral side of the joint was completely unremarkable." Dr. White also noted that Claimant tolerated the procedure well. (CX 1-5 through 1-7).

On September 27, 2002, approximately one week after his total knee replacement, Claimant was seen by Dr. White. Dr. White opined that Claimant was "getting along quite nicely" and that he was weightbearing almost completely. Claimant complained of some calf pain and had some tenderness. Dr. White told Claimant to stay off of his leg and keep it elevated for the following few days. He also told Claimant to continue exercising, and that he would see him again the following Monday. (CX 1-4).

Claimant was seen by Dr. White on October 4, 2002, approximately two weeks after his unicondylar knee replacement on his left knee. The range of motion for his knee was from 5 degrees to 95-100 degrees. While Dr. White noted that Claimant was not walking normally, he was able to walk with little discomfort. Dr. White opined that Claimant needed to continue to work on his range of motion and strengthening and was to return to Dr. White's office two weeks later. Dr. White sent Claimant to physical therapy and he was continued on his DVT prophylaxis. Claimant was given a prescription for Vicodin ES. (CX 1-3).

Claimant was examined by Dr. White on October 22, 2002, approximately four weeks after his operation for his unicondylar knee replacement. Claimant complained of right knee pain and demonstrated a significant right antalgic limp. Upon examination, Dr. White found that Claimant had a range of motion from 0 to 90 degrees, with "fairly good" muscle strength. Claimant had also been attending physical therapy. Dr. White wrote that he was "hard pressed to explain why he continues to be significantly painful with his ambulatory status, particularly in light of the fact that he has no effusion and excellent motion with good quad strength." Claimant was to return in two weeks. Dr. White also wrote "I am going to stop his Coumadin." (CX 1-2).

Dr. White examined Claimant on November 19, 2002, which was approximately eight weeks after his operation. Dr. White noted that Claimant was having a moderate amount of difficulty, had a +2 effusion, and that his knee was slightly warm. Claimant experienced some discomfort with "the extremes of motion." Dr. White aspirated Claimant and sent the fluid for a culture. Claimant was prescribed Darvocet for pain and was also instructed to use Naproxen. (CX 1-1, 1-2).

Claimant was seen by Dr. White, on December 5, 2002. Dr. White's notes state that Claimant "got relief following the aspiration of the knee but he still has a significant antalgic limp. He has trace to +1 effusion. His knee repeat aspiration is done which is blood tinged, probably bloody tapped straw colored fluid." Dr. White injected Claimant with Lidocaine and Celestone. Claimant was to return six weeks later. (CX 1-1).

By letter dated November 19, 2003, Dr. Luck replied to Employer's counsel's request to review the X-rays and medical records of Claimant, noting that the most recent X-rays were taken on June 30, 2003. Dr. Luck noted that Claimant's "arthritic degeneration of his right knee has progressed since the previous films that were reviewed by Drs. White and Tornberg. His medial compartment on the standing AP x-ray now measures 2 mm instead of 3 mm. This is normal arthritic progression, as would be expected over time." Dr. Luck also observed "a unicompartmental replacement of the medial compartment of the left knee that would warrant a rating as well, if it is industrial in origin." Dr. Luck opined that Claimant's rating should be based upon "arthritic degeneration of the medial compartment of his right knee. At a 2-mm measured joint space, he would receive a 20% lower extremity or 8% whole person impairment." Dr. Luck disagreed with Dr. White as to the suggestion that mild anterior cruciate laxity and meniscus removal would add to Claimant's impairment. Dr. Luck concluded by stating that "Most of the patients who have degeneration of the medial compartment at this level have some degree of meniscal degeneration as part of this process, and the arthritic degeneration rating is based on all of those components." (EX 15).

Arguments

During the hearing, counsel for Claimant stated that he had no evidence to offer as to coverage of the 2001 injury under the Act, as he did not believe that that injury would meet the situs requirement, and that nevertheless, the disability rating was assigned prior to the 2001 injury. (TR. at 28). Therefore, I found at the hearing that no coverage existed as to that injury based upon the evidence presented at the hearing. (TR. at 29). As a result, the parties were instructed that only the November 18, 1994, injury would be addressed in this decision and order and that the 1994 injury was the only one that needed to be dealt with in the post-hearing briefs.

Claimant's Argument

In his post-hearing brief, Claimant argues that he suffered a specific injury to his left knee in 1994 and later developed problems with his right knee. Claimant asserts that any problems with his right knee are a direct and compensable consequence of the condition of his left knee, and therefore, he is entitled to benefits from that injury. (Claimant's Brief, at 5). To support his position, Claimant cites the fact that he immediately noticed problems with his right knee

following the 1994 injury, and that he reported these problems to his treating physician. After performing surgery on his left knee, Claimant's treating physician, Dr. White, performed the same surgery on the right knee. Claimant also cites the medical evidence and testimony of Dr. White, who opined that Claimant's right knee problems were a compensable consequence of the left knee injury. (Claimant's Brief, at 6).

Claimant asserts that it is proper to make a claim that his injury is a compensable consequence of another injury and simultaneously receive permanent partial disability benefits. Citing *Bass v. Broadway Maintenance & Lumbermen's Mutual Casualty Co.*, 28 BRBS 11 (1994), Claimant argues that the Benefits Review Board held in that case that "where harm to a part of the body not covered results in harm to a scheduled injury body part, the claimant is not limited to one award for the combined effects of his condition, but may receive a separate award for the consequential injury." (Claimant's Brief, at 6). Claimant asserts that the same analysis applies in the instant matter because he has a scheduled injury and that as a result of that injury, he suffered an injury to another scheduled body part, for which he seeks benefits. (Claimant's Brief, at 7).

