WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

FERNANDO ***Applicant,*** **vs.** **IMPERIUM INSURANCE COMPANY, administered by TRISTAR RISK MANAGEMENT,** ***Defendants.***	**Case No. ADJ6531388** **(Riverside District Office)** **OPINION AND DECISION AFTER RECONSIDERATION**

We previously granted applicant's Petition for Reconsideration of the Findings and Award (F&A) issued on December 14, 2015, by the workers' compensation administrative law judge (WCJ) in order to further study the factual and legal issues. This is our Opinion and Decision After Reconsideration.

In the F&A the WCJ found, in pertinent part, that applicant sustained industrial injury to his left knee and gastrointestinal system, which caused permanent disability of 62%. Applicant contends that the WCJ improperly rejected the *Almaraz-Guzman* rating for applicant's left knee provided by the orthopedic agreed medical evaluator (AME). (*Milpitas Unified School Dist. v. Workers' Comp. Appeals Bd. (Almaraz-Guzman)* (2010) 187 Cal.App.4th 808, 822 [75 Cal.Comp.Cases 837].)

We received an answer from defendant. The WCJ filed a Report and Recommendation on Petition for Reconsideration (Report) recommending that we deny reconsideration.

We have considered the allegations of the Petition for Reconsideration, the answer, and the contents of the WCJ's Report. Based on our review of the record and for the reasons stated below, as our Decision After Reconsideration we will affirm the December 14, 2015 F&A, except that we will amend the F&A to indicate that applicant's level of permanent disability is 81% with a lifetime pension and defer the determination of applicant's attorney's fee pending resolution of the parties' Labor Code section 4658(d) dispute and pending a calculation of any commuted attorney's fee from applicant's lifetime pension awarded herein. (Findings of Fact Nos. 1 and 3, and Award (a) and (c).)

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FACTUAL AND PROCEDURAL BACKGROUND

Applicant, while working as a landscaper, suffered both orthopedic and subsequent internal complaints as a result of an admitted industrial injury that occurred on August 4, 2007[1], when applicant's foot slipped and applicant twisted his left knee. (Exhibit ZZ, Report of Stuart October 27, 2009, p. 2.) The parties utilized Stuart M.D., as an orthopedic AME to evaluate and report upon applicant's case. Dr. initially reported on applicant on October 27, 2009. (*Ibid.*)

Applicant underwent anterior cruciate ligament (ACL) reconstruction and partial medial and later meniscectomies on February 11, 2008. (*Id.* at p. 3.) On July 23, 2008, applicant underwent a second surgery, which was a left knee arthroscopy with lysis of extensive adhesions and excision of a large thick plica from applicant's medial gutter and minor notchplasty. (*Id.* at p. 9.) Following months of physical therapy, applicant's knee did not improve. In December of 2008, applicant underwent an MRI of the left knee, which Dr. described as follows:

> The study revealed a very large effusion. There is tricompartmental degenerative change with marked loss of the articular cartilage. There is a small subchondral cyst in the lateral tibial plateau, but there is no definite marrow edema to suggest osteomyelitis. Doctor Bolt could not exclude a septic joint, but there is no marrow edema. The anterior cruciate ligament graft and the remaining ligaments appear intact. There are medial and lateral meniscal tears. There are marked degenerative changes.

(*Id.* at p. 10.)

Applicant's treating physician described the result of applicant's knee surgeries at that point as having a "very mediocre result." (*Id.* at p. 11.) Dr. did not find applicant to be permanent and stationary in 2009. Instead, Dr. commented as follows:

> With respect to the applicant, it appears that he has what we call a captured knee, with limited range of motion following an anterior cruciate ligament reconstruction.
>
> Looking at today's x-rays, it is difficult for me to tell if the anterior cruciate ligament was inserted in the exact isometric position. However, the passage of time and the failure of a second operation to correct this man's problem suggest that more needs to be done.

[1] Although it appears from the medical record that applicant's injury occurred on August 4, 2007, the parties stipulated to August 9, 2007, as applicant's date of injury. This was the date that applicant first sought treatment for his injury.

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> Dr. Steiger has proposed using a Dynasplint, a knee splint that contains built-in springs that can stretch out a stiff joint. He also mentions the possibility of a repeat arthroscopic surgery.
>
> I've come to the conclusion that neither one of these measures will make much of a difference in this man's outcome. Instead, he needs a far more aggressive approach. I suggest that he be sent to a recognized authority in anterior cruciate ligament reconstruction issues[.]

(*Id.* at p. 20.)

