

U.S. Department of Labor

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Issue Date: 11 May 2012

Case No.: 2011-LHC-00876

OWCP No.: 02-173791

In the Matter of

LEONARD L. SIMONSON, JR.
Claimant

v.

MAHER TERMINALS, LLC
Employer

Appearances: JAMEELAH SALAHUDDIN, Lay Representative¹
For the Claimant

CHRISTOPHER J. FIELD, Esq.
For the Employer

Before: ADELE HIGGINS ODEGARD
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This is a claim for benefits under the Longshore and Harbor Workers' Compensation Act (LHWCA or "the Act"), 33 U.S.C. § 901, *et seq.*, and implementing regulations found at 20 C.F.R. Part 702, brought by the Claimant against his employer. The Act provides for payment of medical expenses and compensation for disability or death of maritime employees, other than seamen, injured on navigable waters of the United States or adjoining areas.

I conducted a hearing on this claim on August 18, 2011, in Cherry Hill, New Jersey. All Parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure for Administrative Hearings before the Office of Administrative Law Judges, 29 C.F.R. Part 18.

¹ By Order dated August 1, 2011, I authorized Ms. Salahuddin, a non-lawyer, to act on behalf of the Claimant, pursuant to his earlier written request.

At the hearing, Claimant's Exhibits ("CX") A through Z, and AA through II, and Employer's Exhibits ("EX") 1 through 12 were admitted into evidence. Transcript ("T.") at 18, 23, 52. The record was held open after the hearing for receipt of the transcript of the deposition of Dr. David Greifinger, as well as records pertaining to the Claimant's medical treatment with Dr. Munir Ahmed. T. at 52-54. After the hearing, the Claimant submitted Dr. Ahmed's treatment records. I denominate these documents as CX JJ. The Employer submitted Dr. Greifinger's deposition, and denominated it as EX 13.

By Order dated November 3, 2011, I closed the evidentiary record. The parties submitted post-hearing briefs, containing their closing arguments.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits, the testimony at hearing, the parties' motions and other submissions, and the post-hearing briefs of the parties.²

STIPULATIONS

At the hearing, the Parties entered into the following stipulations:

- The Act applies to this matter.
- The Claimant injured his left leg on February 7, 2008.
- The injury occurred at Maher Terminals' Port Elizabeth (New Jersey) facility.
- The Claimant's injury arose out of and in the course of his employment.
- An employer-employee relationship existed at the time of the injury.
- The Employer was timely notified of the injury.
- A claim and a notice of controversion were timely filed.
- There has been no informal conference regarding this claim.
- The Claimant's average weekly wage was \$1,668.17.

T. at 5-6.

These stipulations have been admitted into evidence and are therefore binding upon the Claimant and Employer. See 20 C.F.R. § 18.51; Warren v. Nat'l Steel & Shipbuilding Co., 21 BRBS 149, 151-52 (1988). Although coverage under the Act cannot be conferred by stipulation, Littrell v. Ore. Shipbuilding Co., 17 BRBS 84, 88 (1985), I find that such coverage is present here. I have carefully reviewed the foregoing stipulations and find that they are reasonable in light of the evidence in the record. As such, they are hereby accepted as findings of fact and conclusions of law.

² By Order dated January 6, 2012, I excluded from consideration various items the Claimant had submitted as "Exhibits" to the post-hearing brief. My Order noted that I had closed the evidentiary record on November 3, 2011. Order of Jan. 6, 2012, at 2.

ISSUES

As discussed by the parties at the hearing and in their post-hearing submissions, the issues remaining for resolution are as follows:

1. Whether the Claimant attained maximum medical improvement (MMI) on January 9, 2009, as the Employer asserts;
2. If the Claimant did not reach MMI in January 2009, did he ever reach MMI, and if so, on what date?
3. Is the Claimant due additional temporary total disability compensation, for a period related to his second surgery, in November 2010;
4. Whether the Claimant should be authorized additional medical care and treatment, at the Employer's expense;³
5. Whether the Claimant suffers from work-related injuries to his neck and/or back;
6. Whether the Claimant is currently capable of returning to his previous work; and, if not, the Claimant's current wage-earning capacity.

THE PARTIES' POSITIONS

Based on my careful review of the parties' post-hearing briefs, I discern the parties' respective positions to be as follows:

Claimant

- The Claimant did not reach MMI in January 2009;
- Dr. Greifinger (Employer's consulting physician) and Dr. Spagnuola (physician who performed initial surgery in August 2008) are biased in favor of the Employer and are not credible;
- The Claimant re-injured his quadriceps in November 2008;
- The re-injury of the quadriceps was related to the Claimant's initial occupational injury and, thus, is compensable;
- Surgery in November 2010 was medically necessary and was related to the Claimant's occupational injury;
- The Claimant's knee replacement surgery in August 2011 was medically necessary and was related to the Claimant's occupational injury;
- The Claimant has additional medical problems (neck and back injuries), which were precipitated by his re-injury to his quadriceps and are occupationally-related; and
- The Employer should be responsible to bear the cost of the two surgeries the Claimant underwent in 2010 and 2011, and should also pay for further medical care and treatment.

³ At the hearing, I informed the Claimant that, based on the record, it did not appear that there were any claims for payment for medical treatment that had been previously provided to the Employer. T. at 37.

Employer

- The determination that the Claimant reached MMI in January 2009 is supported by the medical evidence, and there is no medical evidence contradicting that conclusion;
- The Claimant failed to obtain authorization to change physicians, so the costs of medical treatment cannot be charged to the Employer;
- There is no medical or vocational evidence that states the Claimant is unable to perform alternate employment after January 2009, so compensation benefits cannot be entered for any period prior to the Claimant's November 2010 surgery;
- If the November 2010 surgery is deemed "reasonable and necessary" then the maximum period of temporary total disability owed ends when the Claimant presented himself for re-employment with the Employer in December 2010;
- There is no evidence to indicate the Claimant is unable to perform the level of work he was defined as being able to perform in January 2009; and
- There is no evidence establishing entitlement to increased permanent impairment benefits.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Disability Payments to Date

At the hearing, the Employer stated that the Employer paid temporary total disability for the period from February 8, 2008, until January 8, 2009, a period of 48 weeks. In addition, the Employer paid a payment of \$96,118.94, equating to a 30% disability of the lower extremity at the applicable compensation rate.⁴ T. at 8-9.

Summary of the Testimonial Evidence

The Claimant.

The Claimant was called by the Employer to testify at the hearing, and testified under oath. The Claimant indicated he has not applied for any non-longshore jobs in the timeframe since January 9, 2009. The Claimant stated, however, that he was told by his union to try to go back to work, and in December 2010 he presented himself for re-employment. The Claimant stated that the New York Shipping Association told him that the Employer's position is that he was not well enough to return to work. The Claimant stated he was told to re-apply for work, but has not done so, because he still needs surgery. The Claimant also stated that when he applied for work, he believed he was physically capable of returning to work. T. at 40-42.

⁴ Employer's counsel agreed that the Employer credited itself for any overpayment of temporary total disability payments for the period after the Employer determined the Claimant had attained maximum medical improvement. T. at 9. As I noted at the hearing, the record indicates the Employer continued to pay temporary total disability payments through December 30, 2009. T. at 15.

The Claimant verified that the physician who performed his initial surgery was Dr. Spagnuola. He stated he saw Dr. Spagnuola 30-35 times, and commented that he was “forced” by the Employer to have this physician perform his surgery. The Claimant stated he wished to be treated by other physicians at the practice that Dr. Spagnuola is associated with. The Claimant stated that, in the course of evaluations by physicians and other professionals, he answered all questions to the best of his ability. He stated he told Dr. Spagnuola about his neck and back pain, and disputed that Dr. Spagnuola ever reviewed the results of his December 2008 MRI with him. The Claimant indicated he is a high school graduate and has completed some college courses. T. at 42-47.

On cross-examination, the Claimant reiterated that he told Dr. Spagnuola about his neck and back pain, and also commented that he told the doctor “constantly” about pain in his leg. The Claimant stated that the Employer’s adjuster approved Dr. Spagnuola as his surgeon but would not approve other physicians in the same practice group. T. at 47-49.

In response to my questions, the Claimant stated that he is currently receiving Social Security disability, and stated he applied for disability shortly after his initial surgery, perhaps in September or October 2008. The Claimant also commented that his initial application for disability was denied. T. at 49-50.

The Claimant’s deposition, dated June 21, 2011, was also admitted into evidence. EX 12. At his deposition, the Claimant testified that he last saw Dr. Spagnuola in January 2009, and since that time he has treated with Dr. Munir Ahmed and Dr. Ahmed’s associate, Dr. Dickerson. The Claimant stated he had received treatment at hospitals on several occasions since January 2009, and indicated he had surgery in November 2010. The Claimant stated that his insurance company refused a claim for his November 2010 surgery. EX 13 at 4-12.

The Claimant stated that he is currently receiving Social Security disability. He also remarked that, after his November 2010 surgery, he had post-operative physical therapy, as much as he could afford, and he stated that he believed the physical therapy ended in early March 2011. The Claimant stated that Dr. Ahmed recommended additional physical therapy, as well as further surgery, that being a knee replacement. The Claimant stated that Dr. Ahmed is also treating him for his back and neck, but has not yet made any specific treatment recommendations. EX 13 at 13-17.

Regarding employment, the Claimant stated he has not worked anywhere since January 2009, nor has he looked for work. He stated he was still an active member of his local, 1233, of the International Longshoreman’s Union. The Claimant stated he applied for reinstatement with the Employer in late 2010, after his surgery, by sending a form letter. As to his physical condition, the Claimant stated he believed he was physically capable of returning to work. He also stated that Dr. Ahmed’s surgery, in November 2010, improved his condition “to a point.” The Claimant indicated that his request for reinstatement with the Employer was denied, but stated he did not know the reason for the denial. He indicated he did not pursue reinstatement, and did not file a grievance on this issue. EX 13 at 17-21.

As to other injuries, the Claimant stated that his “leg buckled coming down the stairs” in November 2008. He indicated he had a valid driver’s license and was able to drive a vehicle. EX 13 at 22-23.

Dr. David Greifinger. EX 13.

As noted above, the Employer submitted the transcript of Dr. Greifinger’s deposition, taken on October 5, 2011, post-hearing. Dr. Greifinger is a Board-certified orthopedic surgeon in active practice; he stated that he engages primarily in treating patients, but stated he also conducts evaluations of individuals. Dr. Greifinger stated that he has both treated and evaluated individuals who were injured at the Employer’s facilities. Dr. Greifinger stated that he saw the Claimant for evaluation on the following occasions: February 2008 (twice); February 2009; April 2009; May 2009; November 2010; and July 2011. He stated that he prepared a written report relating to each visit.⁵ EX 13 at 4-11.

At the initial evaluation, on February 13, 2008, Dr. Greifinger stated, upon examination he determined the Claimant to have a partial rupture of the quadriceps of the left knee. He stated he informed the Claimant that the injury needed to be surgically repaired and this surgery should be done quickly. Dr. Greifinger also commented that in addition to surgery, the knee would need to be immobilized, and then physical therapy would also be necessary. EX 13 at 12-15.

At the next visit, on February 29, 2008, Dr. Greifinger stated, the Claimant had not yet undergone surgery. Dr. Greifinger remarked the Claimant mentioned to him some personal issues that interfered with scheduling surgery. Ultimately, Dr. Greifinger stated, the Claimant had surgery on August 7, 2008, which was performed by Dr. Spagnuola. Dr. Greifinger testified he had reviewed Dr. Spagnuola’s operative report, which reflected that the Claimant underwent a reconstruction of the quadriceps tendon with a graft; as well, Dr. Spagnuola repaired tears of the medial and lateral menisci. Dr. Greifinger commented that the reconstruction was necessary because of the time that had lapsed since the initial injury, and he stated that Dr. Spagnuola placed an allograft to reinforce the tendon. He stated the allograft is attached to the quadriceps musculature and to the kneecap. EX 13 at 15-19.