As to the extent of his disability, Claimant asserts that he was assigned a disability rating on his right knee by Dr. White on October 2, 2000, following arthroscopic surgery on that knee, as Dr. White opined that Claimant reached maximum medical improvement on that date. (Claimant's Brief, at 4, 7). Claimant argues that Dr. White found that Claimant qualified for an impairment rating based upon partial medial and lateral meniscectomy, and that the appropriate impairment ratings was 14% of the whole person and 33% of the right knee. Claimant contends that Dr. White's opinion is entitled to great weight because he is Claimant's long-term treating physician. (Claimant's Brief, at 7).

To this extent, Claimant reasons that the opinion of Dr. Tornberg should be rejected because at the time of the evaluation, Dr. Tornberg was a full-time employee of Employer. Further, Claimant states that Dr. Tornberg's one-time evaluation was at the direction of Employer. (Claimant's Brief, at 7-8). Claimant also argues that Dr. Luck's opinion should be rejected as well because Dr. Luck never physically examined Claimant and is unfamiliar with Claimant's conditions. Even if the court would find Dr. Luck's opinion to be credible, Claimant maintains that the court could average the two physician's ratings. According to Claimant, Dr. Luck assigned a 20% disability rating, and if averaged with that assigned by Dr. White, Claimant would be entitled to a 26% permanent disability rating. (Claimant's Brief, at 8).

Employer's Argument

Employer asserts that Claimant did not give credible testimony at trial, as Claimant refused to acknowledge that his November 18, 1994, injury did not involve an injury to his left knee. Employer argues that "it is questionable whether the osteoarthritic changes of the Claimant's right knee are the result of the sedentary activity to which he was assigned at work following his 1994 injury as opposed to the natural effects of every day activity, including walking and climbing outside of the workplace." (Employer's Brief, at 10-11). However, Employer goes on to state, "The presumption of causation, however, cannot be rebutted and thus, causation at least in part is not contested." (Employer's Brief, at 11).

Instead, Employer posits that when an injury under Section 8(c) of the Act occurs, "'the situs of the injury controls the right to compensation under the Schedule, rather than the nature of the disability.'" (Employer's Brief, at 11 (citing *Vasko v. Newport News Shipbuilding & Dry Dock Co.*, BRB No. 99-0955, at *3 (June 2, 2000)). Employer submits that Claimant's *temporary* total loss of wage earning capacity was compensable and voluntarily paid under Section 8(a) of the Act, and that Claimant was also entitled to medical benefits for the consequential impairment of his right leg, which Employer has also paid; however, there is no basis to extend further benefits to Claimant under the schedule beyond that paid for the situs of the injury, which is Claimant's left leg in this case. (Employer's Brief, at 11-12).

Employer asserts that the AMA Guides to Evaluation of Permanent Impairment should be used as the basis to determine Claimant's permanent impairment, as this was the basis for the opinions given by the three physicians in this case and no other methodology has been suggested. However, according to Employer, Dr. White's testimony suggests that he did not follow the AMA Guide as he claims. (Employer's Brief, at 12). In addition, Employer argues that Dr. White's opinion should not be credited because Dr. White stated that it is irrelevant whether a physician evaluating the case is a treating or examining physician with regard to the AMA Guides. (Employer's Brief, at 12). Dr. White also stated that, although he added a rating for cruciate ligament laxity, the AMA Guides do not permit such a rating since it is included in an arthritis-based rating. (Employer's Brief, at 12-13).

Instead, Employer argues that the ratings of Drs. Tornberg and Luck are entitled to greater weight when their credentials are compared with those of Dr. White. According to Employer, Dr. Luck is the Editorial Chair of the applicable AMA Guides chapter and "is in the best position to interpret their correct application." Further, Employer states that Dr. Tornberg is a Board-certified orthopedist as well as a Board-certified Medical Examiner and a Board-certified Independent Medical Examiner, which surpasses Dr. White's only Board certification, which is in orthopedics. Therefore, Employer argues that the proper impairment rating, if one is assessed would be those determined by Dr. Tornberg for the period between October 2, 2000, and November 19, 2003, and the rating assigned by Dr. Luck for the time thereafter. (Employer's Brief, at 13).

Analysis

The parties do not dispute that Claimant suffered an injury on November 18, 1994, nor do they dispute that Claimant's employment is subject to coverage under the Longshore & Harbor Workers' Compensation Act. However, Employer argues that it is the situs of Claimant's injury as opposed to the nature of the disability that controls the right to compensation under the schedule. Employer argues that the injury was to Claimant's left leg, and while Claimant is entitled to benefits for the impairment to his right leg as well, Claimant has already been paid compensation under Section 8(a) of the Act, and therefore, Claimant is not entitled to further compensation beyond that paid for the situs of the injury (Claimant's left leg). Thus, the dispute is whether Claimant is entitled to additional compensation in the form of permanent partial disability for the impairment to his right leg.

