In the Matter of,	)	
	)	
KEVIN BURNETTE,	)	
	)	
Claimant,	)	
	)	AHD No. 07-243
v.	)	OWC No. 590623 & 608142
	)	
WASHINGTON METROPOLITAN AREA TRANSIT AUTHORITY,	)	
	)	
Self-Insured Employer.	)	

Appearances:

ROGER C. JOHNSON, ESQUIRE
For the Claimant

DONNA J. HENDERSON, ESQUIRE
For the Self-Insured Employer

Before:

HENRY W. MCCOY
ADMINISTRATIVE LAW JUDGE

COMPENSATION ORDER

STATEMENT OF THE CASE

This proceeding arises out of a claim for workers' compensation benefits filed pursuant to the provisions of the District of Columbia Workers' Compensation Act of 1979, D.C. Code, as amended, §§32-1501 *et seq*., (hereinafter, the Act).

After timely notice, a full evidentiary hearing was convened on July 26, 2007, before Henry W. McCoy, Administrative Law Judge. Kevin Burnette (hereinafter, Claimant) appeared in person and by counsel. Washington Metropolitan Area Transit Authority (hereinafter, Employer) appeared by counsel. Claimant testified on his own behalf. No one testified on behalf of Employer. Claimant Exhibit (hereinafter, CE) Nos. 1 - 3, and Employer Exhibit (hereinafter, EE) Nos. 1 - 8 described in the Hearing Transcript (hereinafter, HT), were admitted into evidence. The record closed on August 10, 2007, upon receipt of the Hearing Transcript.

BACKGROUND

While working for Employer as a train operator, Claimant sustained two accidental injuries to his left knee resulting in two surgeries. After the second surgery, Claimant returned to full duty work at his pre-injury job with some residual pain, but minimal restrictions. Claimant now seeks an award of permanent partial disability to his left lower extremity. The parties disagree as to the percentage of disability.

CLAIM FOR RELIEF

Claimant seeks a schedule award under the Act of permanent partial disability of forty-three percent (43%) to the left lower extremity, causally related medical expenses, and interest.

ISSUE

The nature and extent of Claimant's disability, if any.

FINDINGS OF FACT

The parties stipulated, and I accordingly so find, that jurisdiction over this case is vested in the District of Columbia; an employer/employee relationship exists; that Claimant sustained an initial accidental injury to the left knee on July 22, 2003 and injured the left knee again on November 8, 2004; that each injury arose out of and in the course of his employment and each is medically causally related; that Claimant gave timely notice of each injury and filed timely claims; that Employer controverted Claimant's claims for benefits in a timely fashion; and, that Claimant's average weekly wage was $1,228.29 for the first injury and, $1,301.97 for the second injury. I further find that Employer voluntarily paid temporary total disability benefits for the period July 23, 2003 to July 28, 2004 on the 2003 claim; and, for the period November 15, 2004 to July 24, 2005 on the 2004 claim.[1]

Based on the record evidence, I make the following additional findings of fact:

I find Claimant is a 42 year old man who started working for Employer in 1998 as a bus operator and in 2000 became a train operator. I find the physical demands of Claimant's job included walking, going up and down stairs, sitting, getting up and down from a seated position, and occasionally coupling and uncoupling train cars.

I find on July 22, 2003 Claimant was operating a train when the door between the passenger compartment and the operator's cabin gave way under the press of rush-hour passengers leaning against it and slammed into Claimant's left knee. Claimant treated initially on July 24, 2003 with his primary care physician at Kaiser Permanente with complaints of swelling, pain, and a tingling sensation in his left knee.

I find on July 31, 2003 Claimant started treating with orthopedist Dr. Bruce Knolmayer with complaints of increasing pain. After an examination and x-rays, Claimant was diagnosed with contusion of the left knee and patellofemoral knee pain, and prescribed Mobic, an anti-inflammatory, taken off work, given knee exercises to perform at home, and given a cane to use with ambulation until he could be fitted and provided with a hinged knee brace.