Dr. Greifinger testified that he next saw the Claimant in February 2009, and stated he was aware at that time that the Claimant had reported that he had fallen at home and may have re-injured the quadriceps tendon. Dr. Greifinger stated that, on evaluation, the Claimant had considerable weakness in quadriceps function; however, he stated, he did not find evidence of any fluid in the joint, the ligaments were all stable, and the graft was intact, as best he could determine. Dr. Greifinger also commented that, based on Dr. Spagnuola’s reports, Dr. Spagnuola determined there was some atrophy of the quadriceps muscle and some extension lag. However, Dr. Spagnuola concluded that the graft was intact. This conclusion was repeated in Dr. Spagnuola’s January 2009 report. Dr. Greifinger noted the Claimant was able to perform a straight leg raise against resistance, for which an intact quadriceps tendon would be necessary. EX 13 at 19-23.

⁵ At the hearing, the Employer submitted Dr. Greifinger’s medical reports. EX 6.

Dr. Greifinger testified that, based on his own evaluation of the Claimant in February 2009, the medical evidence did not indicate a new rupture. He remarked: “the tendon was palpably intact, so whatever did happen in November of 2008 was not a tear of the quadriceps or reconstruction that Dr. Spagnuola had done.” Dr. Greifinger also stated that he reviewed a functional capacity evaluation of the Claimant, dated December 2008, and that report also indicated the Claimant was able to function and his quadriceps was functional.⁶ EX 13 at 24-25.

Regarding the December 2008 MRI, Dr. Greifinger stated he reviewed the report of the interpreting radiologist, Dr. Kaplan, and he indicated that Dr. Kaplan expressed concern about the integrity of the allograft quadriceps tendon at the level of the patella.⁷ Dr. Greifinger commented that Dr. Kaplan is not necessarily saying there is a tear of the allograft, and he remarked that a radiologist’s report must always be correlated with clinical evaluation. He reiterated that his opinion was he did not think there was a tear to the allograft. EX 13 at 25-28.

Dr. Greifinger testified that he had reviewed the November 2009 report by Dr. Malcolm Coblenz and the December 2009 report by Dr. Steven Nehmer.⁸ He stated that neither physician diagnosed a re-tear of the quadriceps tendon repair, and noted that Dr. Coblenz’s report indicated the Claimant was able to fully extend the knee, which is not possible if the quadriceps is torn. EX 13 at 28-29.

As to the Claimant’s other symptoms, Dr. Greifinger stated the Claimant first complained of back and/or neck pain in February 2009. At that time, Dr. Greifinger testified, he evaluated the Claimant’s lumbar and cervical spine, and he determined there was no disability, and no need for treatment. Dr. Greifinger indicated his findings were consistent with the findings of the December 2008 functional capacity evaluation. EX 13 at 29-33.

Regarding Dr. Ahmed’s treatment of the Claimant, Dr. Greifinger testified that he had reviewed Dr. Ahmed’s treatment records.⁹ Regarding an MRI that was done in September 2010, before Dr. Ahmed’s surgery, Dr. Greifinger stated that it appeared that he believed the allograft was intact. He stated he was able to see it at the region of the quadriceps, across the kneecap, and down to the patellar tendon. EX 13 at 34-35.

Dr. Greifinger stated he evaluated the Claimant in November 2010, two days prior to Dr. Ahmed’s surgery. He stated that, on physical evaluation and from a functional and range of motion standpoint, he believed the Claimant’s quadriceps graft was intact. Dr. Greifinger also testified that he reviewed Dr. Ahmed’s operative report. Dr. Greifinger stated that Dr. Ahmed removed what Dr. Ahmed had characterized as a large amount of excess tissue, and then Dr. Ahmed placed stitches directly at the site of the original quadriceps rupture, and then he did a new graft. Dr. Greifinger confirmed that Dr. Ahmed’s surgery reflected that the Claimant’s

⁶ The Employer submitted the functional capacity evaluation report at the hearing. See EX 9.

⁷ The Claimant submitted the MRI report at the hearing. See CX I.

⁸ The Employer submitted these reports at the hearing. See EX 7 and 8, respectively.

⁹ The transcript reflects that Dr. Ahmed’s treatment records were to be appended to Dr. Greifinger’s deposition (“Greifinger 1”). EX 13 at 33. However, they are not. Dr. Ahmed’s treatment records were submitted post-hearing. See CX JJ.

“God-given” quadriceps tendon had torn; he stated it is not clear whether the allograft had torn, and he noted that Dr. Ahmed’s surgical report does not state that the allograft was torn. Asked whether Dr. Ahmed has effectuated any additional repair other than restitching the “God-given” quadriceps tendon, Dr. Greifinger responded that Dr. Ahmed “took down the so-called scar and he put some stitches in the God-given tendon and then he went ahead and did a new graft.” EX 13 at 35-38.

Dr. Greifinger commented that on the basis of the medical evidence he saw, he believed that the Claimant’s tendon was intact, and he would not have recommended further surgery. He also noted that other physicians – Dr. Coblenz and Dr. Nehmer – also found the Claimant to have had good function. Dr. Greifinger testified that he examined the Claimant in July 2011. At that time the Claimant had 10 more degrees of flexion of the knee, and Dr. Greifinger stated that the quadriceps tendon was “palpably similar” to its state before the surgery in November 2010. At that time, Dr. Greifinger stated, the Claimant did not mention any lower back or cervical spine complaints. EX 13 at 38-41.

As to the Claimant’s ability to work, Dr. Greifinger commented that the December 2008 functional capacity evaluation and Dr. Spagnuola’s January 2009 report both indicated that, with certain job alterations (such as limitations on climbing), the Claimant could perform his longshore job. He cited his own evaluation of February 2009, as offering a similar conclusion. Dr. Greifinger also noted that Dr. Nehmer’s evaluation indicated the Claimant had more significant limitations, and that an employability report, dated August 2009, stated the Claimant was capable of doing some tasks.¹⁰ Dr. Greifinger also indicated he agreed with the conclusions in the vocational and market survey evaluations dated October 2010 and June 2011, that the Claimant was capable of some types of work.¹¹ EX 13 at 41-45.

Dr. Greifinger testified that, based on his review of Dr. Ahmed’s records (including X-rays) the Claimant has mild to moderate degenerative arthritis of the knee. Typically, he stated, knee replacement surgery is not warranted for such a condition. He stated that the Claimant underwent a total knee replacement on August 31, 2011. Dr. Greifinger reiterated that the Claimant has a permanent impairment to the left knee, caused by the quadriceps tendon tear. He also stated that the Claimant is able to return to work on a full-time basis. EX 13 at 46-53.

On cross-examination, Dr. Greifinger acknowledged that delaying the repair of a torn quadriceps tendon makes matters worse, and stated that an extended delay can make matters even worse. He indicated that it could not be expected that a surgical repair of the tendon made at the time of the Claimant’s initial surgery would hold, and that was why a graft would be necessary. Dr. Greifinger also acknowledged that, due to the delay, the Claimant lost the opportunity to achieve a better result. Dr. Greifinger stated he had never spoken with Dr. Spagnuola, and he questioned a comment in Dr. Spagnuola’s report that seemed to suggest he had. EX 13 at 53-57.

¹⁰ The Employer submitted the August 2009 report at the hearing. See EX 10.

¹¹ The Employer submitted these reports at the hearing. See EX 11.

On the issue of maximum medical improvement (MMI), Dr. Greifinger stated this determination was based on the Claimant's clinical evaluation, level of function, degree of treatment, functional capacity evaluation, opinion of the treating surgeon, etc. He stated that a reference in his report of February 2009 to the radiologist's opinion pertaining to the December 2008 MRI was in error, and acknowledged that the radiologist did not say for sure the Claimant's tendon was intact. Dr. Greifinger stated the determination regarding maximum medical improvement was based on multiple factors, and not solely Dr. Spagnuola's evaluation. For example, Dr. Greifinger stated, he reviewed Dr. Cohen's reports, the functional capacity evaluation, and the MRI report.¹² Dr. Greifinger acknowledged that Dr. Cohen had concluded the Claimant had not reached MMI. EX 13 at 58-64.

Dr. Greifinger further explained his MMI determination by stating that he did not think that any additional care would help the Claimant with his ongoing complaints, and he found the quadriceps tendon to be "functionally and palpably intact," which was consistent with Dr. Spagnuola's findings. Dr. Greifinger also commented that Dr. Cohen was not treating the Claimant for his knee, but rather for his back. EX 13 at 64-73.

Dr. Greifinger listed the fees he obtained for his evaluations of the Claimant. He acknowledged that he had a "long-time" relationship with the Employer, and had treated patients who worked for the Employer for 20 to 25 years. Regarding photos of Dr. Ahmed's surgical procedure, Dr. Greifinger stated that he saw some graft on some of the photos.¹³ He also stated that Dr. Ahmed's report reflects that Dr. Ahmed removed "excess tissue" but did not specify whether the excess tissue was graft, and did not use the term, "graft." EX 13 at 72-81.

Dr. Greifinger acknowledged that he had reviewed Dr. Spagnuola's report of surgery.¹⁴ Regarding Dr. Nehmer's report, Dr. Greifinger remarked that Dr. Nehmer's assessment of the radiologist's comments about the Claimant's MRI of December 2008 was not quite accurate, and also commented that Dr. Nehmer did not indicate he saw the film himself.¹⁵ Regarding Dr. Kaplan's (the radiologist) report of the Claimant's December 2008 MRI, Dr. Greifinger agreed that the radiologist was concerned about the integrity of the allograft tendon, and remarked that the radiologist also was concerned about the surface cartilage of the medial tibial plateau.¹⁶ EX 13 at 82-97.

On the issue of the accuracy of an MRI, Dr. Greifinger stated they are not 100% accurate. He stated the most important way to understand a patient's condition is through the clinical exam, and remarked that obtaining a history is also important. Dr. Greifinger stated it was not appropriate to conduct surgery just because a patient complains of pain. Dr. Greifinger also stated that he evaluated the Claimant and determined that further surgery was not indicated. He acknowledged that he represented the Employer regarding the Claimant's case. He stated that, on evaluating the Claimant, had he believed that additional treatment was indicated, he would

¹² The Claimant submitted Dr. Cohen's reports at the hearing. See CX P.

¹³ The Claimant introduced these items at the hearing. See CX C.

¹⁴ The parties submitted Dr. Spagnuola's operative report at the hearing. See EX 5; CX G.

¹⁵ The parties submitted Dr. Nehmer's report at the hearing. See EX 8; CX S.

¹⁶ The Claimant submitted the radiologist's report at the hearing. See CX I.

have recommended it. Dr. Greifinger also commented that maximum medical improvement does not necessarily mean that normal function is restored. He acknowledged that if the second surgery resulted in improvement, then perhaps additional treatment after the first surgery may have been indicated. EX 13 at 97-112.

Regarding his relationship with the Employer, Dr. Greifinger acknowledged he had evaluated patients on the Employer's behalf, and stated he does not have a contract with the Employer and has no financial interest in the Employer. He reiterated he did not agree with Dr. Cohen on the issue of the Claimant's maximum medical improvement. EX 13 at 112-119.

On re-direct examination, Dr. Greifinger stated that the photographs from the surgery Dr. Ahmed performed do not show a tear of the allograft repair. As to the Claimant's September 2010 MRI, Dr. Greifinger stated he reviewed the MRI films. He said he noted some truncation of the meniscus and a small effusion, both of which the radiologist also noted. Dr. Greifinger stated he also saw some arthritic changes. He stated that his clinical evaluation indicated the Claimant had an intact functioning quadriceps tendon. EX 13 at 119-123.

The parties also submitted Dr. Greifinger's medical reports. See EX 6; CX D, R, X, Y, EE, II.¹⁷ I have reviewed these reports in their entirety.¹⁸ In sum, Dr. Greifinger was of the opinion that the Claimant's initial injury, in February 2008, involved a partially ruptured quadriceps tendon of the left knee, and he recommended immediate surgery.

In February 2009, the Claimant reported to Dr. Greifinger that he had undergone surgery in August 2008, Dr. Spagnuola, and that in November 2008, "the knee gave way." The Claimant complained of pain in the knee and persistent weakness. The Claimant also indicated he had injured his lower back and neck in a fall in November 2008, but his primary concern was his left knee. On examination at that time, Dr. Greifinger noted "considerable weakness of the quadriceps function" but also concluded "as best I could determine, the quadriceps was palpably intact." At that time Dr. Greifinger also reviewed Dr. Spagnuola's records, physical therapy records, and Dr. Cohen's report.¹⁹ He remarked that appropriate job limitations should include restrictions on repetitive squatting or heavy lifting involving quadriceps function.