Section 20(a) Presumption

Section 20(a) of the Act provides a claimant with a presumption that his condition is causally related to his employment if he shows that he suffered a harm and that employment conditions existed or a work accident occurred which could have caused, aggravated, or accelerated the condition. *See U.S. Indus./Fed. Sheet Metal, Inc. v. Director, OWCP*, 455 U.S. 608, 614-15 (1982); *Merrill v. Todd Pac. Shipyards Corp.*, 25 BRBS 140, 144 (1991); *Gencarelle v. General Dynamics Corp.*, 22 BRBS 170, 174 (1989), *aff'd*, 892 F.2d 173 (2d Cir. 1989). Claimant's credible subjective complaints of symptoms and pain can be sufficient to establish the elements of physical harm. *Sylvester v. Bethlehem Steel Corp.*, 14 BRBS 234, 236 (1981), *aff'd sub nom. Sylvester v. Director, OWCP*, 681 F.2d 359 (5th Cir. 1982). However, as the Supreme Court has noted, "[t]he mere existence of a physical impairment is plainly insufficient to shift the burden of proof to the employer." *U.S. Indus.*, 455 U.S. at 615. Once the claimant has invoked the presumption, the burden of proof shifts to the employer to rebut it with substantial countervailing evidence. *Merrill*, 25 BRBS at 144. If the presumption is rebutted, the administrative law judge must weigh all the evidence and render a decision supported by substantial evidence. *See Del Vecchio v. Bowers*, 296 U.S. 280, 286 (1935).

Claimant testified that he was injured on November 18, 1994, when he slipped and fell as he tried to get under a piece of electrical equipment. He stated that he fell onto both of his knees and had to wait a few minutes to pull himself up. (TR. at 15-16). Claimant was seen by Dr. White on December 5, 1994, and has treated with Dr. White for this injury since that time. (TR. at 16). Claimant's medical records show that he was also seen at the shipyard clinic on November 23, 1994, for the injury that occurred on November 18, 1994. (EX 3-2). The evidence also shows that both a "Report of Occupational Injury" as well as an "Insurer's First Report of Injury" were completed following the accident. (EX 1; EX 2).

To invoke the presumption, all that Claimant must show is that he suffered a harm and that employment conditions existed or a work accident occurred that could have caused, aggravated, or accelerated the condition. The parties have stipulated that Claimant's employment is subject to coverage under the Longshore & Harbor Workers' Compensation Act. It is undisputed that Claimant sustained an injury on November 18, 1994, and that Claimant suffered a harm as a result. Claimant has alleged that this injury arose out of and in the course of employment; therefore, it is proper to invoke the Section 20(a) presumption. *U.S. Indus.*, 455 U.S. at 615 (finding that a prima facie claim for compensation must allege that the injury arose out of and in the course of employment).

Upon consideration of the evidence as well as the stipulations entered by the parties, I find that Claimant has established a prima facie case for compensation and is entitled to the presumption of Section 20(a) that his right leg problems are casually related to the injury he sustained on November 18, 1994. The burden of proof then shifts to Employer to rebut the presumption with substantial countervailing evidence.

Rebuttal of Section 20(a) Presumption

Since the presumption has been invoked, the burden now shifts to the employer to rebut the presumption with substantial countervailing evidence that establishes that the claimant's employment did not cause, aggravate, or accelerate his condition. *Swinton v. J. Frank Kelly, Inc.*, 554 F.2d 1075, 1082 (D.C. Cir. 1976); *Peterson v. General Dynamics Corp*., 25 BRBS 71, 78 (1991); *James v. Pate Stevedoring Co.*, 22 BRBS 271, 273 (1989). Substantial evidence is relevant evidence such that a reasonable mind might accept it as adequate to support a conclusion. *Richardson v. Perales*, 402 U.S. 389, 401 (1971); *Universal Camera Corp. v. Nat'l Labor Relations Bd.*, 340 U.S. 474, 477 (1951); *Consol. Edison Co. v. Labor Bd.*, 305 U.S. 197, 229 (1938).

The employer must produce facts, not speculation, to overcome the presumption of compensability. Reliance on mere hypothetical probabilities in rejecting a claim is contrary to the presumption created by Section 20(a). *Dearing v. Director, OWCP*, 998 F.2d 1008, at *2 (4th Cir. 1993) (unpublished) (per curiam); *Steele v. Adler*, 269 F. Supp. 376, 379 (D.D.C. 1967); *Smith v. Sealand Terminal, Inc.*, 14 BRBS 844, 846 (1982). Rather, the presumption must be rebutted with specific and comprehensive medical evidence proving the absence of, or severing, the connection between the harm and the employment. *See Am. Grain Trimmers, Inc. v. Director, OWCP*, 181 F.3d 810, 817-19 (7th Cir. 1999); *Hampton v. Bethlehem Steel Corp.*, 24 BRBS 141, 144 (1990).

The employer may also rebut the presumption with negative evidence, but again, negative evidence must be "specific and comprehensive enough to sever the potential connection between a particular injury and a job-related event." *Swinton*, 554 F.2d at 1083. An employer cannot rebut the presumption on the basis of suppositions or equivocal testimony. *Dewberry v. S. Stevedoring Corp.*, 7 BRBS 322, 325 (1977), *aff'd mem.*, 590 F.2d 331 (4th Cir. 1978). Rather, an employer must show either facts or negative evidence that is both specific and comprehensive to overcome the presumption. If the employer presents specific and comprehensive evidence sufficient to sever the connection between a claimant's harm and his employment, the presumption no longer controls, and the issue of causation must resolved on the whole body of proof. *See Del Vecchio v. Bowers*, 296 U.S. 280, 286 (1935); *Volpe v. Northeast Marine Terminals, Inc.*, 671 F.2d 697, 700 (2d Cir. 1981); *Leone v. Sealand Terminal Corp.*, 19 BRBS 100, 102 (1986).