Dr. specifically recommended removing applicant's reconstructed ACL followed by aggressive physical therapy and if such surgery was unsuccessful, repeating the ACL reconstruction. (*Id.* at p. 21.)

Dr. re-evaluated applicant and issued a report on January 6, 2014. Dr. summarized his conclusions of the re-evaluation as follows:

> The applicant returns to my office for reevaluation. The parties will recall that when I last saw this gentleman, I concluded that he had 'capture' of his left knee as a result of an anterior cruciate ligament reconstruction surgery. That is to say, the knee lacked both extension and flexion, probably because the ACL ligament is not isokinetic in its location. I thought that the treatment program that Doctor Steiger had instituted was not aggressive enough and suggested that the applicant be sent to an expert in anterior cruciate ligament problems because I concluded, that the only way to deal with the applicants captured knee would be to remove the entire reconstructed ligament, regain motion with an intensive exercise program, and then make a decision about reinserting a ligament in a more optimal position at a later date and time.
>
> Apparently, Doctor Clarence Shields saw the applicant as a consultant and recommended surgery, apparently corresponding to my proposal. However, the applicant developed some colitis issues (probably related to the medication he was taking for his knee pain) which delayed the surgery. Indeed, it has not yet been done.
>
> In the interim, the applicant has gained some additional knee motion, 10° more to be exact, but it is all in the direction of flexion. The applicant continues to have loss of a full extension of his knee (-15°) just as he did the last time he was here. Under the circumstances, the applicant walks with a flexed knee gait pattern because the knee does not extend all the way at heel strike and push off, as it should.
>
> I asked the applicant today whether or not he wishes to continue with the recommended surgery to regain some more knee extension and perhaps even some additional knee flexion. The applicant says that he is, indeed, so inclined. I asked him why the operation has not yet been done, and the applicant told me that 'it has not been approved' [translated from Spanish, of course].

> Under the circumstances, even though the instant industrial injury occurred in 2007, the applicant would benefit, in my opinion, from resection of the anterior cruciate ligament and debridement of arthrofibrosis in the joint.
>
> Having said that, today's x-rays demonstrate findings associated with a knee that is rapidly deteriorating. There is already tibial-femoral joint space narrowing and marginal osteophytes on the edges of the tibia, femur, and patella on the left.
>
> Were the applicant older, I would suggest that this matter of the tight ACL be brought to closure at this juncture and the applicant be set up for total knee replacement, which is the ultimate endpoint of the current process within the knee. (The anterior cruciate ligament is resected the time of a total knee replacement.) However, since the applicant is only 36 years old, he is too young, I believe, for a total knee replacement; the Synvisc injections and other kinds of Visco supplementation are at this juncture are (*sic*) not likely to help very much, although the applicant is entitled to such injections as a temp rising (*sic*) measure.
>
> Under the circumstances, unless I received instructions from the parties to the contrary, I continue to press forward with the concept that both Doctor Shields and I apparently agree upon: a surgical approach to this man's knee involves removal (or at least transection) of the anterior cruciate ligament, which seems to be limiting extension and perpetuating the limp.

(Exhibit XX, Report of Stuar M.D., January 6, 2014, pp. 20-21.)

Dr. (re-evaluated applicant again and issued his final report on February 5, 2015. (Exhibit X, Report of Stuart M.D., February 5, 2015.) Dr. noted that applicant had an antalgic limp on his left side, moderate to severe and a moderate flexed knee gait on the left side. (*Id.* at p. 19.) Dr. commented upon applicant's condition as follows:

> The applicant returns to my office for reevaluation. I had hoped, by this point in time, that the applicant would have had the surgery that I recommended; that is, removal of the tight anterior cruciate ligament, physical therapy and rehabilitation to regain range of motion, and, if the applicant felt instability, reinsertion of a new anterior cruciate ligament graft in a more physiologic position.
>
> Instead, the applicant has had no such treatment. He has been seen by a number of doctors, each one of whom had a different proposal for this gentleman, which perhaps has confused him somewhat.
>
> For example, the applicant eventually ended up in the office of Doctor Clarence Shields, one of the practitioners that I recommended for reconstructive anterior cruciate ligament surgery. Doctor Shields, however, was concerned by the fact that the applicant developed medical problems from the anti-inflammatory medication he was taking, resulting in colitis and other problems. [This will be dealt with by a specialist in another field, most likely a gastroenterologist.]