In April 2009, Dr. Greifinger's evaluation of the Claimant reflected that the quadriceps tendon/graft is "palpably intact." Dr. Greifinger continued to note the Claimant had "manifest weakness of quadriceps" and hamstring function. Dr. Greifinger recommended a home exercise program. In May 2009, on further evaluation, Dr. Greifinger again noted "the fibers [of the quadriceps] are palpably intact." The Claimant was able to extend the knee, but lacked full

¹⁷ Some of the evidence is duplicated and appears in both the Claimant's Exhibits and the Employer's Exhibits. In general, the Employer's practice was to consolidate all reports from a specific physician into one exhibit, whereas the Claimant's practice was to make each report a separate exhibit.

¹⁸ I choose not to summarize these reports in detail because I have summarized Dr. Greifinger's testimony extensively, and much of Dr. Greifinger's testimony relates to the content of his reports.

¹⁹ These will be summarized below.

extension. Dr. Greifinger concluded the Claimant should be restricted from climbing high ladders.

In November 2010, a few days before the Claimant's second surgery, Dr. Greifinger evaluated him again. Dr. Greifinger noted: "I was able to palpate the quadriceps graft as being continuous from the quadriceps across the area of the prior defect. [The Claimant] was able to extend the knee, albeit not fully."²⁰ Dr. Greifinger reviewed the images of an MRI from September 2010, and commented that the films "revealed an area of quadriceps defect but what appeared to be an intact graft." He was unable to review the images of a December 2008 MRI but commented that the report of the September MRI found no substantive change.²¹ Dr. Greifinger also noted that, on examination with Dr. Spagnuola after the December 2008 MRI, the Claimant had a full range of motion and "motor testing at 5/5."

Dr. Greifinger's opinion dated June 6, 2011, listed the items he reviewed, which included reports from the Claimant's second surgery. He noted the Claimant initially suffered a rupture of the quadriceps tendon in February 2008, and this was not repaired until August 2008, when an allograft repair was made. After the Claimant's report of a re-injury to the area, in November 2008, there was a question regarding whether the graft remained intact; however, according to Dr. Greifinger, based on the medical evidence available, the graft remained intact, as the Claimant had the ability to extend the leg, albeit with extensor lag. The second surgery, by Dr. Ahmed in November 2010, applied a new graft.²² Dr. Greifinger commented that such a surgery would generally require at least six months of physical therapy and healing.

On further examination, in July 2011, the Claimant continued to complain of knee pain, including pain on walking and at the extremes of flexion. On evaluation, Dr. Greifinger concluded that total knee replacement would not be related to the Claimant's quadriceps tendon injury.²³

Summary of Other Medical Evidence

In addition to the testimony and reports of Dr. Greifinger, the parties submitted the following medical opinions and reports:²⁴

²⁰ Additionally, Dr. Greifinger commented that the clinical findings he noted "are not un-anticipated" and noted the Claimant should have undergone surgery immediately after his injury.

²¹ Dr. Greifinger also commented that images from both MRIs appeared to focus more on the knee area than on the quadriceps tendon area.

²² Dr. Greifinger also concluded that Dr. Ahmed also removed the old graft, based on Dr. Ahmed's operative report that he removed scar tissue.

²³ At the hearing, the Claimant testified that he was about to undergo knee replacement surgery but did not specify which knee was involved. Dr. Greifinger's report of July 2011 indicates the knee replacement surgery was to the left knee.

²⁴ The Claimant also submitted a report of a coronary procedure Dr. Ashish Patel performed on the Claimant in October 2010. I have reviewed this item. It is not summarized because I find it is not relevant to the issues before me.

Dr. Christopher Spagnuola. EX 5; CX E, G, H, J, L, O, FF.²⁵

Dr. Spagnuola first examined the Claimant on April 4, 2008. At that time, Dr. Spagnuola noted “patella baja and a defect in the lateral aspect of the quadriceps tendon, but some of the VMO fibers do appear intact.” Dr. Spagnuola stated he believed “some of the quad mechanism is intact” but also stated the Claimant may require reconstruction of the tendon or possibly may only require repair of the retracted tendon. He prescribed an MRI. Dr. Spagnuola’s records from April 25, 2008 reflect the Claimant was to be scheduled for surgery for the following: left knee diagnostic and operative arthroscopy, possible anterior cruciate ligament repair with allograft, quadricep tendon repair, possible reconstruction with allograft. The Claimant underwent surgery on August 7, 2008. According to Dr. Spagnuola’s operative report, the following procedures were performed: left knee repair of chronic quadriceps tendon tear with allograft reconstruction; left knee diagnostic arthroscopy with arthroscopic partial medial and lateral menisectomies; open repair of medial patellofemoral ligament; chondroplasty of the patellofemoral joint.

After surgery, Dr. Spagnuola’s reports reflect, the Claimant began physical therapy. The report dated November 21, 2008 indicates the Claimant was progressing well. Dr. Spagnuola noted a 5 degree extensor lag, but no defect in the quadriceps tendon. Some atrophy of the tendon was noted. A report dated November 26, 2008 notes that the Claimant reported that a few days earlier he “was coming down the steps and he misplanted his left foot and he felt a tear in his knee.” On examination, Dr. Spagnuola noted “a palpable defect just above the patella region in the area of the distal quad” and “some significant quad atrophy” as well as a 10-15 degree extension lag and significant weakness in the quad muscle. Dr. Spagnuola concluded that the Claimant appeared to “possibly have re-ruptured his quadriceps reconstruction.” An MRI was ordered.

On December 10, 2008, Dr. Spagnuola assessed the Claimant as follows: ambulating with an antalgic gait, favoring the left lower extremity; persistent quadriceps atrophy, from prior to surgery; 5 degree extensor tension lag; significant quadriceps atrophy and weakness; no significant palpable defect on examination. On review of the MRI, Dr. Spagnuola concluded the “quadriceps allograft appears intact.” He also noted significant quadriceps atrophy. Dr. Spagnuola did not believe surgery was warranted.

On December 19, 2008, Dr. Spagnuola concluded the Claimant did not have an extensor tendon lag, as he could attain a full extension and there was no palpable defect in the quadriceps muscle. Dr. Spagnuola stated the Claimant had a “significant chronically retracted quad tendon” but again noted he did not see any significant defect in the reconstruction, and stated the Claimant was able to do a straight leg raise against resistance. Dr. Spagnuola recommended a functional capacity evaluation.

²⁵ The parties’ submissions are not identical. Several reports from Dr. Spagnuola’s reports (4/25/2008, 11/21/2008) appear in EX 5, but are not in the Claimant’s Exhibits. The second page of Dr. Spagnuola’s report of 4/4/2008 is in CX E, but is not in EX 5. The first document is CX H is an undated report from Dr. Spagnuola; from its context, it appears that it was written prior to the Claimant’s 2008 surgery. EX 5 does not include a copy of this report.

At the Claimant's next visit, on January 9, 2009, Dr. Spagnuola again noted quadriceps atrophy, but no palpable defects of the quadriceps tendon. Some weakness was noted, as well as a 10 degree extension lag with pushing resistance. Dr. Spagnuola reviewed the results of the functional capacity evaluation and stated he agreed with that assessment in general regarding the Claimant's ability to return to his usual job, but recommended limitations on climbing ladders. Dr. Spagnuola stated the Claimant had reached maximum medical improvement, and discharged him from active orthopedic care.

Dr. Malcolm Coblentz. EX 7.

At the request of the Employer, Dr. Coblentz evaluated the Claimant in November 2009. According to his letterhead, Dr. Coblentz is a Board-certified surgeon. In addition to conducting a physical examination, Dr. Coblentz also reviewed reports/records of Dr. Greifinger, Dr. Spagnuola, and Dr. Cohen; the report of the December 2008 MRI; and the functional capacity evaluation.

Dr. Coblentz noted visual defects in the quadriceps tendon and muscle (depressions), as well as some atrophy in the Claimant's left thigh. Dr. Coblentz stated the tendon appeared to be intact. The Claimant had some weakness with extension in the left leg, but was able to fully extend the leg.

Dr. Coblentz opined the Claimant's work related injury consisted of a quadriceps rupture and injury to the menisci. He concluded the Claimant attained a good result, and had a disability of 15% of the left leg. He also concluded the Claimant was able to perform his usual job duties "within the limits of the functional capacity evaluation."

Dr. Steven Nehmer. CX S; EX 8.

At the request of the Claimant's former counsel, Dr. Nehmer evaluated the Claimant in December 2009, and submitted a written report. According to his letterhead, Dr. Nehmer is Board-certified in orthopedic surgery. Dr. Nehmer also reviewed some records relating to the Claimant's injury, including the reports of Dr. Greifinger, Dr. Spagnuola, and Dr. Coblentz, as well as the functional capacity evaluation dated December 2008.²⁶

Dr. Nehmer noted a 15-degree active extension loss of the left knee, as well as a "palpable and visible defect above the left patella at the site of the quadriceps rupture and [the Claimant's] surgery." He also noted atrophy of the left thigh and calf.²⁷ Dr. Nehmer found the

²⁶ I presume that Dr. Nehmer reviewed Dr. Spagnuola's records/reports because he lists "Records from Shrewsbury Surgery Center" and "Records of Seaview Orthopedics" among the items he reviewed. These are, respectively, the facility at which Dr. Spagnuola performed the Claimant's surgery and the name of Dr. Spagnuola's medical practice.

²⁷ Dr. Nehmer also referred to an MRI study of December 2, 2009, in which the radiologist "states that the allograft is not attached to the patella." I presume this to be the MRI of December 2008. The radiologist's statement is discussed above, in the summary of Dr. Greifinger's testimony, and also below.

Claimant to have a permanent disability based on his “scar, pain, loss of extension, weakness in the left lower extremity, disability, and need for further treatment.”²⁸ He assessed the Claimant’s residual disability at 30% of the left lower leg. Dr. Nehmer also stated it was his opinion the Claimant was limited to working a “sedentary type job” because the Claimant could not lift, carry, climb, bend, or kneel.

Dr. Marc Cohen. CX P.

The Claimant submitted various treatment notes from Dr. Cohen, covering the time period from February 2009 to April 2009. Dr. Cohen’s treatment notes reflect the Claimant reported a work-related injury in November 2008, in which he fell down, and injured his neck and lower back. The Claimant also reported still having problems with his quadriceps.

In February 2009, Dr. Cohen assessed the Claimant with a “low back strain” and opined the condition was “causally related to the injury of February 6, 2009 [sic].” Dr. Cohen recommended a conservative treatment of physical therapy, and stated the Claimant was unable to work.

In April 2009, the Claimant reported persistent pain and radiculopathy. Dr. Cohen assessed “decreased range of motion in his lumbar sacral spine” as well as paravertebral spasm, decreased sensation in the S1 nerve root, and a positive straight leg with increasing back and leg pain. Dr. Cohen stated the Claimant should remain out of work.

Dr. Munir Ahmed. CX C, V, JJ.

The Claimant submitted medical treatment records from Dr. Ahmed, covering the time period from October 2010 to August 2011. CX JJ. The Claimant also submitted photographs taken during a surgery Dr. Ahmed performed on his quadriceps on November 19, 2010, and Dr. Ahmed’s operative report. CX C, V.

Dr. Ahmed’s notes indicate that at the Claimant’s initial visit, in October 2010, the Claimant reported knee pain, acute and worsening on the left side. The Claimant also reported back pain, and lumbar-sacral spine pain, radiating down both legs. Dr. Ahmed’s report stated that an MRI of the left knee was reviewed which shows “the allograft is completely torn” and “there is discontinuity of the quadriceps muscle to the patellar tendon” as well as degenerative changes.²⁹ The notes state the following: “August 7 of 2008 patient had an injury to his left leg . . . There was a delay between a repair. Saw that point allograft was placed in which failed he was given therapy range of motion exercises and basically told this was his maximum improvement. But seems to get worse...”³⁰ X-rays done at the time of the Claimant’s visit to

²⁸ Dr. Nehmer did not specify what further treatment was necessary. However, his report indicated he gave the Claimant a prescription for physical therapy, at the Claimant’s request.