Employer has offered no direct or indirect evidence to rebut the Section 20(a) presumption that his right leg problems are casually related to the injury he sustained on November 18, 1994. Employer only asserts in its post-hearing brief that Claimant did not give credible testimony at trial. While Employer suggests that "it is questionable whether the osteoarthritic changes of the Claimant's right knee are the result of the sedentary activity to which he was assigned at work following his 1994 injury as opposed to the natural effects of every day activity, including walking and climbing outside of the workplace," Employer goes on to state, "The presumption of causation, however, cannot be rebutted and thus, causation at least in part is not contested." (Employer's Brief, at 10-11).

Therefore, I find that Employer has not sustained its burden of proof in showing that the November 18, 1994, did not cause, aggravate, or accelerate Claimant's condition. Because Employer has not met its burden of proof in rebutting the Section 20(a) presumption, I find that Claimant's injury is causally related to his employment. The discussion must now turn to whether Claimant is entitled to additional compensation or whether he has already been fully compensated under the Act.

Nature and Extent of Disability

Claimant in this case seeks an award for permanent partial disability benefits for problems with his right leg, which he argues is a compensable consequence of the injury to his left leg in 1994. As set forth above, Claimant argues that he may properly make a claim for a separate award for a consequential injury that results from another scheduled injury. Employer argues that Claimant has already been compensated for the problems to the situs of the injury and is not entitled to additional compensation beyond that which he has already received.

If there is a natural progression, or an injury that is the natural and unavoidable consequence of a previous injury, that injury is also compensable and the employer is liable for the entire disability. *Merrill v. Todd Pac. Shipyards Corp.*, 25 BRBS 140, 144-45 (1991). Therefore, before it is determined whether Claimant is entitled to additional compensation, it must first be determined whether Claimant's injury is the natural and unavoidable consequence of his previous injury. If Claimant's injury is the result of a natural progression of his injury, then the issue becomes whether Claimant has already been fully compensated for his injury.

Employer does not appear to contest that Claimant's problems with his right leg are the result of the natural progression of the problems with Claimant's left leg, and has offered no evidence to this extent. To be sure, Employer and Claimant stipulated that Claimant suffered an injury to both his left and right knees on November 18, 1994. (JX 1). The evidence offered by Claimant, however, demonstrates that his right leg problems are the result of the natural progression of his previous left leg injury.

Claimant testified that he began having problems with his right knee after the initial injury in 1994, and told the shipyard clinic doctor that he had injured both knees in the accident. Because the problems were not as bad as those with his left knee, no treatment was rendered on the right knee. Claimant was told that if his left knee were treated, the problems with the right knee should improve. (TR. at 17, 21-22). Dr. White testified that Claimant's right knee problems were likely a result of Claimant shifting his weight from his left side to his right. Dr. White stated that Claimant never really got over his left knee problem. (CX 3-6 through 3-8). Dr. White's notes from December 5, 1994, also note that Claimant was shifting his weight to the right side and that Claimant was experiencing problems with his right knee, which Dr. White notes as "general discomfort." (CX 1-33; EX 4-16).

The medical evidence shows that Claimant continued to have problems with his left knee, even after he had an arthroscopic meniscectomy on December 16, 1994. Claimant was in excessive pain approximately one week after the surgery, and was referred to physical therapy by Dr. White. (CX 1-31, 1-32; CX 6-1). Claimant was still symptomatic in his left knee in March,

1995, when Dr. White administered an injection of Lidocaine and Celestone. (CX 1-29; EX 4-13). When a second MRI was performed in August, 1995, Dr. O'Neil found "residual irregularities) in Claimant's left knee, and on September 15, 1995, a second operation was performed on Claimant's knee by Dr. White. (CX 1-26; 4-2). Claimant remained symptomatic in his left knee and had trouble bearing weight on his left leg in January, 1996. (CX 1-23; EX 4-6). Dr. White noted that Claimant's symptoms were unchanged in April, 1996. (CX 1-23; EX 4-6). Dr. White provided permanent physical restrictions to Claimant in August, 1996. (EX 4-4, 4-5).

When Claimant returned to see Dr. White on March 9, 1998, to have his left knee reevaluated, he also related to Dr. White that he was having difficulty with his right knee, which he used as his "climbing leg." Dr. White recommended no stair climbing at all. Claimant remained symptomatic in both knees when he saw Dr. White in October, 1998. Dr. White found that Claimant was shifting his weight to his left leg. (CX 1-18, 1-19). When Claimant saw Dr. White in June, 1999, Dr. White noted no significant change in Claimant's condition, and his impression was "residual from previous industrial injury." (CX 1-18). On December 9, 1999, Dr. White scheduled Claimant for an arthroscopy and partial medial meniscectomy on his right knee, which was performed on December 27, 1999. (CX 1-16, 1-17). Claimant saw Dr. White several times in 2000, and attended physical therapy as well. On October 2, 2000, Dr. White determined that Claimant had reached maximum medical improvement with respect to his right knee and provided a final permanent impairment rating. (CX 1-12).