I find Dr. Knolmayer continued treating Claimant for the remainder of 2003 with conservative methods, including physical therapy and a

[1] Employer's offer of 5% permanent partial disability for each injury and calculated upon Claimant's average weekly wage at the time of each accident was rejected by Claimant.

cortisone shot with no significant improvement in the left knee. On February 6, 2004, Dr. Knolmayer performed left knee arthroscopy and a resection of the left medial plica. I find following surgery and further physical therapy, Claimant's left knee improved sufficiently that he was released to return to work and returned on or about July 12, 2004. Claimant returned to full duty performing his pre-injury job with the restriction to take periodic breaks and to wear a knee brace. I find Claimant was able to perform his pre-injury job, negotiated stairs slowly, and had manageable, residual pain in his left knee.

I find on or about November 8, 2004 as the train was slowly going down a hill, the cabin door swung open by itself and slammed into Claimant's left knee. I find the impact was in virtually the same place as the previous injury: the left side of the knee at the patella level. Claimant went off work and returned to Dr. Knolmayer with complaints of swelling, soreness, and pain. I find Dr. Knolmayer treated Claimant conservatively as before with more intensive physical therapy, a cortisone shot, and anti-inflammatory drugs. Surgery was recommended and performed on March 11, 2005, which provided Claimant some improvement when walking.

I find after the second surgery Claimant participated in another course of physical therapy. I find Claimant informed Dr. Knolmayer of a problem he was experiencing with his left knee buckling when walking. Dr. Knolmayer again recommended the use of a knee brace which Claimant wears when he is at work. Claimant returned to full duty work on July 24, 2005 with the restrictions to wear the knee brace and to take periodic rests.

I find Claimant's left knee pain increases when he has to walk fast or over-exerts himself. I find that since returning to work in 2005 Claimant has fallen several times due to his left knee buckling. I find Claimant obtains great relief by having his left leg extended, especially while working. At work, Claimant tries to avoid those duties, like coupling and uncoupling train cars, that require him to put stress on his left knee. I find after a day of work Claimant's pain level is a 6 out of 10 and his pain level while at home and relaxing is at level 1 or 2, with sometimes no pain at all.

I find Claimant has started taking classes at Lincoln Technical Institute in the field of heating, ventilation, and air conditioning (HVAC) in anticipation of a second career. I find Claimant has not been informed by Employer that he has not been performing his job adequately. I find Claimant has been off work since May 2007 due to carpal tunnel syndrome in his right wrist.

I find Claimant has been able to satisfactorily carry out the duties and perform the physical requirements of his job as a train operator. I find that over-exertion at work causes Claimant's pain level to increase. I find Claimant currently wears a knee brace every day and has continuing problems with pain and instability in the left knee. I find as of July 20, 2006 Claimant reached maximum medical improvement (MMI). I find Claimant continues to have chronic pain in his left knee which has not responded well to either a conservative or surgical approach. Accordingly, I find that Claimant sustained a twenty-seven percent (27%) permanent partial disability to his left lower extremity.

DISCUSSION

The evidence and arguments of the parties were reviewed and given equal consideration.[2] To the

[2] While each of the parties' exhibits is not specifically referenced in this discussion, each was

extent an argument is consistent with my findings and conclusions, it is accepted. To the extent an argument is inconsistent, it is rejected.

The sole issue for resolution is the nature and extent of Claimant's disability, if any, i.e., whether Claimant is entitled to the requested percentage schedule award under the Act. The Act does not provide Claimant with a presumption regarding the nature and extent of his present disability. Therefore, Claimant has the burden of proving by a preponderance of the evidence that he is entitled to the relief requested. See *Dunston v. D. C. Department of Employment Services*, 509 A2d 109 (D.C. App. 1986). In order to prevail on his claim, Claimant must demonstrate that (1) he has reached MMI, (2) he has retained a permanent impairment, and (3) the permanent impairment is to a scheduled member.