²⁹ This appears to be the MRI of 12/2/2008, as this is the MRI referred to elsewhere in Dr. Ahmed’s treatment notes from this visit.

³⁰ It is not clear whether this portion of the treatment note reflects the Claimant’s report to Dr. Ahmed or Dr. Ahmed’s assessment.

Dr. Ahmed showed the patella in the “south position” and “evidence of separation of the quadriceps tendon from the patella itself.” Dr. Ahmed recommended arthrotomy repair of quadriceps muscle with possible additional allograft. He recommended an MRI of the Claimant’s lower back be done. In all, Dr. Ahmed assessed the Claimant with the following conditions: pain in knee (worsened); rupture of quad tendon (worsened); lumbago (low back pain) (worsened); degenerative lumbar/lumbosacral intervertebrate disc (worsened).

At a visit on November 11, 2010, the Claimant again reported knee pain and lower back pain. Dr. Ahmed scheduled the Claimant for “repair of the quadriceps muscle left leg with application of graft.” Dr. Ahmed also stated that an MRI of the lumbar spine, performed in October, had showed “evidence of L4-L5 broad based disc bulge continuity to mild central canal and moderate bilateral neuroforaminal stenosis with impingement of bilateral exiting nerve roots.” He concluded the Claimant probably would eventually be a candidate for epidural injection.

Dr. Ahmed’s operative report (CX V) included the following observations:

Large amount of excess tissue was identified, however, it was definitely a defect in the quadriceps muscle at the attachment to the patella...it was decided that the remnant of the quadriceps muscle was not really holding on to the patella and this had to be detached in order to expose the patella better, as well as the tendon and the quadriceps muscle, the unhealthy quadriceps muscle more medially....Bunnell type sutures were then placed over the quadriceps muscle in order to bring this down....After this was done, it was decided that the repair had to be reinforced and accordingly the suture passer was used to pass the tibialis anterior tendon graft which is 9 x 28 through the mid-portion of the patella through this heavy thick scar tissue, and also underneath the attachment of the quadriceps muscle and then was brought superiorly and again passed through the quadriceps muscle and then brought through the other end....The tendon was then reinforced to the quadriceps muscle... After this was done, the graft jacket was then placed directly over the quadriceps muscle as well as the patella and then ... sutures were used to close this as well.

Dr. Ahmed’s treatment notes also reflect post-operative visits in late November 2010, in December 2010, and in January 2011. At the first post-operative visit, the Claimant reported improvement in his left knee, but still noted pain. Dr. Ahmed’s notes stated: “patient is being seen status post open repair quadriceps muscle rupture left leg. As well as application of semi-tendinosis allograft. As well as application of graft jacket.” Dr. Ahmed assessed the Claimant as “overall progressing satisfactory.” At the visit in December 2010, the Claimant reported no knee pain, “just slight weakness.” Dr. Ahmed’s notes state: “Patient is being seen status post quadricep rupture left knee treated with the tibialis allograft along with application of the graft jacket. Clinically now has full extension.” Dr. Ahmed recommended the Claimant could bear weight “to tolerance.” At the January 2011 visit, the Claimant stated his knee is “weak and slightly painful.” Dr. Ahmed assessed the Claimant as clinically doing very well; he recommended “quad strengthening exercises” and remarked that maximum medical improvement could be achieved with physical therapy.

The Exhibit also contains an operative report, reflecting that Dr. Ahmed performed a total knee replacement on the Claimant’s left knee in August 2011. The gross findings, according to Dr. Ahmed’s report, were “degenerative osteoarthritis of the left knee.”

MRI Reports. CX F, I, U. Also CX A (spreadsheet).

The Claimant submitted several reports (interpretations) of MRI tests. These are as follows:

Left Knee. CX I

The date of this test is 12/02/2008. The interpreting physician, Dr. Sheldon Kaplan, (whose qualifications are not of record) stated the following (among other things):³¹

There is marked thickening of the allograft quadriceps tendon. There is a significant separation of the allograft tendon from the underlying torn quadriceps tendon....The visualized allograft tendon is seen ventral to the patella itself. I am not certain that it remains attached to the patella. The most distal aspect of the allograft is very thick and ends at the mid patellar tendon level. There is no recurrent medial or lateral meniscal tear....The anterior and posterior cruciate ligaments appear to be intact....There is minimal irregularity of the patella articular cartilage....

Dr. Kaplan stated the following "Impression:" "I am concerned about the integrity of the allograft quadriceps tendon at the level of the patella. Focal loss of articular cartilage of the medial tibial plateau."

Left Knee. CX U

The date of this study is 09/28/2010. Dr. Marshall Koven (whose qualifications are not of record) stated the following (among other things).

There appears to be a quadriceps allograft in place anterior to the patella extending to the level of the patellar tendon. This is thickened with increased signal. The distal portion of this allograft appears torn as there is no connection to the underlying bone or tendons. This appearance is similar to the prior study. The medical and lateral collateral ligaments appear intact....On the coronal images there is truncation of the body of the lateral meniscus, consistent with a small tear.... There is evidence of moderate chondromalacia involving the patellofemoral joint. This is particularly significant involving the femoral articular cartilage.... There is severe cartilage loss involving the medial joint space.

Dr. Koven's impressions were as follows: 1) Patellar tendinosis; 2) The quadriceps allograft is likely torn (appearance unchanged compared to prior study); 3) Lateral meniscal tear; 4) Chondromalacia involving the lateral joint space and the patellofemoral joint space; 5) small joint effusion.

Claimant's Spreadsheet. CX A

The Claimant prepared and presented a spreadsheet comparing various aspects of the MRI studies of his left knee. Three MRIs are compared, with dates of 04/08/2008, 12/2/2008,

³¹ Dr. Kaplan also noted that images extend only four centimeters above the upper pole of the patella.

and 09/28/2010. The reports of the latter two MRI tests are summarized above. The first MRI, dated 04/08/2008, is not of record.³²

Lumbar Spine MRI. CX F

The date of this test is 11/03/2010. The interpreting physician, Dr. Paresh Rijisinghani (whose qualifications are not of record) recorded the following impressions:

L4-L5 broad-based disc bulge contributing to mild central canal and moderate bilateral neural foraminal stenosis with impingement of right exiting L4 nerve root. Grade 1 spondylolisthesis of L5 on S1 resulting in pseudobulge contributing to moderate central canal and moderate-to-severe bilateral neural foraminal with impingement of bilateral existing L5 nerve roots. Mild levoscoliosis.

Physical Therapy Reports. CX K, M, N

The Claimant presented a series of physical therapy reports, covering the timeframe from December 2008 to January 2009, subsequent to the Claimant's surgery in August 2008. The reports reflect the Claimant reported that he had been attending physical therapy for several months after his surgery, but on 11/23/2008 he fell down the stairs, had increased swelling, started using crutches and wearing a brace again. The reports reflect the Claimant had been "sent to MRI for fear of tearing quad repair, but MRI showed intact repair" so he was referred back to physical therapy with focus on quad strengthening.

Summary of Vocational/Work Ability Evidence

The parties presented vocational and work ability evidence, in addition to the medical evidence summarized above.

The Employer submitted the following items: a Functional Capacity Evaluation and Work Ability assessment ("FCE"), dated December 2008 (EX 9); an Employability and Earning Capacity Evaluation, by Occupational Assessment Services, Inc. ("OAS Study"), dated August 2009 (EX 10); and a Vocational/Labor Market Survey, dated October 2010, with addendum dated June 2011 (EX 11).³³ Except for the addendum to the Vocational/Labor Market Survey, all three items were prepared after the Claimant's initial surgery in August 2008 and before his second surgery, in November 2010.

Functional Capacity Evaluation and Work Ability Assessment (EX 9).

The FCE, authored by "Kinematic Consultants, Inc." was undertaken at the request of Dr. Spagnuola, the Claimant's surgeon.³⁴ It is based on testing done in December 2008, and reflects

³² Claimant's Index of Exhibits lists Exhibit F as the MRO of 04/08/2008. However, this Exhibit is the Lumbar Spine MRI of 11/03/2010.

³³ The Claimant submitted an additional copy of the OAS Study. See CX Q.

³⁴ The report is signed by three individuals: a licensed physical therapist, a person with a B.S. degree, and a "bioengineer." Except for the license number of the physical therapist, the

that the Claimant fell on 11/22/2008 and “had follow up MRI.” The report stated the Claimant underwent testing of his physical strength and work capabilities, and also concluded that the Claimant (“the examinee”) demonstrated maximum effort throughout the testing.

As the FCE indicates, the Claimant was determined to be capable of performing Medium-Heavy category work (occasional lifting up to 75 pounds), with some modifications, principally a restriction on climbing to “occasional” (1-33% of the time). The report also noted that the Claimant’s gait was reflective of “moderate residual low back and/or low extremity imbalance.” Further, the report recommended that the Claimant be allowed “postural changes during periods of prolonged or repetitive mid to end range left knee flexion or moderate weight bearing. In sum, the examiners concluded that the Claimant could return to his pre-injury work, albeit with some modifications.

Employability and Earning Capacity Evaluation (EX 10).

The OAS Study was prepared in August 2009, at the request of the Claimant’s then-counsel. The author of the report is Edmond Provder, a certified rehabilitation counselor and a Diplomat, American Board of Vocational Experts. The evaluation included an interview of the Claimant, as well as standardized testing and a vocational analysis of the Claimant’s past work (including the position of straddle operator, which he held when he was injured in February 2008). In addition, a labor market analysis was conducted to determine the ability of the Claimant to enter the labor market, given his skills and abilities. The report reflects that medical records, including Dr. Spagnuola’s treatment records and Dr. Kaplan’s report of the MRI of December 2, 2008, were reviewed.

The report classified the physical demands of the Claimant’s job as a straddle operator as “light work” and noted that occasional climbing was also required. The Claimant self-reported work limitations due to left knee weakness and pain.

The report concluded that the Claimant had suffered significant vocational limitations due to his injury. These limitations included handicaps in sitting, walking, bending, stooping, kneeling, squatting, and carrying, as well as “reduced physical stamina and endurance.” Mr. Provder concluded that the Claimant is unable to perform his past work as a straddle operator, and was unemployable for any job in the labor market from 02/07/2008 to 01/09/2009. Further, Mr. Provder opined that the Claimant is “unable to perform any light, medium, heavy, or very heavy work existing in the local or national economy on a sustained full-time, regular, competitive basis.” He identified several jobs for which the Claimant had the vocational capacity, and noted that all of these jobs are unskilled, sedentary jobs.

Vocational/Labor Market Survey (EX 11).

This survey, dated October 2010, was prepared at the request of the Employer. It presumed the Claimant had the ability to perform medium to heavy work, with some limitations (ladder climbing limited to 10 steps occasionally, restrictions on repetitive squatting or lifting

professional credentials of these individuals are not of record.

involving quadriceps function). Among the records reviewed were the medical records of Dr. Spagnuola, the reports of Dr. Greifinger and Dr. Nehmer, the FCE, and the OAS Study (all summarized above).

The report reflects that multiple jobs were identified that appeared to fit within the Claimant's physical capabilities, including positions as assembler, courier, driver, and office clerk. Most positions were sedentary or light work in nature, and did not require climbing. The wages generally were between \$9 and \$12 per hour, although one position (as a shipper/packer) was listed at \$16 per hour.

The record also includes an addendum to the initial Vocational/Labor Market Survey, dated January 2011. Additional available jobs were identified that appeared to fit within the Claimant's physical capabilities, including stock clerk, driver, inspector, production worker, and customer service representative.³⁵ Wages ranged from approximately \$11 per hour to \$17 per hour.

Credibility of the Evidence

At the hearing, the Claimant expressed that he was frustrated and disheartened by the outcome of his medical treatment for his work-related injury, and placed much of the blame for what he believes to be a poor outcome on his treating physician, Dr. Spagnuola, and the Employer. He was clearly quite emotional on this point.

I find the Claimant to be generally credible, based on his demeanor at the hearing. I find, however, based on my observations of his demeanor, that the Claimant's conclusions about his medical treatment have been heavily influenced by his bitterness and disappointment at the outcome. Thus, I find that the Claimant's opinion regarding his medical treatment, and the Employer's handling of his case, should be considered in that light.