> Doctor recommended a more conservative approach. Perhaps he recognized that the applicant had, by the time Doctor saw him, developed patellofemoral chondromalacia associated with constantly walking with a flexed knee attitude. Also, perhaps Doctor Shields recognized that, in light of the patellofemoral chondromalacia and evolving medial compartment osteoarthritis, the results of the reconstructive ACL surgery might be limited,
>
> Meanwhile, Doctor , the applicant's primary treating physician, is talking about total knee replacement for this applicant. The beauty of that approach, it turns out, is that the anterior cruciate ligament is always removed in total knee replacement surgery, so the tightness 'that the applicant experiences may go away (although I expect that there are secondary constraints within the knee that have, by now, tightened, making the results of a total knee replacement suboptimal for this reason. Also, as Doctor Steiger mentioned in one of his reports, for such a young gentleman, total new placement means future surgeries to repair worn-out parts.
>
> The applicant has decided to throw in the towel. He does not want any surgery at this juncture. After all, the original injury occurred on August 9, 2007, we are now eight years into it.

(*Id.* at pp. 22-23.)

Dr. provided the following opinion regarding applicant's level of disability:

> Regarding the AMA impairment, according to the strictest AMA interpretation, the gait derangement is the most logical and best description of the applicant's problem. Since he routinely uses a cane or crutch and a knee brace, he fits into category f on table 17 - 5 (page 529) with a 30% whole person impairment.
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> Having said that, I feel I must impose Almaraz Guzman II to best characterize the constellation of problems this applicant actually has as a result of his injury to his left knee and the captured knee problem that I have been talking about the last few years.
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> I direct the intention (*sic*) of the parties to table 17-2 on page 526. Notice that if one selects "gait derangement" as the evaluation method and impairment rating strategy, there is an entire row of little Xs for every other type of impairment consideration, meaning that they cannot be combined with the gait derangement. The same happens in the column headed by "gait derangement," also a column of little Xs, [The only place where there is no X in either the horizontal or vertical column or row associated with, gait derangement is where the two intersect (obviously!).]
>
> The best way to impose Almaraz Guzman II in this case is to disregard 'the little Xs on table 17-2 and provide, in addition to the gait derangement impairment rating, separate ratings for each of the other abnormalities that are so clearly evident today.

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This may be a violation of one of the "rules" in the AMA Guides, but I suspect that the Trier Of Fact will appreciate that I am trying to give a realistic impairment rating for individual who has a hard time moving about on a globe with the mass of planet Earth.

First of all, with respect to the range of motion, the applicant has a 70° total arc of motion. Although there is 90° of flexion, there is a flexed contraction of 20°, which places the applicant into the last column of table 17-10 on page 537, which yields a 14% whole person impairment.

Next, let's turn to page 546, table 17-33. Notice that with respect to the anterior cruciate ligament, when there is laxity an individual receives an impairment rating. The applicant, however, has no laxity; instead, he has the opposite: too much tightness. This is accounted for by the previous impairment award of 14% whole person because the manifestation of the tightness is loss of motion. Therefore, we can disregard table 17— 33,

Next, turn to page 544, table 17-31. Here, we see that articulate cartilage interval narrowing results in an impairment rating. When I first evaluated this applicant in 2009, there was no articulate cartilage narrowing but the screwed-up mechanics of his left knee and walking on a flexed knee gait pattern these last few years has caused articulate cartilage erosion both patellofemoral joint, resulting in a 4% whole person impairment, arid the medial compartment of the knee, resulting in a 3% whole person impairment.

Next, let's look at atrophy. The applicant has a 2 cm thigh atrophy compared to the opposite side, which according to table 17-6 on page 530 results in a 3% whole person impairment. He also has 2 cm of calf atrophy, which results in an additional 3% whole person impairment.

Lastly, the applicant has pain in his contralateral knee associated with limping, on the left knee which yields an additional 3% whole person impairment.

All of these values add up to 60 % whole person impairment.

The question now becomes; Will the Trier Of Fact accept my decision utilize Almaraz Guzman II to disregard. the little Xs in the Cross Usage Chart (table 17-2 on page 526)?

To obtain the best answer to that question, we should look at comparable impairments and see where they stack up. **The 60% whole person impairment in the gait derangement table (item i on table 17-5 on page 529) requires routine use of two canes or two crutches and a long leg brace. In terms of ambulatory function and activities of daily living, this pretty much describes where the applicant is today, right on the nose!** Therefore, a 60% whole person impairment derived the way I chose to do it constitutes a realistic assessment of the applicant's residual impairment with his left lower extremity.