The applicable provisions of the Act governing schedule awards of permanent partial disability were amended effective April 16, 1999. D.C. Official Code, as amended, § 32-1508(c) was amended by adding consideration of the so-called "Maryland factors"[3] to the AMA Guides to the Evaluation of Permanent Impairment into the equation for determining the appropriate level of disability impairment. The factors are: pain, weakness, atrophy, loss of endurance, and loss of function. The role of the fact finder is to weigh competing opinions of the evaluating physicians, together with other relevant evidence such as the Claimant's testimony, and to arrive at an independent determination on the question of the nature and extent of the scheduled loss. The determination can result in accepting one physician's rating over the other or in reaching a different conclusion altogether. The fact finder is not bound by the opinions of the evaluating physicians. See *James B. Bryant v. Powell, Goldstein, Frazier & Murphy*, OHA No. 98-37A, OWC No. 525425 (March 24, 2000); *Womack v. Fischbach & Moore Electric, Inc.*, CORB No. 03-159 (July 22, 2005); *Negussie v. D.C. Dept. of Employment Services*, 915 A.2d 391 (D.C. 2007).

The Court in *Negussie* also set out the distinction between "impairment" and "disability." Impairment means an alteration of an individual's health status that is assessed by medical means. Disability means an alteration of an individual's capacity to meet personal, social, or occupational demands and is assessed by non-medical means. The Court instructs that more than merely adopting medical evaluations of anatomical impairment is required. The extent of loss of use must me assessed by considering how the injury has affected the employee's ability to do his or her job. *Negussie*, 915 A.2d at 397.

In asserting his claim that he has sustained a forty-three percent (43%) impairment of his left upper extremity, Claimant relies upon the rating contained in the medical report of his own independent medical evaluation (IME) physician, Dr. Raymond D. Drapkin, as opposed to the rating provided by his treating physician, Dr. Knolmayer, and his own testimony as to his present condition. In his July 10, 2006 IME report, Dr. Drapkin recounts Claimant's history consisting of two separate injuries to the left knee, the treatment including surgery after each injury, and that he now uses a patellofemoral brace at all times and has continuing pain in the left knee.

In the physical examination, Claimant exhibited significant pain around the region of the knee

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reviewed, considered, and weighed during the course of this deliberation.

[3] See Annotated Code of Maryland, Labor and Employment Article § 9-721.

both over the patella and medially. There was increased pain on flexion, which was limited to 130 degrees. There was patellofemoral pain and pain with quadriceps contraction, and weakness in the quads on the left as compared to that on the right with the knee in extension. There was atrophy, 1 inch, of the quads on the left as compared to the right and Claimant walked with a slight limp. Using the AMA Guides to the Evaluation of Permanent Impairment, without reference to the edition used, he gave Claimant a 7% impairment as a result of the arthroscopic surgeries, 12% for weakness, 8% for atrophy, and 16% for pain, loss of endurance, and loss of function for a total of 43% permanent partial impairment of the left lower extremity.[4]

Claimant's treating physician, Dr. Knolmayer, also provided an impairment rating on November 20, 2006, which Claimant would have the undersigned disregard as not accurately reflecting his current condition. Drawing upon his continuous treatment of Claimant from the initial 2003 injury, Dr. Knolmayer, without a separate physical examination, noted that Claimant continued to have chronic pain in his left knee which has not responded well to either a conservative or surgical approach. He again deemed Claimant to have reached MMI and that each of his injuries contributed equally to his current underlying impairment. Using the 5th Edition of the AMA Guides, he gave Claimant a 7% impairment due to patellar instability, 8% for atrophy, and 15% for loss of endurance, function, and pain for a combined 27% left lower extremity impairment, with half attributable to each accident.[5]