Additionally, I note that the Claimant's recounting of how he allegedly re-injured himself, in November 2008, has changed. Initially, as reflected in Dr. Spagnuola's report, the Claimant stated that he "misplanted his foot and he felt a tear in his knee" when coming down stairs. EX 5; CX H. In later medical reports, the Claimant is cited as stating that he fell down the stairs. See, e.g., CX CC. I do not conclude that the Claimant has deliberately falsified his story about this event; rather, I find that the Claimant is so emotional about his condition that he is unable to recount past events clearly.

In the post-hearing brief, the Claimant's lay representative argued vociferously that Dr. Spagnuola and Dr. Greifinger were not credible, and therefore their opinions should not be given any consideration. There is no testimonial evidence (such as a deposition) from Dr. Spagnuola. However, I have carefully reviewed Dr. Spagnuola's written reports, which are of record. EX 5; see also CX E, G, H, J, L, O. Based on the reports, I find no basis to discredit Dr. Spagnuola's opinion that the Claimant's quadriceps tendon was intact post-surgery, and that the Claimant had

³⁵ The report reflects that, in some instances, the availability of specific jobs could not be confirmed.

reached MMI, in January 2009. Most notably, in November 2008, after the Claimant reported he may have suffered a re-injury, Dr. Spagnuola immediately ordered an MRI. The treatment notes of December 10, 2008 (after the MRI was taken) reflect Dr. Spagnuola's conclusion that the quadriceps allograft appeared to be intact, as it was palpably intact on clinical examination.³⁶ As to the Claimant reaching MMI in January 2009, Dr. Spagnuola's treatment note of that date did note a quadriceps atrophy, some weakness, and extension lag, but also indicated he had reviewed the FCE, which stated the Claimant was able to return to work (albeit with restrictions). As additional medical care was not indicated, the Claimant was discharged from active care. As will be discussed below, Dr. Spagnuola's conclusion is consistent with the criteria for MMI. Thus, I find that Dr. Spagnuola's opinion that the Claimant achieved MMI in January 2009 to be credible.

Regarding Dr. Greifinger's credibility, the Claimant's post-hearing brief is replete with attacks on his truthfulness. Though the basis for the Claimant's assertion is somewhat unclear, upon careful review I conclude that the Claimant's position is that Dr. Greifinger's deposition testimony was inconsistent with his written reports, and also that Dr. Greifinger did not actually review the MRI images, contrary to his testimony. I have carefully reviewed Dr. Greifinger's testimony. I find it to be generally consistent with his written reports.³⁷

I note that the Claimant's representative did not introduce any evidence regarding the utility of an MRI in making determinations on issues such as the integrity of a tendon. Dr. Greifinger testified that an MRI is helpful, but is not definitive evidence, and is not as determinative as a clinical examination. EX 13 at 103. In light of Dr. Greifinger's unrebutted testimony on this point, and considering Dr. Greifinger's credentials as a Board-certified orthopedic specialist, I find that Dr. Greifinger's conclusion regarding the integrity of the Claimant's quadriceps tendon to be credible.

Additionally, I note that Dr. Greifinger's deposition testimony reflects that he responded to the Claimant's lay representative, who was at times extremely hostile in her questioning, with remarkable patience. As to the Claimant's allegation that Dr. Greifinger is biased toward the Employer because he has a longstanding relationship with the Employer and is paid by the Employer for his services, or because he treated Employer's counsel's son one time in the remote past, I note that Dr. Greifinger's medical opinion regarding the Claimant's condition is consistent

³⁶ At this time Dr. Spagnuola also noted a defect in the tendon from "chronic quadriceps rupture, which pre-existed prior to his allograft reconstruction." Dr. Spagnuola's treatment notes of April 4, 2008, and April 25, 2008 both note the chronic quadriceps rupture issue.

³⁷ For example, in his testimony Dr. Greifinger stated he reviewed the MRI of September 2010 but was unable to review the MRI of December 2008 because the CD was cracked. EX 13 at 59-61. Contrary to the Claimant's contention, this is consistent with his report dated November 17, 2010. EX 6. On cross-examination, Dr. Greifinger acknowledged an error in his report of February 25, 2009 regarding the radiologist's comment in the December 2008 MRI. EX 13 at 58-59; EX 6. I note, however, that earlier in this report Dr. Greifinger summarized the radiologist's MRI report and cited the radiologist as commenting on "significant separation of the allograft tendon from the underlying torn quadriceps tendon." Dr. Greifinger's report clearly indicates that he reviewed the MRI report, not the MRI itself.

not only with Dr. Spagnuola's opinion, but also with the opinion of Dr. Coblenz.³⁸ Put simply, based on the record of the Claimant's condition that is before me, Dr. Greifinger's opinion, as expressed at his deposition, is supported by the evidence.

In conclusion, I find that Dr. Greifinger's opinion and testimony are credible.

Injury Arising Out of Employment

Section 20(a) of the Act, 33 U.S.C. § 920(a), provides a presumption that a claim comes within the provisions of the Act "in the absence of substantial evidence to the contrary." To establish a prima facie claim for compensation, a claimant has the burden of establishing that: (1) the claimant sustained physical harm or pain; and (2) an accident occurred in the course of employment, or conditions existed at work, which could have caused, aggravated, or accelerated the harm or pain. Kier v. Bethlehem Steel Corp., 16 BRBS 128, 129 (1984). When this prima facie case is established, a presumption is created that the employee's injury arose out of employment. 33 U.S.C. § 920(a); Merrill v. Todd Pacific Shipyards Corp., 25 BRBS 140 (1991).

When the presumption in § 20(a) is invoked, the burden shifts to the employer to rebut the presumption with substantial evidence. If a non-work related event occurs which causes the Claimant to be injured, then the Employer may rebut the § 920(a) presumption by introducing substantial evidence that the claimant's disability was not caused by an earlier work-related injury. James v. Pate Stevedoring Co., 22 BRBS 271 (1989). Thus, once the presumption applies, the relevant inquiry is whether Employer has succeeded in establishing the lack of a causal nexus. Brown v. Pacific Dry Dock, 22 BRBS 284, 285 (1989); Rajotte v. General Dynamics Corp., 18 BRBS 85, 86 (1986). The Benefits Review Board has held: "Unequivocal testimony of a physician that no relationship exists between the injury and claimant's employment is sufficient to rebut the presumption." Holmes v. Universal Maritime Serv. Corp., 29 BRBS 18, 20 (1995).

If the presumption is rebutted, it no longer controls and the record as a whole must be evaluated to determine the issue of causation. Id. In such instance, the administrative law judge must weigh all of the evidence relevant to the causation issue. If the record evidence is evenly balanced, then the employer must prevail, because the Claimant has not met the ultimate burden of persuasion. Dir., OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

Discussion

Claimant's initial injury

The parties have stipulated that the Claimant suffered a work-related injury to his left leg on February 7, 2008. T. at 7. Medical evidence establishes that this injury included a torn quadriceps tendon, as well as damaged meniscal ligaments. EX 6, 5. The Claimant initially had

³⁸ In terms of his observations, Dr. Greifinger's opinion is also consistent with the opinions of Dr. Nehmer and Dr. Ahmed.

surgery to repair his injury in August 2008. EX 5. As Dr. Spagnuola, his surgeon noted, the quadriceps tendon injury was “chronic” as of April 2008. *Id.* The Claimant asserts that he suffered an additional injury to his left leg in November 2008. *Id.*; *see also* EX 12 at 22. Dr. Spagnuola determined that he reached MMI in January 2009. EX 5. Dr. Greifinger, the Employer’s consulting physician, concurred in this assessment. EX 6. The medical opinion evidence is unanimous that the Claimant was left with a permanent residual impairment to his leg. EX 7, 8. The Claimant asserts that he did not reach maximum medical improvement in January 2009, and claims that he is, at present, totally disabled. Claimant’s brief at 3.³⁹

Claimant’s alleged subsequent injury to leg

Regarding the Claimant’s assertion that he suffered an additional injury to his leg in November 2008, the Claimant has stated that this occurred when he “fell” or that he “twisted his leg.” EX 5; *see also* EX 12 at 22. This incident occurred after the Claimant had surgery to repair his work-related injuries, in August 2008. The Claimant’s position appears to be that this incident resulted in a re-tear of his quadriceps tendon. Claimant’s brief at 12-13, 27-28. The Claimant’s position also appears to be that this subsequent injury was work-related. Claimant’s brief at 30.

If a claimant “sustains an injury at work that is followed by the occurrence of a subsequent injury or aggravation outside work, the employer is liable for the entire disability only if the subsequent injury is the natural and unavoidable result of the initial work injury.” *Mijangos v. Avondale Shipyards, Inc.*, 19 BRBS 15, 17 (1986); *see also* *Bailey v. Bethlehem Steel Corp.*, 20 BRBS 14 (1987); *Hicks v. Pac. Marine & Supply Co., Ltd.*, 14 BRBS 549 (1981). This to say, if a disability results from the natural progression of an injury, and would have occurred whether or not the second injury took place, liability for the disability must be assumed by the employer for whom a claimant was working when first injured. *Abbott v. Dillingham Marine & Manuf. Co.*, 14 BRBS 452 (1981). However, an aggravation of a covered injury occurring after the termination of employment is not covered by the Act, and is not compensable by the employer. *Brown v. Bath Iron Works Corp.*, 22 BRBS 384 (1989). Moreover, if the second injury occurs outside the workplace and is precipitated by the claimant’s carelessness, or is otherwise separated from the first injury by an intervening cause, the claimant cannot recover from the employer. *Cyr v. Crescent Wharf & Warehouse Co.*, 211 F.2d 454 (9th Cir. 1954); *Bludworth Shipyard, Inc. v. Lira*, 700 F.2d 1046 (5th Cir. 1983). An onset of complications from an initial injury can be considered a progression of the initial injury, rather than an aggravation or a new injury. *See Admiralty Coatings Corp v. Dir., OWCP*, 228 F.3d 513 (4th Cir. 2000).

The medical evidence clearly shows that the Claimant’s recovery from his surgery in August 2008, up to November 2008, was progressing well. EX 5. The evidence on whether the Claimant even sustained a new injury in November 2008 is in dispute. The chief item the Claimant cites in support of his position is Dr. Kaplan’s interpretation of his MRI of 12/02/2008,

³⁹ Claimant’s assertion on this point is not entirely clear, from his brief. I infer that this is the Claimant’s position based on the record as a whole, and the Claimant’s statements controverting that he reached MMI in January 2009.

in which Dr. Kaplan expresses concern about the integrity of the quadriceps tendon graft, which had been placed in the Claimant's August 2008 surgery. CX I. Notwithstanding Dr. Kaplan's concern, both Dr. Spagnuola, the Claimant's treating surgeon, and Dr. Greifinger, the Employer's consulting physician, concluded that the graft was intact. In addition, as reflected by the FCE in late December 2008, as well as by Dr. Spagnuola's evaluation in January 2009, the Claimant's physical condition reflected recovery, albeit with significant limitations. Interestingly, as Dr. Greifinger testified, the Claimant could not have performed physically as stated in Dr. Spagnuola's report, had his repaired quadriceps tendon been re-torn. EX 13 at 23-24.

In assessing the evidence, I give more weight to the opinions of Dr. Greifinger and Dr. Spagnuola, who opined that the Claimant's quadriceps tendon graft was intact, than to the Claimant's assertion, that it had re-torn. I note that Dr. Kaplan's opinion, on which the Claimant bases his assertion, was not definitive on this point.

Dr. Ahmed's operative report (from the Claimant's November 2010 surgery) does not indicate that Dr. Ahmed discovered the quadriceps tendon to be torn.⁴⁰ CX V. The operative report reflects that a "defect in the quadriceps muscle at the attachment to the patella" was identified and surgically corrected. *Id.* Dr. Ahmed also decided to reinforce the quadriceps tendon graft. Moreover, Dr. Ahmed's surgical report does not indicate the cause of the Claimant's condition, as observed at the 2010 surgery. Nor does the report indicate whether the defect Dr. Ahmed observed was a progression of the original injury, or whether it was due to a subsequent injury. Accordingly, on review, I find that the Claimant has not established that his condition at the time of Dr. Ahmed's surgery in November 2010 was a natural progression of his initial work-related injury, as would be necessary for the Employer to be liable for any additional disability.