But wait, says the employer, look at table 17-33 on page 545, which describes impairment estimates for amputation. If the applicant had his entire left lower extremity amputated through the hip joint, he would get

> only 40% whole person impairment. How the heck can a failed ACL surgery result in half as much again impairment as that?
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> Here's my answer:
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> I've concluded that the applicant would get around better, and be more functional, and be able to do more ADL things, if he had lost his entire left lower extremity and had been fitted for a modern hip disarticulation prosthesis [Indeed, look again at the gait derangement table: item h, which requires two canes or two crutches and a short leg brace, and yields a higher impairment rating than a hip level amputation.]

(*Id.* at pp. 24-25 (emphasis added).)

At trial the parties agreed that the consultative rating provided by the Disability Evaluation Unit accurately rated applicant's orthopedic disability. (Minutes of Hearing and Summary of Evidence, September 3, 2015, p. 2, lines 20-24.) The consultative rating provided an orthopedic rating of 40% permanent disability based on a strict AMA Guides analysis and a 71% rating based on Dr. *Almaraz-Guzman* analysis. (Exhibit 1, DEU Consultative Rating, May 28, 2015.)

The WCJ found that Dr. report was detailed and made sense, however, in rejecting Dr. Green's *Almaraz-Guzman* opinion, the WCJ explained:

> The principle enunciated in Almaraz/Guzman allows for a departure from a strict application of the AMA Guides by way of utilization of any chapter, table or method in the Guides to assess impairment assuming that a strict application of the Guides does not adequately or accurately describe the injured employee's impairment. While Dr. Green does explain his departure from a strict application of the Guides and how he arrived at his impairment assessment (and does so in great detail), his use of Table 17-2 at page 526 of the Guides violates the metric or constraints of that table by combining gait impairment with other impairments. The doctor must, if he is to utilize another table, chapter or method in departing from a strict application of the Guides, use (as in this case) that table and follow the constraints or metric of the table. He cannot modify the table to achieve the result he desires.

(Opinion on Decision, December 14, 2015, pp. 1-2.)

The WCJ found that Dr. ; strict rating of 40% applied to applicant's injury and awarded applicant 62% permanent disability (40% orthopedic + 36% internal = 62%).

At trial, the parties disputed applicant's internal permanent disability rating. However, the WCJ assigned 36% permanent disability as the proper rating for applicant's internal complaints and no party

has sought reconsideration of that finding. The sole issue before us is applicant's orthopedic rating and whether Dr. _ *Almaraz-Guzman* rating should apply.

DISCUSSION

The parties presumably choose an AME because of the AME's expertise and neutrality. (See *Power v. Workers' Comp. Appeals Bd.* (1986) 179 Cal.App.3d 775, 782 [51 Cal.Comp.Cases 114].) The AME's opinion should generally be followed unless good reason exists to find the AME's opinion unpersuasive. (*Ibid.*)

The overarching goal of rating permanent impairment is to achieve accuracy. (*Milpitas Unified School Dist. v. Workers' Comp. Appeals Bd.* (*Almaraz-Guzman*) (2010) 187 Cal.App.4th 808, 822 [75 Cal.Comp.Cases 837].) As the Sixth District stated in *Almaraz-Guzman*:

> Section 4660, subdivision (b)(1), recognizes the variety and unpredictability of medical situations by requiring incorporation of the descriptions, measurements, and corresponding percentages in the Guides for each impairment, not their mechanical application without regard to how accurately and completely they reflect the actual impairment sustained by the patient. (*Id.*)

To properly rate using *Almaraz-Guzman* the doctor is expected to: (1) provide a strict rating per the AMA Guides; (2) explain why the strict rating does not accurately reflect the applicant's disability; (3) provide an alternative rating using the four corners of the AMA Guides; and (4) explain why that alternative rating most accurately reflects applicant's level of disability. (*Id.* at 828-829.)

Here, the AME provided a strict rating of 30% whole person impairment and provided a detailed opinion as to why applicant's actual impairment was greater than 30%. The WCJ rejected Dr. Green's *Almaraz-Guzman* rating because Dr did not follow the strict rules of the AMA Guides in combining applicant's gait derangement with other impairments. However, per the holding in *Almaraz-Guzman*, the physician is not relegated ". . . to the role of taking a few objective measurements and then mechanically and uncritically assigning a WPI that is based on a rigid and standardized protocol and that is devoid of any clinical judgment." (*Id.* at p. 827.) We find that Dr opinion conforms to the holdings in *Almaraz-Guzman* and constitutes substantial medical evidence. Dr. _ analogized applicant's disability with the gait derangement table on page 529 of the AMA Guides. Dr. ultimately opined that applicant's disability was equivalent to the ambulation of someone with two canes

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or crutches and a long leg brace, which described applicant's impairment "right on the nose." Thus, using Table 17-5, Dr. (properly analogized applicant's disability via *Almaraz-Guzman* and applicant's accurate level of whole-person impairment is 60%.