In contrast, Employer presented the IME report of Dr. Clifford Hinkes, an orthopedist, who saw Claimant on May 9, 2006. At this evaluation, Dr. Hinkes accounted for Claimant's type of work, both work injuries and the following surgeries, and Claimant's then complaints of left knee pain with weakness before relating his physical examination findings. On examination, extension of the knee was full, but flexion was limited to 125 degrees; there was mild patellofemoral crepitus, and measurable atrophy was noted in the left thigh and left calf. Claimant was deemed to be a MMI. Using the AMA Guides, without reference to the edition used, Dr. Hinkes gave Claimant a 7% lower extremity impairment for patellar instability with a minor impairment for atrophy, but no impairment for motion given a relatively good range of motion. It was his opinion that Claimant had a 10% left lower extremity impairment, with half related to each of the two accidents.

It is generally accepted in this jurisdiction that in weighing and evaluating the competing medical experts, the opinion of the treating physician is accorded preference over a doctor who was retained to examine the claimant solely for litigation purposes. *Stewart v. D.C. Dept. of Employment Services*, 606 A.2d 1350, 1353 (D.C. 1992). In the instant matter, the stated preference would not apply if the undersigned acceded to Claimant's desire to have his IME physician weighed against Employer's IME physician. However, after reviewing the medical reports rating Claimant's level of impairment, there are no justifiable reasons for disregarding

[4] It was Dr. Drapkin's opinion that of the 43%, half was related to each injury; with 21.5% impairment due to the injury of July 22, 2003, and 21.5% impairment due to the injury of November 8, 2004.

[5] In his deposition, Dr. Knolmayer explained that he used the combined values charts in the AMA Guides book to arrive at a 27% impairment, as opposed to the numerical total of 30%. CE 3 at deposition transcript pages 49, 75-76.

the treating physician's report in favor of Claimant's IME physician, except to endorse a higher impairment rating. Thus, the evaluation report from Claimant's treating physician is accorded the preference to which it is entitled.

In weighing and assessing the reports of the parties' medical experts, the report of Claimant's treating physician, Dr. Knolmayer, is deemed more persuasive in that he has a lengthy history of evaluating, treating, and assessing Claimant's condition starting shortly after his initial accidental injury in 2003 and up to July 20, 2006, the last documented visit before the impairment rating. During that last visit, Dr. Knolmayer acknowledged Claimant's level of pain (6/10) and that it was aching and sharp. In a subsequent office visit on February 12, 2007, Claimant complained of an exacerbation of his left knee with stabbing and throbbing pain. On examination the knee had full range of motion, no swelling, but was tender along medial and lateral joint lines as well as the medial patellar facet of the left knee only. Claimant had good strength and stability in each knee with a slight degree of crepitus with range of motion in the left knee.

It is noteworthy that Dr. Knolmayer sat for his deposition on June 29, 2007 and fully endorsed his November 2006 rating. In the deposition, he is taken through his various treatments of Claimant to point where Claimant's counsel requested that he provide an evaluation of permanent disability. He explained the process he used to evaluate Claimant, including why the numbers assigned to each aspect of Claimant's impairment did not add up to the numerical total, but was somewhat less based on using the AMA Guides' charts.

Dr. Knolmayer's assessment demonstrates a clear understanding and appreciation of Claimant's complaints and current physical condition both at the time of the evaluation and later when he reviewed and explained that evaluation during his deposition. It is the opinion of the undersigned, and contrary to Claimant's counsel's argument, that Dr. Knolmayer's evaluation more accurately reflects Claimant's current condition and any ongoing problems Claimant has with his left knee. Dr. Knolmayer's explanations as to how he arrived at his rating gives the undersigned greater confidence in his rating with regard to Claimant's left lower extremity as opposed to the inflated rating of Dr. Drapkin and the less than adequate rating of Dr. Hinkes.