I also find that, in the event that the Claimant sustained any additional injury to his quadriceps in November 2008, as he has asserted, any such injury was a distinct event caused by the Claimant's own action (either a fall or a "twisting" event) and was not occupationally-related. Consequently, I find that the Employer is not liable for any disability stemming from any additional injury.

Claimant's other alleged injuries

As noted above, the parties have stipulated to a work-related injury on February 7, 2008. However, the parties have not stipulated to any other injuries. Therefore, the Claimant still must establish a prima facie case regarding his other alleged injuries. The Claimant's position is that he also sustained neck and back injuries. It appears to be the Claimant's position that neck and back problems are a consequence of his fall in November 2008. Claimant's brief at 30.⁴¹

⁴⁰ Dr. Ahmed's operative report comments that there was a "defect in the quadriceps muscle at the attachment to the patella." Because the report also states that the repair needed to be reinforced, but does not mention that the repair had failed, I infer that the quadriceps tendon repair was likely still intact. CX V.

⁴¹ "The fall caused injury to the claimant's back and neck. Caused (sic) it was left untreated for a

The medical evidence is somewhat in conflict on this issue. For example, Dr. Cohen, in February 2009, opined the Claimant had a “low back strain.” CX P. Dr. Cohen also opined the Claimant’s condition was causally related to his initial injury; however, notably, Dr. Cohen’s report also indicated the Claimant reported he “fell down and subsequently injured his neck and lower back.” Therefore, it appears, based on Dr. Cohen’s report, that Dr. Cohen concluded that the Claimant’s condition was precipitated by his “fall-down” event.⁴² Dr. Cohen did not make any findings regarding the Claimant’s asserted neck complaint (and, indeed, did not note any abnormalities in the Claimant’s neck region). In late 2009, neither Dr. Coblenz nor Dr. Nehmer addressed any issues regarding the Claimant’s neck or back.⁴³ Based on the record, it does not appear that the Claimant reported any problems with these areas of his body to these physicians.

Dr. Ahmed’s treatment records reflect that in October 2010 Dr. Ahmed assessed the Claimant. According to Dr. Ahmed’s treatment records an MRI of the lumbar spine was reviewed, which showed “evidence of L4-L5 broad-based disc bulge” with “impingement of right exiting L4 nerve root,” as well as L5 and S1 spondylolisthesis. CX JJ; see also CX F. According to Dr. Ahmed, the Claimant may be a candidate for eventual epidural injection. CX JJ. Dr. Ahmed’s treatment records do not indicate any opinion whether the Claimant’s back condition was causally related to his initial injury.

I find, based on the medical evidence, that the Claimant has not established, by a preponderance of the evidence, that he has deficits in his neck. I do find the Claimant has established that he has a condition in his lower back, as evidenced by the MRI results and Dr. Ahmed’s treatment records. CX F, JJ.

The second element of the prima facie case, that the Claimant must establish, is that an incident at work occurred, or conditions were present, that could have caused his physical condition. As set forth above, I have already found that any injury stemming from a fall or other incident in November 2008 is not compensable, because any such new injury is unrelated to the Claimant’s employment.⁴⁴ However, there is no evidence, other than the Claimant’s assertion, to link his back condition to conditions he encountered in his employment. Therefore, I conclude that the Claimant is unable to establish the second element of a prima facie case regarding any neck or back injury. Consequently, I must find that the Claimant has not established any prima facie case regarding any neck or back injury.

significant period of time, the claimant started walking with a limp. For that reason, the limp aspirated (sic) his back injury. The back injury brought about problem (sic) with loss of flexion and poor gait...”

⁴² The Claimant also reported neck and back problems to Dr. Greifinger in February 2009. EX 6.

⁴³ Dr. Coblenz’s report reflects he reviewed Dr. Cohen’s report and Dr. Greifinger’s report dated February 25, 2009.

⁴⁴ As noted above, Dr. Cohen’s opinion links the Claimant’s condition to his occupational injury, but also to his “fall” in November 2008. CX P.

Degenerative condition of left knee

The Claimant also alleges that a degenerative condition of his left knee is occupationally related. Claimant's brief at 22-24.⁴⁵ At his deposition, the Claimant testified that Dr. Ahmed had recommended a knee replacement. EX 12 at 15-17. At the hearing, the Claimant's representative stated it was the Claimant's position that this surgery was related to his initial injury. T. at 26-27. The Claimant had knee replacement surgery on August 31, 2011, performed by Dr. Ahmed. CX JJ. As reflected in Dr. Ahmed's operative report, the "gross findings" were "degenerative osteoarthritis of the left knee." Dr. Ahmed's medical treatment notes indicate the Claimant had a "prior history of chronic knee instability." CX JJ.

Based on the record before me, I find that the Claimant has established the first element of a prima facie case: that is, that he has sustained a physical harm to his left knee. However, I also find that there is no evidence of record, other than the Claimant's unsupported opinion, regarding the second element of his prima facie case. Dr. Ahmed's treatment records do not indicate whether the Claimant's degenerative arthritis of the knee is related to his initial injury, or to his work conditions or occupational history.⁴⁶ Dr. Greifinger opined that a knee replacement would not be related to the Claimant's initial work-related injury. EX 13 at 52; EX 6.

In sum, I find the Claimant has not established a prima facie case with regard to any condition of the knee for which knee replacement surgery would or might be appropriate. In light of the foregoing, I find that the Claimant has not established any basis for liability on the part of the Employer with regard to any injury to or condition of the knee for which a knee replacement operation would be indicated.

Conclusion

As the Claimant has not established his prima facie case with regard to any neck or back injuries, or any degenerative condition of his knee, I find it is not necessary to examine the Employer's evidence on these issues.

I turn, then, to the issues before me that stem from the Claimant's work-related injury, of February 2008.

⁴⁵ In the brief, Claimant states that the MRI of April 2008 "uncovers several effective areas of the knee." Claimant's brief at 23. However, the April 2008 MRI is not of record. I note, however, that both the December 2008 and September 2010 MRIs indicate the Claimant has degenerative changes in the knee. CX I, U.

⁴⁶ I also note that Dr. Greifinger is of the opinion that knee replacement surgery is not warranted for the Claimant. CX 13 at 47-50. It appears that Dr. Greifinger's conclusion on this issue is based in part on review of treatment notes of Dr. Ahmed that are not of record.

Disability

Disability under the Act is defined as “incapacity because of injury to earn wages which the employee was receiving at the time of injury in the same or any other employment.” 33 U.S.C. § 902(10). Disability is an economic concept based upon a medical foundation distinguished by either the nature (permanent or temporary) or the extent (total or partial). A permanent disability is one which has continued for a lengthy period and is of lasting or indefinite duration, as distinguished from one in which recovery merely awaits a normal healing period. Care v. Wash. Metro. Area Transit Auth., 21 BRBS 248, 251 (1988). An injured employee’s impairment may be found to have changed from temporary to permanent when the employee’s condition reaches the point of maximum medical improvement (MMI). James v. Pate Stevedoring Co., 22 BRBS 271, 274 (1989).

Permanent or Temporary Disability

The traditional approach for determining whether an injury is permanent or temporary is to ascertain the date of MMI. A claimant is permanently disabled if after reaching MMI, he has a residual disability. Phillips v. Marine Concrete Structures, 21 BRBS 233 (1988). The date that MMI is reached is to be determined by medical factors without regard to a claimant’s economic situation. Ballesteros v. Willamette W. Corp., 20 BRBS 184, 186 (1988). A condition is permanent if a claimant is no longer undergoing treatment with a view towards improving his condition, Leech v. Service Engineering Co., 15 BRBS 18, 21 (1982), or if his condition has stabilized, Lusby v. Wash. Metro. Area Transit Auth., 13 BRBS 446, 447 (1981); see also Seidel v. General Dynamics Corp., 22 BRBS 403, 407 (1989). When a claimant’s condition is continuing to improve, the claimant has not reached MMI. Dixon v. John J. McMullen & Assoc., 19 BRBS 243, 245 (1986).

Alternatively, a disability will be considered permanent if the impairment has continued for a lengthy period and appears to be of a lasting or indefinite duration. Crum v. General Adjustment Bureau, 738 F.2d 474, 480 (D.C. Cir. 1984); see also Care v. Washington Metro Area Transit Auth., 21 BRBS 248, 251 (1988). A prognosis stating that the chances of improvement are remote is sufficient to support a finding that a disability is permanent. Walsh v. Vappi Constr. Co., 13 BRBS 442, 445 (1981). However, a recommendation that a claimant receive further medical treatment may justify a finding that the claimant has not reached MMI. Dorsey v. Cooper Stevedoring Co., 18 BRBS 25, 32 (1986), *pet. dismissed sub nom. Cooper Stevedoring Co. v. Director, OWCP*, 826 F.2d 1011 (11th Cir. 1987). Moreover, MMI may be found even if an individual’s condition later deteriorates, so long as it was initially determined to be permanent and stable. Davenport v. Apex Decorating Co., 18 BRBS 194 (1986).

Maximum Medical Improvement (MMI)

The Claimant asserts either that he never reached MMI with regard to his quadriceps injury, or that he reached MMI at a date later than January 2009. See Claimant’s brief at 3. The medical evidence on this issue is summarized above. In brief, both Dr. Spagnuola and Dr. Greifinger concurred that the Claimant attained MMI in January 2009. Dr. Spagnuola was the Claimant’s treating physician. His report reflects that his determination that the Claimant had

met MMI was based on the Claimant's demonstrated recovery from surgery, as illustrated by the Claimant's physical capabilities. Dr. Spagnuola determined that no additional medical or surgical treatment was necessary at that time. Dr. Greifinger concurred in this conclusion.

There is no contradictory medical opinion, regarding the Claimant's need for additional treatment, until Dr. Ahmed opined that further surgical treatment was appropriate. Notably, Dr. Ahmed's recommendation for surgery was premised, at least in part, by a conclusion that the Claimant's quadriceps tendon repair had failed. As noted above, Dr. Ahmed's opinion on this point conflicts with the opinions of Dr. Greifinger and Dr. Spagnuola, both of whom were of the opinion that the graft was intact, as of January 2009. Dr. Kaplan's MRI report reflects his conclusion that the tendon graft may have failed; however, as noted above, this conclusion is not determinative and conflicts with Dr. Spagnuola's and Dr. Greifinger's clinical assessment.

On review of all the evidence, I find that the opinions of two Board-certified orthopedic physicians on the integrity of the tendon graft outweigh the opinion of Dr. Kaplan, the radiologist, based solely on the MRI he interpreted.⁴⁷ I also note that Dr. Ahmed's suspicion about the integrity of the tendon graft is not supported by his operative note.

Consequently, I conclude that the evidence establishes that the Claimant attained MMI on January 9, 2009, the date cited by Dr. Spagnuola and Dr. Greifinger. I note that neither Dr. Nehmer, who rendered an opinion in December 2009, nor Dr. Coblenz, who evaluated the Claimant in November 2009, contradicted the conclusions of Dr. Spagnuola and Dr. Greifinger with regard to achievement of MMI. Notably, although these physicians differed on the level of the Claimant's residual disability and also disagreed on whether he was able to return to his pre-injury work, neither recommended additional treatment.⁴⁸

I have considered whether the Claimant's condition, after January 2009 but before his 2010 surgery, could have deteriorated further, as a result of a natural progression from his first injury.⁴⁹ However, upon review of the medical evidence, I find that there is no medical evidence to support this proposition. I note that Dr. Greifinger saw the Claimant on multiple occasions during that time period: February 2009, April 2009, May 2009, and November 2010 (shortly before the Claimant's second surgery). EX 6. Dr. Greifinger's observations did not specifically indicate that the Claimant's condition had further deteriorated. Dr. Coblenz and Nehmer evaluated the Claimant, in November and December 2009, respectively. EX 7; CX S. These physicians had the opportunity to review most of the reports from Dr. Spagnuola and Dr. Greifinger.⁵⁰ Neither specifically stated that the Claimant's condition appeared to have deteriorated.

⁴⁷ I also note that the principal evidence regarding the value of an MRI report is Dr. Greifinger's statement at his deposition that MRI evidence must be correlated with clinical examination. EX 13 at 103-105.