I accept Dr. White's testimony that Claimant's right knee problems are a result of weight shifting to that knee. The records clearly indicate that Claimant was having trouble bearing weight on his left knee, and it stands to reason that Claimant's right leg would necessarily have to bear the increased burden of supporting his body weight as Claimant tried to ambulate. Therefore, based upon the evidence and testimony, I find that the problems that Claimant suffers in his right leg are a natural and unavoidable consequence of his previous injury.

However, a question arises as whether a claimant, such as the one in the instant matter, is entitled to compensation for the natural progression of a scheduled injury, for which he has already received compensation, when the progression leads to the impairment of another scheduled body part. The parties have cited several cases, including *Vasko v. Newport News Shipbuilding & Dry Dock Co.*, BRB No. 99-0955 (June 2, 2000) (unpublished) (per curiam); *Bass v. Broadway Maintenance and Lumbermen's Mutual Casualty Co.*, 28 BRBS 11 (1994); and *Bond v. Newport News Shipbuilding & Dry Dock Co.*, ALJ No. 2003-LHC-02082 (Feb. 26, 2004).

In *Bass v. Broadway Maintenance and Lumbermen's Mutual Casualty Co.*, 28 BRBS 11 (1994), the claimant suffered an injury to both of his knees in the course of his employment. The claimant was treated and paid for his knee injury. *Id*. at 13-14. After undergoing rehabilitation and returning to work, the claimant subsequently injured his back. The administrative law judge found that the back injury was a natural and unavoidable result of the previous knee injury and that the claimant suffered a loss in wage-earning capacity; thus, the claimant was entitled to permanent partial disability benefits. *Id*. at 14. The employer filed a motion for reconsideration, arguing that, based on the decision in *Frye v. Potomac Electric Power Co.*, 21 BRBS 194 (1988),

the claimant was entitled to only one award for the combined effect of the knee injury (a scheduled injury) and the back injury (an unscheduled injury). The administrative law judge found that the claimant's earlier settlement exceeded the award for his unscheduled injury under Section 8(c)(21), and therefore found that the claimant was not entitled to further benefits. *Id.* at 14. The claimant filed the second motion for reconsideration, but the administrative law judge rejected his argument that he was entitled to an increased disability rating on his knees based on the reasoning set forth in the decision issued following the employer's motion for reconsideration. *Id*.

The claimant appealed to the BRB, contending that the administrative law judge misconstrued the holding in *Frye*, and that he should be allowed to elect to receive either a scheduled award or an award under Section 8(c)(21) if he is limited to only one award. *Id*. The Board discussed its previous decision in *Frye*, and found that *Frye* created inequitable results between claimants who suffered multiple injuries simultaneously and claimants who suffered multiple injuries consequential to the initial injury. Therefore, the Board held that:

> [W]here harm to a part of the body not covered under the schedule results from the natural progression of an injury to a scheduled member, a claimant is not limited to one award for the combined effect of his conditions, but may receive a separate award under Section 8(c)(21) for the consequential injury, in addition to an award under the schedule for the initial injury.

Id. at 17.

In *Vasko v. Newport News Shipbuilding & Dry Dock Co.*, BRB No. 99-0955 (June 2, 2000) (unpublished) (per curiam), the Board discussed the fact that the situs of the injury controls the right to compensation under the schedule, and that the schedule will not apply where the situs of the actual injury is to a non-scheduled body part. *Id*. at *3. The Board recited the holding of the Ninth Circuit Court of Appeals in *Long v. Director, OWCP*, 767 F.2d 1578 (9th Cir. 1995), where the court held that if a non-scheduled injury results in the impairment of a scheduled body part, a liquidated damages award under the schedule is not necessary to fully compensate the claimant because the loss of wage-earning capacity is addressed under Section 8(c)(21). *Id*. at *3-4. The claimant in *Vasko* suffered an injury to his back, which is an unscheduled body part, and the back problems produced problems in his leg. The Board found that the fact that the back injury produced leg problems did not establish that the site of the injury was claimant's leg, and therefore, the schedule did not apply. *Id*. at *4. The Board flatly rejected the claimant's argument, which relied on *Bass*. The Board wrote that the facts presented in *Vasko* were converse to those presented in *Bass*, and therefore, limited the *Vasko* claimant to recovery under Section 8(c)(21). *Id*.

Claimant in the instant matter relies on the undersigned's recent decision in *Bond v. Newport News Shipbuilding & Dry Dock Co.*, ALJ No. 2003-LHC-02082 (Feb. 26, 2004), arguing that the undersigned did not follow *Vasko* when he decided *Bond*, and therefore, *Vasko* should likewise not apply to the instant matter. The claimant in *Bond* was initially injured when a steel plate fell across his waist, fracturing his pelvis, and alleged that as a result of this injury, he also suffered nerve and vascular damage to both of his lower extremities. Therefore, the

claimant argued that he was not limited to the scheduled award because the lower extremity damage was a direct result of the injury to his pelvis, an unscheduled body part. The employer argued that the claimant was limited to an award under Section 8(c)(21) because the situs of the injury was to the claimant's waist, which is an unscheduled body part. Because there was no dispute as to the situs of the injury (to the claimant's pelvic area), and that the steel plate did not strike the claimant's legs, I found that the claimant was limited to an award under Section 8(c)(21). *Id*. at *3. However, the claimant was awarded a *de minimis* amount of compensation, as, while the claimant did not demonstrate a current loss of wage-earning capacity, he did have a significant likelihood of a future loss of wage-earning capacity. *Id*. at 3-4.