It is the further opinion of the undersigned that no logical reason is evident to justify accepting the rating of Dr. Drapkin over that of Dr. Knolmayer, except to assign a greater percentage impairment. In the instant matter, Dr. Knolmayer has appropriately accounted for Claimant's current condition and adequately explained his reasons for doing so. Dr. Drapkin has merely added a separate percentage rating for weakness without any basis stated in his report. Accordingly, his opinion, along with that of Dr. Hinkes, is rejected without further comment. See *Washington Hospital Center v. D.C. Dept. of Employment Services*, 821 A.2d 898, 904 (2003) (an administrative law judge must give reasons for rejecting medical testimony only of a treating physician, not an independent medical examination physician).

Accepting the rating of Dr. Knolmayer over that of Drs. Drapkin and Hinkes, does not end the analysis in this matter. While Dr. Knolmayer has provided an acceptable assessment of Claimant's medical impairment, it is still left to the undersigned to determine the degree of disability. *See Negussie, supra*. For as the D.C. Court of Appeals stated in *Negussie*, "disability" is an economic and legal concept which should not be confounded with a medical condition. Thus, an

assessment needs to be made of Claimant's "industrial capacity"; that is, consideration his scheduled injury or loss from the standpoint of the injured member's use in employment. *Corrigan v. Georgetown University*, CRB No. 06-094, AHD No. 06-256, OWC No. 604612 (Sept. 14, 2007).

The facts are, and Claimant so testified, that following his second arthroscopic surgery on his left knee, he returned to full duty work performing his pre-injury job. Also, before returning to work, Claimant had participated in work hardening, wherein he demonstrated the ability to perform at the heavy physical demand level. However, he continues to complain of, and his treating physician acknowledges, that he has chronic pain in his left knee, which rises to a level 6 out of 10 on those days at work where he really has to exert himself. At the same time, Claimant testifies to no duties that he is unable to perform, only those that cause him to put more stress and strain on his left knee and that he accordingly tries to avoid. There is also evidence in the record that increased activity at work has caused occasional flare-ups of pain to the point where he has found it necessary to take a few days off work to allow the pain level to subside.

Thus, the record is clear regarding Claimant's injuries, surgeries, and the continuing ongoing chronic pain in his left knee. Claimant had demonstrated the capacity to preform his job as a train operator up to the time he stopped work due to a totally unrelated injury, carpal tunnel syndrome in his right wrist. It would be logical to assume, therefore, that once the problem with his wrist has been resolved he should be able to return to work.

Claimant has taken it upon himself to start a course of study to learn and pursue a different vocation should he decide that his current occupation places too much stress on his knee or management begins to question his ability. However, at the present time, Employer has expressed no dissatisfaction with his performance and, as stated, he is fully capable of carrying out his work responsibilities, notwithstanding the chronic pain.

Having carefully reviewed and weighed Claimant's testimony with appropriate consideration given to the ratings concerning the nature and extent of Claimant's permanent impairment, the impairment rating assigned by Claimant's treating physician also is accepted as the best numerical assessment of Claimant's current disability. Accordingly, it is the conclusion of the undersigned that Claimant has sustained a twenty-seven percent (27%) permanent partial disability to his left lower extremity, with half attributable to each accident.[6]

CONCLUSIONS OF LAW

Based upon a review of the record evidence and the foregoing discussion, I find and conclude that Claimant has reached maximum medical improvement, and has experienced a 27% permanent partial disability to his left upper extremity.

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[6] A schedule award is available where a disability to a schedule member results from an injury in an anatomical situs other than and not including the schedule member. *Morrison v. D.C. Dept. of Employment Services*, 736 A.2d 223 (1999); see also, *Sullivan v. Boatman & Magnani*, et al., CRB No. 03-74, OHA No. 90-597E, OWC No. 088187 (August 31, 2005).

ORDER

It is **ORDERED** that Claimant's claim for relief is hereby **GRANTED IN PART** and **DENIED IN PART:** Claimant is hereby awarded benefits for a twenty-seven percent (27%) permanent partial disability to his left lower extremity, with half attributable to each accident.

HENRY W. MCCOY
ADMINISTRATIVE LAW JUDGE

November 9, 2007
Date