⁴⁸ Dr. Nehmer's report indicates that he gave the Claimant a prescription for physical therapy "at his request."

⁴⁹ From my review of the Claimant's brief, it does not appear that the Claimant is asserting this position. Nevertheless, I will address it.

⁵⁰ The items they reviewed are listed or summarized in their reports.

Dr. Greifinger did comment, in his report of November 2010, that the Claimant's quadriceps defect was "actually anticipated" and he cited the delay from the Claimant's injury to his initial surgery. I conclude therefore, that the weight of the medical opinion evidence is that the Claimant did not experience further deterioration from 2008 to 2010, but rather that the Claimant never attained full recovery to his quadriceps. This conclusion is supported by the Employer's concession that the Claimant has a residual disability of 30% to his leg, for which the Claimant has been compensated. Employer's brief at 18; see also T. at 8.

Scheduled Disability

Employer argues that because the Claimant's injury to his quadriceps involves his leg, Claimant thereby suffered a scheduled injury, entitling him only to benefits based on the schedule in § 8(c) of the Act, 33 U.S.C. 908(c) under Potomac Electric Power Co. v. Dir., OWCP, 449 U.S. 268, 14 BRBS 363 (1980) (hereinafter, "PEPCO").

In PEPCO the Supreme Court addressed compensation regarding a claimant's permanent partial disability. Specifically the Court stated: if the injury is of a kind specifically identified in the schedule set forth in §§ 8(c)(1)-(20) of the Act, the injured employee is entitled to receive two-thirds of his average weekly wages for a specific number of weeks, regardless of whether his earning capacity has actually been impaired. 449 U.S. at 269, 14 BRBS at 363.

Sections 8(c)(2) and 8(c)(19) of the Act state the following:

(c) Permanent partial disability: In case of disability partial in character but permanent in quality the compensation shall be $66 \frac{2}{3}$ per centum of the average weekly wages, which shall be in addition to compensation for temporary total disability or temporary partial disability paid in accordance with subdivision (b) or subdivision (e) of this section, respectively, and shall be paid to the employee, as follows:

(2) Leg lost, two hundred and eighty-eight weeks' compensation.

(19) Partial loss or partial use: Compensation for permanent partial loss or loss of use of a member may be for proportionate loss or loss of use of the member.

As the Supreme Court stated in PEPCO, the scheduled award is the exclusive recovery available to a claimant who suffers an injury to a body part listed in § 908(c) of the Act. PEPCO, 449 U.S. at 274, 14 BRBS at 365. The compensation provided in a scheduled injury is intended to address a permanent loss of earning capacity. Porter v. Newport News Shipbuilding & Dry Dock Co., 36 BRBS 113, 118 (2007).

The schedule is applied only when a claimant has a permanent partial disability after reaching maximum medical improvement. Id.; Sinclair v. United Food & Commercial Workers, 13 BRBS 148 (1989); Trask v. Lockheed Shipbuilding & Const. Co., 17 BRBS 56 (1985). It does not apply when a claimant has a total disability. 449 U.S. at 277 n. 17; 14 BRBS at 366-67 n. 17; see also DM & IR Ry. Co. v. Dir., OWCP, 151 F.3d 1120 (8th Cir. 1998). Therefore, I will turn to the issue of whether a total disability has been established.

Total or Partial Disability

The Act does not provide standards to distinguish between classifications or degrees of disability. Case law has established that in order to establish a prima facie case of total disability under the Act, a claimant must establish that he can no longer perform his former longshore job due to his job-related injury. Manigault v. Stevens Shipping Co., 22 BRBS 332, 333 (1989); see also Brown v. Potomac Elec. Power Co., 15 BRBS 337, 339 (1983). He need not establish that he cannot return to any employment, only that he cannot return to his former employment. Elliot v. C&P Tel. Co., 16 BRBS 89, 91 (1984). The burden is on a claimant to establish his prima facie case. Harrison v. Todd Pac. Shipyards Corp., 21 BRBS 339 (1988); see also Meehan Seaway Serv. Co., v. Dir., OWCP, 125 F.3d 1163, 1170 (8th Cir. 1997), cert. denied, 523 U.S. 1020 (1998).

After a claimant establishes his prima facie case of total disability, the burden then shifts to the employer to establish the availability of suitable alternative employment. Clophus v. Amoco Prod. Co., 21 BRBS 261, 265 (1988). Total disability becomes partial on the earliest date on which the employer establishes suitable alternative employment. Rinaldi v. Gen. Dynamics Corp., 25 BRBS 128, 131 (1991). If the employer is unable to provide evidence of suitable alternate employment, a finding of total disability may be affirmed. Clophus, 21 BRBS at 265 (1988). Where suitable alternate employment is not established and an award of permanent total disability is made, a permanent loss of all wage-earning capacity is presupposed. See generally Hoey v. Owens-Corning Fiberglass Corp., 23 BRBS 71, 73 (1989) (an award for permanent total disability cannot coincide with a scheduled award because the former presupposes the loss of all wage earning capacity).

The FCE, dated December 2008, concluded that the Claimant could perform work classed as medium to heavy, albeit with limitations. It did not specifically address whether the Claimant could perform the functions of his prior job as a straddle operator, and it recognized the Claimant had physical limitations preventing him from performing certain specific tasks, such as climbing ladders. EX 9. The record reflects that, in January 2009, Dr. Spagnuola reviewed the FCE before determining that the Claimant could return to his former employment, with some limitations. This was on the same occasion where Dr. Spagnuola concluded that the Claimant had met MMI. EX 5. In February 2009, on his evaluation, and after reviewing the FCE, Dr. Greifinger concurred that the Claimant was able to function in his former employment, albeit with additional limitations. EX 6. Thus, the record reflects that two physicians, including the Claimant's treating physician, reviewed the Claimant's FCE, almost contemporaneous with the MMI determination. Both concurred that the Claimant was able to perform his former longshore employment.

Additionally (or alternatively) to his contention that he did not meet MMI in January 2009, the Claimant asserts that he remains totally disabled at present.⁵¹ Claimant's brief at 3. As noted above, in the event the Claimant is totally disabled, then he is due compensation, as set out in § 8(a) or (b), without regard to any schedule in § 8(c).

There is no evidence of record pertaining to the Claimant's condition from February 2009 (Dr. Greifinger's evaluation) to August 2009 (the OAS Study). There are two medical evaluations from late 2009: Dr. Coblenz, in November, indicated the Claimant could perform his usual work, and Dr. Nehmer, in December, indicated he could not. EX 7, 8. The Employer has conceded that the Claimant may have a period of temporary total disability, based on his surgery in November 2010 and a necessary recovery period.⁵² Employer's brief at 21-24.

In addition to the FCE, summarized above at length, the record also includes the OAS Study, dated August 2009, prepared at the behest of the Claimant's former counsel. EX 10. This document classified the Claimant's prior longshore job as "light" work and concluded that he was unable to perform this job, due to his physical impairments. EX 10 The report also concluded that the Claimant was able to performed sedentary unskilled jobs, as of January 2009 (the date cited as the date of his maximum medical improvement).

On review, I conclude that the OAS study and the FCE are inconsistent. I note that both studies were performed by credentialed professionals. I presume that the credentials are relevant to the issues addressed in the studies.

I find that the FCE consisted principally of physical tests to which the Claimant was subjected. The Claimant's performance was measured on each of these tests (which measured capabilities such as lifting, pulling, pushing). The Claimant was noted to have exerted "maximum effort" throughout the FCE. He was measured at being able to lift 226 pounds floor to waist; 70 pounds waist to shoulders; and 50 pounds shoulders to overhead. EX 9. The Claimant was also assessed as being able to carry 56 pounds occasionally, 28 pounds frequently, and 11 pounds continuously. Id. Limitations, based on the Claimant's left leg condition, were noted. Id.

I find that the OAS Study included an interview with the Claimant; review of medical records and employment history; and physical and verbal tests. Some of the physical tests involved hand and arm movement; a weight-lifting-and-carrying test was also administered. According to the OAS Study, this test involved "lifting a weight and carrying it for a total of 20 feet. [The Claimant] performed this test using a 10-pound weight with his right hand at a rate of two times slower than that of an able-bodied person. He reported experiencing left leg pain,

⁵¹ Claimant's brief clearly states that he disagrees that he reached MMI in January 2009, as the Employer has asserted. Claimant's brief at 3. The Claimant also states he is currently totally disabled, as of September 5, 2010. The basis for this date is not explained in the Claimant's brief. The Claimant is not clear on whether he was totally disabled from January 2009 (when the Employer asserts he reached MMI) continuously to the present.

⁵² It is not clear, from the record, whether this concession applies only in the event I determine that the Claimant's surgery was related to the stipulated injury of February 2008.

while walking during this test.” EX 10. The OAS Study reflected also that the Claimant complained of left knee and left leg pain, becoming more intense after working more than two hours on sedentary and light tasks. The study author concluded, based on observations, that the Claimant had the following physical capabilities: able to sit 60 minutes, stand 15 minutes, lift and carry 10-20 pounds, and could alternately perform these movements for an eight-hour workday. The OAS Study also concluded the Claimant has significant handicaps in (among other things) sitting, walking, standing, bending, stooping, kneeling, lifting and carrying, general stamina and endurance. Id. The author stated it was his opinion that the Claimant “worked to the highest level of his capability” during the assessment. Id.

Based on my review of the record, there is no medical opinion addressing why the Claimant’s condition would have deteriorated from December 2008, the time of the FCE, to August 2009, when the OAS Study was performed. Although the OAS Study reflects that the FCE was reviewed, the OAS Study does not attempt to reconcile its conclusions with the conclusion of the FCE, conducted earlier.⁵³

I find, on review, that the FCE is more credible than the OAS study, for the following reasons: first, the FCE tests actually and objectively measured the Claimant’s physical capabilities in skills such lifting, pulling, pushing, thereby providing a measure of the Claimant’s limits. In the OAS Study, the Claimant was asked to perform a specific task, and then assessed on how well he performed that task. The limits of the Claimant’s actual capabilities are not assessed under such a protocol. Secondly, the OAS Study, which was later in time, did not attempt to reconcile its results – that the Claimant could not perform his longshore job – with the earlier FCE, which stated that he could. I would expect that an “Employability Evaluation” such as the OAS study, would address any apparent inconsistency such as this.

On review, I find that Dr. Nehmer’s medical report, dated December 2009, is consistent with the Claimant’s claim that he is totally disabled, because it concludes the Claimant is unable to do his most recent longshore job. CX S. Notably, however, Dr. Nehmer’s conclusion is inconsistent with the opinion of Dr. Coblenz, dated November 2009, and also with the opinions of Dr. Spagnuola and Dr. Greifinger.⁵⁴ See EX 13 at 46.

Both Dr. Coblenz and Dr. Nehmer found the Claimant to have significant residual disability. Dr. Coblenz, in November 2009, found the Claimant capable of “full extension” of the left knee; Dr. Nehmer, in December 2009, noted a 15-degree extension loss of that limb. However, Dr. Nehmer noted the Claimant’s flexion was to 130 degrees, and Dr. Coblenz indicated the Claimant could flex to 100 degrees. Dr. Coblenz noted the Claimant limped; Dr.

⁵³ Notably, the injury the Claimant claimed in November 2008 took place prior to the FCE study, so in the event that the Claimant suffered any sequelae from that event, such would have been reflected in the FCE results.

⁵⁴ The later evaluations of Dr. Greifinger, dated November 2010 and July 2011, do not address the issue of whether the Claimant was able to perform his longshore job. EX 6. However, in his deposition, Dr. Greifinger indicated that, as of the date of his February 2009 evaluation, and up to the present time, he would permit the Claimant to resume full-time employment as a straddle driver. EX 13 at 46.

Nehmer noted he “ambulates slowly.” Regarding squatting, Dr. Coblenz remarked it was “not performed” and Dr. Nehmer stated the Claimant “is not able to even attempt” it. Both noted atrophy of the left leg.

Dr. Nehmer’s report reflects he reviewed the OAS Study and the FCE.⁵⁵ According to the OAS study, the Claimant is capable of standing for 15 minutes, and can lift and carry 10-20 pounds, alternating these movements throughout the workday. EX 10 at 109. Dr. Nehmer, however, stated that the Claimant is unable to “lift, carry, climb, bend, or kneel,” and should have limited job requirements regarding standing and ambulation. These conclusions are even more restrictive than the conclusion in the OAS Study. Dr. Nehmer does not explain the basis for the difference between his opinion and the OAS Study.