The instant case is distinguishable from *Bond*, because Claimant's initial injury was to a scheduled body part, and by its nature, the schedule takes into account only the disability that a claimant suffers to that particular body part, whereas in the case of a non-scheduled injury, Section 8(c)(21) takes into account the claimant's total loss of wage-earning capacity due to the injury or accident. *See Vasko*, BRB No. 99-0955, at *3. The Board announced as much in *Bass*, in which it held that a claimant who initially suffered an injury to a scheduled body part, which led to the natural and unavoidable injury to an unscheduled body part could recover both under the schedule (for the scheduled body part) and under Section 8(c)(21) for the unscheduled body part. *Bass*, 28 BRBS at 14. Although Claimant slightly misstates the law announced in *Bass*, that certainly does not preclude its applicability to Claimant's case.

Employer is confusing the issue of situs of the injury with that of an employer's responsibility to pay for natural and unavoidable results of a work-related injury. While Employer's statement of the law is correct, that the situs of the injury controls the right to compensation, Employer fails to take the additional step necessary in this case. That is, if there is an injury to a scheduled body part that leads to a natural and avoidable injury to another body part, whether scheduled or unscheduled, the injured claimant is entitled to additional compensation from the employer, as the employer is liable for the entire disability. *Merrill v. Todd Pac. Shipyards Corp.*, 25 BRBS 140, 144-45 (1991).

In short, while the parties attempt to distinguish the above-discussed cases from one another, *Bass*, *Vasko*, and *Bond* are all based upon the same conclusions of law. First, if the initial injury is to a scheduled body part, and, as a natural and unavoidable result of that injury, the claimant suffers an injury to an unscheduled body part, the claimant is entitled to recover not only under the schedule, but also under Section 8(c)(21). Second, if the initial injury is to a non-scheduled body part, thus entitling the claimant to compensation under Section 8(c)(21), and the claimant suffers, as a natural and unavoidable result of that injury, a subsequent injury to a scheduled body part, that claimant is not entitled to additional compensation because Section 8(c)(21) takes into account the loss of wage-earning capacity to the claimant as a whole. Therefore, based upon these principles, it clearly follows that if a claimant suffers an injury to a scheduled body part, and, as a natural and unavoidable result of that injury, suffers an injury to another scheduled body part, the claimant is entitled to disability under the schedule for the second injured scheduled body part. Based upon this reasoning, I find that Claimant is entitled to additional compensation for the injury to his right leg, which I have already found is the natural and unavoidable result of the previous work-related injury to his left leg.

Permanent partial disability is addressed under Section 8 of the Act. As set forth in *Potomac Electric Power Co. v. Director, OWCP*, 449 U.S. 268 (1980) [hereinafter PEPCO], compensation for permanent partial disability is determined in one of two ways. First, if the injury is specifically identified in Section 8 under subsections (c)(1) through (c)(20), an injured employee will receive 66 2/3 of his average weekly wages for the number of weeks specified in the statute. If the injury is not of the nature scheduled in Section 8, the injured employee is entitled to receive 66 2/3 of the difference between his average weekly wage and his post-injury wage-earning capacity. *See PEPCO*, 449 U.S. at 270; *Gilchrist v. Newport News Shipbuilding & Dry Dock Co.*, 135 F.3d 915, 918 (4th Cir. 1998). Section 8 further provides that "[c]ompensation for permanent partial loss or loss of use of a member may be for proportionate loss or loss of use of the member." 33 U.S.C. §908(c)(19) (2002). The Board has consistently held that the proper formula when determining compensation for partial loss or loss of use is to apply the percentage of loss to the number of weeks for which a claimant would be entitled to compensation had the entire body part been lost. *Nash v. Strachan Shipping Co*., 15 BRBS 386, 391 (1983).

The parties do not appear to dispute that Claimant has reached maximum medical improvement on October 2, 2000, and that his residual disability is permanent in nature. The parties do dispute, however, the extent of Claimant's disability. Claimant argues that the disability rating assigned by Dr. White is entitled to greater weight than the ratings assigned by Drs. Tornberg and Luck because Dr. White is Claimant's long-term treating physician, Dr. White physically examined Claimant, and was fully familiar with Claimant's conditions. Conversely, Claimant argues that Dr. Tornberg was employed full-time by Employer at the time he assigned a rating to Claimant, and assigned the rating at Employer's request. Further, Claimant asserts that Dr. Luck never examined Claimant and was not familiar with Claimant's condition.

Employer asserts that Dr. White's rating is not entitled to greater weight than that assigned by either Dr. Tornberg or Dr. Luck because Dr. White did not properly follow the methodology set forth in the AMA Guides to Evaluation for Permanent Impairment. Employer also urges that Dr. White's rating be accorded less weight because of his statement that it was irrelevant whether a physician evaluating a case is a treating or examining physician with regard to the AMA Guides. Employer also argues that Dr. White has lesser credentials when compared with those of Drs. Tornberg and Luck. Finally, Employer maintains that the undersigned should take a bifurcated approach in determining the proper impairment rating, in that Employer suggests that the use of the impairment rating determined by Dr. Tornberg for the period of October 2, 2000, through November 19, 2003, and the rating assigned by Dr. Luck for the time thereafter.