The parties agreed at trial that Dr. *Almaraz-Guzman* analysis rates as follows:

17.05.06.99 - 60 - [2] 69 - 491H - 74 = 71%

The WCJ found that applicant's internal complaints rate to 36% permanent disability and no party has sought reconsideration of that finding. Thus, applicant's final permanent disability rating is 81% (71 CVC 36 = 81).[2] Applicant's disability rating does not require the assistance of a DEU rater in this case. (See *Blackledge v. Bank of America* (2010), 75 Cal.Comp.Cases 613, 624-625 (Appeals Board en banc).)

At trial, the parties deferred the determination of whether applicant's permanent disability indemnity rate should be increased pursuant to Labor Code section 4658(d) because the parties were unsure whether defendant employed at least fifty people at the time of applicant's injury. As this issue is deferred, we will defer the determination of applicant's attorney's fee pending a final determination on any adjustment to applicant's permanent disability indemnity rate. We will also defer the determination of applicant's attorney's fee so that applicant may obtain a calculation from the Disability Evaluation Unit of any commuted attorney's fee from applicant's lifetime pension and present such a commutation request to the WCJ for approval.

Accordingly, as our Decision After Reconsideration we affirm the December 14, 2015 F&A, except that we amend the F&A to indicate that applicant's level of permanent disability is 81% with a lifetime pension and defer the determination of applicant's attorney's fee pending resolution of the parties' Labor Code section 4658(d) dispute and pending a calculation of any commuted attorney's fee from applicant's lifetime pension awarded herein. (Findings of Fact Nos. 1 and 3, and Award (a) and (c).)

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[2] We will increase applicant's permanent disability indemnity rate from $230.00 to $270.00 in accordance with our finding of permanent disability.

For the foregoing reasons,

IT IS ORDERED as the Decision After Reconsideration of the Workers' Compensation Appeals Board, that Findings and Award issued on December 14, 2015, by the WCJ is **AFFIRMED**, except that Findings of Fact Nos. 1 and 3, and Award (a) and (c) are **AMENDED** as follows:

FINDINGS OF FACT

1. The injury caused permanent disability of 81%, equal to 609.25 weeks of indemnity payable at the rate of $270.00 per week in the total sum of $164,497.50 commencing the day following the last date temporary disability was paid and thereafter a lifetime pension in the amount of $160.85 per week, subject to Labor Code section 4659(c). The issue of whether the applicant is entitled to a 15% increase pursuant to Labor Code section 4658 is deferred.

3. The issue of applicant's attorney's fee is deferred pending resolution of the Labor Code section 4658 dispute and pending a calculation of the commutation of such fee from applicant's life pension and approval of said commutation by a workers' compensation judge.

AWARD

AWARD IS MADE in favor of Fernando Perez against Imperium Insurance Co., administered by Tristar Risk Management of:

(a) Permanent disability of 81%, equal to 609.25 weeks of indemnity payable at the rate of $270.00 per week in the total sum of $164,497.50, less attorney's fees, commencing the day following the last date temporary disability was paid and thereafter a lifetime pension in the amount of $160.85 per week, subject to Labor Code section 4659(c). The issue of whether the applicant is entitled to a 15% increase pursuant to Labor Code Section 4658 is deferred.

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(c) The issue of applicant's attorney's fee is deferred pending resolution of the Labor Code section 4658 dispute and pending a calculation of the commutation of such fee from applicant's life pension and approval of said commutation by a workers' compensation judge.

WORKERS' COMPENSATION APPEALS BOARD

MARGUERITE SWEENEY

I CONCUR,

KATHERINE ZALEWSKI

FRANK M. BRASS

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

MAY 20 2016

SERVICE MADE ON THE ABOVE DATE ON THE PERSONS LISTED BELOW AT THEIR ADDRESSES SHOWN ON THE CURRENT OFFICIAL ADDRESS RECORD.

CIPOLLA, CALABA, MARRONE, WOLLMAN, & SILVA
FERNANDO PEREZ
LAW OFFICE OF RENE H. PIMENTEL

EDL:mm

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