The Claimant also has implied that he is totally disabled, under the Act, because he has been awarded Social Security Disability benefits. Claimant’s brief at 28. The Claimant testified at the hearing that he was awarded Social Security Disability benefits at some point after his February 2008 injury. T. at 49-51. It is not entirely clear, from the record, what the basis for the Claimant’s Social Security disability award may be, though apparently the Claimant’s work-related injury played a role in the determination.

The Commissioner of Social Security applies a unique statutory definition of disability under Titles II and XVI of the Social Security Act. The Social Security regulations specifically state that the Commissioner will not be bound by disability determinations of other governmental agencies, 20 C.F.R §§ 404.1501 (a); 404.1504; 416.904. The Commissioner’s determination that the Claimant became entitled to Social Security disability insurance benefits on a certain date is not outcome determinative in a Longshore Act claim. Jones v. Midwest Mach. Movers, 15 BRBS 70, 73 (1982); Hunigman v. Sun Shipbuilding & Dry Dock Co., 8 BRBS 141, 145 (1978). Consequently, although I note that the Claimant’s application for Social Security disability has been approved, it is not determinative of any of the issues before me.

Based on the foregoing, I find that the Claimant is unable to establish that he was unable to perform his prior job, effective as of January 9, 2009, when Dr. Spagnuola determined he was able to perform his prior job, with limitations. Consequently, I find the Claimant is unable to establish that he was totally disabled as of that date. Therefore, I find that the provisions of § 908(c), regarding scheduled injuries, apply, regarding the Claimant’s permanent partial disability. Pursuant to PEPCO, I find that any permanent partial disability award in this case must be made under Section 8(c)(2) based on the degree of permanent physical impairment because Claimant’s injury to his leg is covered under the schedule at § 908(c).

As to the level of the Claimant’s permanent partial disability, I find there are two medical opinions of record: that of Dr. Coblenz, which concludes the Claimant’s permanent partial disability is 15% of the left leg, and that of Dr. Nehmer, which concludes the Claimant’s permanent partial disability is 30% of the left leg. The Employer has compensated the Claimant at the higher rate. See T. at 8. I find there is no medical opinion evidence of record to establish

⁵⁵ Dr. Nehmer also commented that the Claimant had “chronic right lower extremity problems.” It is unclear how much this conclusion affected Dr. Nehmer’s opinion.

a higher degree of permanent partial disability. Consequently, I find it is unnecessary to enter any finding as to the degree of the Claimant's permanent partial disability.

Additional Period of Temporary Disability

Regarding the Claimant's left knee, as discussed above, the evidence indicates that the purpose of his November 2010 surgery, from Dr. Ahmed, is arguably related to his initial injury in February 2008. It involved the same area of the body (left quadriceps) the Claimant injured in February 2008. According to Dr. Ahmed's surgical operative note, the preoperative diagnosis was "status post attempted repair of quadriceps muscle with allograft which has failed, with large defect in the quadriceps muscle, as well as failure of the allograft." CX V.

The issue of whether the allograft tendon repair had failed has been addressed exhaustively above. Dr. Ahmed's operative note indicates that "the [earlier] repair had to be reinforced." CX V. This also suggests that the Claimant's surgery was related to the initial injury, as it involved a reinforcement of the initial repair.⁵⁶

Although I find this to be an extremely close question, it does appear that Dr. Ahmed's surgery of November 19, 2010 was related to the Claimant's initial injury, in that it attempted to address conditions that could be related to that event – specifically, defects in the quadriceps muscle and the need to reinforce the original tendon repair.

In light of the foregoing, and considering all of the evidence of record, I find that the surgery of November 19, 2010, was related to the Claimant's initial injury. As noted above, however, this finding does not mean that the medical determination that the Claimant had reached MMI in January 2009 was incorrect.

Surgery brings with it a concomitant period of temporary partial disability, as it is undisputed that the Claimant would be unable to perform his longshore job while he is recuperating from surgery. In this case, the Employer has conceded that, should I find the Claimant's surgery to have been occupationally-related, the Claimant is temporarily and totally disabled as a result of that surgery. Employer's brief at 21-22.

The Employer contends, however, that any period of temporary disability should be limited to the period between the date of the surgery and the date the Claimant attempted to return to work, in December 2010. Employer's brief at 10. The basis for the Employer's assertion is that the Claimant would not have attempted to return for work, unless he believed he was capable of performing work. *Id.*, at 22-24.

There is little evidence of record on the Claimant's condition, after his November 2010 surgery. I do note, however, that Dr. Greifinger stated that typical recovery would require "at least six months of physical therapy and healing." EX 6. Additionally, Dr. Ahmed's medical

⁵⁶ As set forth above, I have found the weight of the medical evidence to indicate that the quadriceps tendon graft was intact. I infer that any need for additional reinforcement of the original repair must be related to the initial injury.

treatment note, dated January 10, 2011, indicated MMI could be achieved with physical therapy. I infer from this statement that Dr. Ahmed concluded that, as of that date, the Claimant had not yet reached MMI. Based on these items of evidence, I conclude that the Claimant was temporarily and totally disabled for a period of six months (that is, 26 weeks), commencing on the date of his surgery, November 19, 2010.

The Employer has not paid compensation for any period following January 2009. Based on the foregoing, I find the Employer is responsible to pay temporary total disability to the Claimant for the period from November 19, 2010 to May 19, 2011, a period of 26 weeks and zero days.⁵⁷

Medical Expenses

Section 7(a) of the Act provides that “the employer shall furnish such medical, surgical, and other attendance or treatment . . . for such period as the nature of the injury or the process of recovery may require.” 33 U.S.C. § 907(a); 20 CFR §§ 702.401, 702.402. In general, the employer is responsible for those medical expenses reasonably and necessarily incurred as a result of a work-related injury. Perez v. Sea-Land Services, Inc., 8 BRBS 130, 140 (1978).

Pursuant to Section 7(b) of the Act, an employee has a right to choose an attending physician authorized by the Secretary to provide medical care. 33 U.S.C. § 907(b); 20 CFR § 702.403. Section 7(d) of the Act sets forth the prerequisites for an employer’s liability for payment or reimbursement of medical expenses incurred by a claimant by requiring a claimant to request his employer’s authorization for medical services performed by any physician. 33 U.S.C. § 907(d). An employer is not generally responsible for the payment of medical benefits if a claimant has not requested authorization for treatment. Swain v. Bath Iron Works Corp., 14 BRBS 657 (1982). However, when an employer refuses a claimant’s request for authorization for treatment, or refuses to provide treatment, the claimant is released from the obligation of continuing to seek approval for subsequent treatments, and thereafter need only establish that subsequent treatment was necessary for his injury in order to be entitled to such treatment at employer’s expense. Pirozzi v. Todd Shipyards Corp., 21 BRBS 294, 295 (1988); Schoen v. U.S. Chamber of Commerce, 30 BRBS 112, 113 (1996); Anderson v. Todd Shipyards Corp., 22 BRBS 20, 23 (1989).

The record before me does not indicate that the Claimant attempted to have the Employer authorize additional medical care and treatment for the period from January 2009 and beyond.⁵⁸ Specifically, the record does not indicate whether the Employer refused to authorize Dr. Ahmed’s surgery in November 2010.⁵⁹

⁵⁷ The Claimant’s average weekly wage was stipulated at hearing to be \$1,668.17. The record reflects the Claimant was paid compensation at the rate of \$1,112.12. EX 4.

⁵⁸ In the post-hearing brief, the Claimant asserts that he did not have the physician of his choice to perform his initial surgery. Claimant’s brief at 18. As noted at the hearing, the Employer covered the Claimant’s initial surgery. T. at 6-8.

⁵⁹ At the hearing, the Claimant’s representative stated that “Medicare” paid for the November 2010 surgery. T. at 37-38.

As there is no evidence the Employer was requested to authorize additional medical care for the Claimant and refused to do so, I find that the Employer is not responsible for any medical expenses incurred by the Claimant after January 9, 2009, the date the Claimant attained MMI.

Future Medical Treatment

Section 7(b) of the Act authorizes the Secretary through her designees to oversee the provision of health care. 33 U.S.C. § 907(b); 20 CFR § 702.407. Administrative law judges have authority to order payment for medical expenses already incurred, and generally to order future medical treatment for a work-related injury. They do not have the authority to specify a particular facility to provide future treatment. McCurley v. Kiewest Co., 22 BRBS 115, 120 (1989).

The record is devoid of medical evidence indicating that future treatment for the Claimant's work-related injury is medically necessary or appropriate. Consequently, I find it is not necessary for me to direct that the Employer provide future medical treatment for the Claimant.

Interest

The Claimant is entitled to interest on any accrued unpaid compensation benefits. Canty v. S.E.L. Maduro, 26 BRBS 147, 153 (1992). The purpose of interest is not to penalize employers but, rather, to make claimants whole, as employer has had the use of the money until an award issues. Renfroe v. Ingalls Shipbuilding, Inc., 30 BRBS 101, 104 (1996); Smith v. Ingalls Shipbuilding Div., Litton Systems, Inc., 22 BRBS 47, 50 (1989). Interest is mandatory and cannot be waived in contested cases. Byrum v. Newport News Shipbuilding & Dry Dock Co., 14 BRBS 833, 837 (1982). Interest is to be calculated at the rate set out in 28 U.S.C. § 1961. Grant v. Portland Stevedoring Co., 16 BRBS 267-, 270-71 (1984), on recon., 17 BRBS 20 (1985); B.C. v. Stevedoring Serv. of Am., 41 BRBS 107, 110-12 (2007).

Fees and Costs

Under § 28(a) of the Act, an award of fees may be made to an "attorney at law" who successfully prosecutes a case. Although the Act specifically limits awards of fees to attorneys at law, in certain circumstances awards may be approved for non-attorney representatives. See, e.g., Jordan v. Lake Union Drydock Co., BRB No. 11-0519 (Feb. 14, 2012)(unpub.).⁶⁰ In general, an award of an attorney fee is discretionary. See Muscella v. Sun Shipbuilding & Dry Dock Co., 12 BRBS 272 (1980). However, even in instances in which a claimant is represented by counsel, an award of attorney's fees is generally authorized only when there has been an informal conference before the District Director prior to the hearing. § 928(b); see also Davis v. Eller & Co., 41 BRBS 58 (2007). The parties have stipulated that there has been no informal conference in this matter.

⁶⁰ In this case, the Benefits Review Board authorized an award of a fee equivalent to a rate for a paralegal, for a representative who was an attorney not in good standing with a state bar, "in light of [his] legal experience." Slip op. at 4.

Because there is no specific provision in the Act mandating awards of fees to non-attorney representatives, and because the prerequisites of § 928(b) have not been met, I decline to award any fee to the Claimant's representative.

Under the Act, costs of prosecuting a claim may be assessed against an Employer. § 928(d); see also Exell v. Direct Labor, Inc., 33 BRBS 19 (1999). Because the Claimant has successfully attained additional compensation, I find that an award of costs is appropriate. Within 30 days, the Claimant's representative may file an application for reimbursement of costs related to the prosecution of the Claimant's claim. Such application must contain full documentation of any costs claimed. A service sheet showing that service has been made upon all parties, including the Employer's counsel and the Claimant, must accompany the application. The parties have 30 days following service of the application within which to file any objections.

ORDER

The claim for benefits filed by the Claimant is GRANTED. I therefore ORDER:

The Employer is to pay temporary total disability compensation for the period from November 19, 2010, to May 19, 2011, a period of 26 weeks, based on the Claimant's stipulated average weekly wage of \$1,668.17.

The Employer also shall pay interest on the unpaid temporary total compensation (as set forth above), at the rate indicated in 28 U.S.C. § 1961.

The District Director shall make all calculations necessary to carry out this Order.

The Claimant's lay representative shall have thirty 30 days to file a fully supported application for costs, serving a copy on the Claimant and opposing counsel, who shall have 30 days to file any objections.

A

Adele H. Odegard
Administrative Law Judge

Cherry Hill, New Jersey