As discussed above, Claimant was diagnosed with chondromalacia in his right knee, as well as with torn cartilage and degenerative changes in the right knee. Claimant continued to have pain and eventually underwent an arthroscopy and partial medial meniscectomy. Claimant was instructed to limit his physical activity and to undergo physical therapy following his surgery. Claimant was placed on permanent limited duty on March 9, 2000. His permanent physical restrictions limited him to walking no further than 1/4 mile; occasional use of foot control; climbing only incline ladders and stairs; and no crawling, kneeling, or squatting. (CX 3-8, 3-9). These restrictions applied to both Claimant's right and left knees. On October 2, 2000,

Dr. White determined that Claimant had reached maximum medical improvement and assessed a permanent partial impairment rating of 33% of the right knee, and 14% of the whole person. (CX 1-12).

During his deposition, Dr. White testified that he utilized the AMA Guides to the Evaluation of Permanent Impairment. Dr. White stated that he based the rating upon the fact that Claimant had both a medial and lateral meniscectomy; cruciate ligament laxity; and loss of joint space on weight-bearing X-rays. He discussed the fact that he disagreed with the methodology utilized in the AMA Guides to the extent that it fails to take into account different characteristics, such as height and weight, between individuals, and that these characteristics can affect conditions such as joint space. In some situations, Dr. White testified that he may divert from the AMA Guide methodology if he thought that the drafters sought to use only one form of rating for each anatomical part. (CX 3).

Employer urges reliance on the opinion of Dr. Luck. Dr. Luck explained the use of Table 62 of the AMA Guides in a letter to Employer's counsel. Dr. Luck wrote that when the AMA Guides were developed, it was the intention of the drafters to rate patients based upon the most severely damaged knee compartment. Dr. Luck explained that this rationale was based upon the fact that when patients need surgery as to the narrowest compartment of the knee, their conditions are not made worse when an additional compartment is narrowed in the process. (EX 3-49, EX 10-1). When subsequently asked to provide an impairment rating by Employer's counsel, Dr. Luck responded with a rating of 20% to the lower extremity and 8% to the whole person. Dr. Luck rejected Dr. White's suggestion that mild anterior cruciate laxity and meniscus removal would add to Claimant's impairment. (EX 15).

Employer also urges reliance on the rating supplied by Dr. Tornberg, who assigned a 10% permanent impairment to Claimant's right lower extremity based on post-traumatic degenerative arthritis in his right knee. Dr. Tornberg suggested that Dr. White did not properly employ the methodology of the AMA Guides, because he believed that Dr. White based his rating on the amount of joint space lost, as opposed to the proper method of determining a rating based upon the amount of joint space remaining. (EX 9-1).

It is the Claimant's burden to prove every aspect of his case by a preponderance of the evidence under the Act, pursuant to the requirements of the Administrative Procedures Act, as amended, 5 U.S.C. §501, *et seq*. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 271 (1994) (holding that the Act is subject to the mandates of the APA). If the evidence is equally balanced, the claimant must lose. *Id*. at 281 (vacating the "true doubt" rule and holding that a claimant must lose if the evidence is equally balanced). When balancing medical ratings, the Board has consistently found that the ALJ is not required to adhere to the AMA Guide or any other particular formula in determining disability ratings; rather, the end result must be reasonably supported by the available medical records. *Griffin v. Gates & Fox Constr. Co.*, 13 BRBS 384, 386-87 (1981); *Mazze v. Frank J. Holleran, Inc.*, 9 BRBS 1053, 1055 (1978). Further, an administrative law judge "may consider a variety of medical opinions and observations in addition to claimant's description of symptoms and physical effects of his injury in assessing the extent of claimant's disability." *Pimpinella v. Universal Mar. Serv. Inc.*, 27 BRBS 154, 159-60 (1993) (citing *Bachich v. Seatrain Terminals of California, Inc.*, 9 BRBS 184

(1978)). Those opinions and observations may include those made by both treating and non-treating physicians. *Grizzle v. Picklands, Mather & Co.*, 994 F.2d 1093, 1097 (4th Cir. 1993) (citing *Gordon v. Schweiker*, 725 F.2d 231, 235 (4th Cir. 1984) (finding that the testimony of a non-examining physician may be relied upon when it is consistent with the record)). The Fourth Circuit has held that a treating physician is entitled to "great, though not necessarily dispositive weight." *Grigg v. Director, OWCP*, 28 F.3d 416, 420 (4th Cir. 1994) (citing *Grizzle*, 994 F.2d at 1097)).

In the instant case, the ratings assessed by Drs. White and Luck vary by thirteen percent, while those assessed by Drs. White and Tornberg vary more greatly, twenty-three percent to be exact. It is to be noted that not only is Dr. White Claimant's long-term treating physician, but Dr. White also performed surgeries on both of Claimant's knees. As a result, Dr. White was afforded the opportunity to not only observe Claimant over a long period of time, but also both pre and post-operation and pre and post-physical therapy, allowing him to view Claimant's progress through regular doctor's appointments.

Employer spent a great deal of time during Dr. White's deposition questioning him regarding his office notes of March 9, 2000, and whether Dr. White misspoke while doing his dictation. I do not find that the supposed error made by Dr. White during his dictation had any affect on the end result of rating Claimant. Having observed Claimant at that point for almost six years, Dr. White was more than aware of Claimant's condition and his physical capabilities. Further, the error occurred over six months prior to Dr. White assigning a disability rating to Claimant, and other X-rays were taken between March and October, 2000, when the rating was actually assigned. Finally, there is no evidence to suggest that Dr. White based his rating solely on the notes he dictated on March 9, 2000.

The parties have submitted the curriculum vitae for each of the doctors. Dr. White is a Board-certified orthopedic surgeon, and he has over thirty years of experience in the field of orthopedic medicine. (CX 2-1). Similarly, Dr. Luck is also a Board-certified orthopedic surgeon with over thirty years of experience. (EX 16-4). According to Employer, Dr. Luck is also the Editorial Chair of the applicable AMA Guides chapter. (Employer's Brief, at 13). Dr. Tornberg is a Board-certified orthopedist and medical examiner as well as a Board-certified independent medical examiner. (EX 17-2). As confirmed by his curriculum vitae, Dr. Tornberg was employed by Employer at the time he assessed Claimant's impairment rating. (EX 17-1).

While I am not bound by the AMA Guides or any other particular methodology in determining an appropriate permanent partial disability rating, because of the lengthy discussion during Dr. White's deposition and in letters from both Drs. Luck and Tornberg regarding the Guides, it is appropriate to discuss them.

It is interesting to note that Dr. Tornberg's letter dated May 7, 2001, misquotes the AMA Guides as to the evaluation method. The Guides actually state that, "[i]n general, only one evaluation method should be used to evaluate a specific impairment. In some instances, however, . . . a combination of two or three methods may be required." (EX 11, at 2; *see also* EX 11, at 11). This is in contrast to Dr. Tornberg's written statement that "In general, only one evaluation method shall be used to evaluate a specific impairment." (EX 9-1). Along these

lines, Dr. Luck attempted, in a letter to Employer's counsel, to explain the intent of the drafters of the AMA Guides as to their use in assigning ratings. However, physicians should not be held to a standard of guessing or assuming what the drafters of the Guides meant. Physicians can only read what the Guides say and use their best judgment in assigning disability ratings to their patients. As stated in the Guides, "This section includes information on using some of the simpler, more reproducible methods of and tests for assessing function. It also includes examples illustrating how the physician selects the best approach to evaluate an impairment. Selecting the optimal approach or combining several methods requires judgment and experience." (EX 11, at 2). Based upon this, it does not appear that the AMA Guides say what Drs. Tornberg and Luck purport that they say. In light of this, I find that their opinions should be given less weight due to problems with their credibility.

I also find that the opinions of Drs. Tornberg and Luck should also be afforded less weight because neither of the physicians ever physically examined Claimant according to the records. Instead, their ratings were based solely on a review of Claimant's X-rays and medical records. Further, it is not clear whether Dr. Tornberg took into account the fact that Claimant underwent a medial and lateral meniscectomy. In the instant matter, given Claimant's long history of problems in his lower extremities, and the course of events leading to Claimant experiencing problems in his right lower extremity, I find that Dr. White was clearly in the best position to evaluate Claimant's condition, the continuing pain that he suffered (and apparently continues to suffer), and subsequent permanent impairment. Not only was Dr. White Claimant's treating physician throughout the course of this injury, but Dr. White also performed the surgery on both of Claimant's knees. Reviewing all of the evidence and testimony indicates that adopting the 33% impairment rating as assessed by Dr. White would compensate Claimant for the loss in his ability to perform day-to-day activities and work-related tasks. Therefore, I find that the proper rating for Claimant's permanent partial disability to his right lower extremity is 33%. As a result, I reject Employer's suggestion to bifurcate the impairment rating as well.

Section 8(c)(2) of the Act provides for compensation for the loss of a leg for 288 weeks. Applying the 33% disability rating to the appropriate number of weeks under the schedule results in a compensation period of 95.99 weeks (288 weeks X 33% = 95.99 weeks).

Order

Accordingly, it is hereby ordered that:

1. Employer, Newport News Shipbuilding & Dry Dock Company, is hereby ordered to pay to Claimant, Billy J. Perry, temporary total disability benefits for the periods of December 16, 1994, through February 12, 1995; September 15, 1995, through January 14, 1996, and December 27, 1999, through May 17, 2000, at the compensation rate of $705.08 per week;

2. Employer, Newport News Shipbuilding & Dry Dock Company, is also hereby ordered to pay to Claimant, Billy J. Perry, compensation for a 33% permanent partial disability to his right lower extremity commencing

October 2, 2000, for a period of 95.99 weeks, at a compensation rate of $705.08 per week;

3. Employer is hereby ordered to pay all medical expenses related to Claimant's work related injuries;

4. Employer shall receive credit for any compensation already paid;

5. Interest at the rate specified in 28 U.S.C. §1961 in effect when this Decision and Order is filed with the Office of the District Director shall be paid on all accrued benefits and penalties, computed from the date each payment was originally due to be paid. See *Grant v. Portland Stevedoring Co.*, 16 BRBS 267 (1984);

Claimant's attorney, within 20 days of receipt of this order, shall submit a fully documented fee application, a copy of which shall be sent to opposing counsel, who shall then have ten (10) days to respond with objections thereto.

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RICHARD E. HUDDLESTON
Administrative Law Judge