MARK STENHAMMER, Employee, v. FLEMING COS. and PACIFIC EMPS. INS. CO., Employer-Insurer/Appellants.

WORKERS' COMPENSATION COURT OF APPEALS
NOVEMBER 16, 2001

No. [REDACTED SSN]

HEADNOTES

PERMANENT PARTIAL DISABILITY; RULES CONSTRUED - Minn.R. 5223.0510, subp. 1. Where an employee's knee condition is not among those specifically listed in either the "exclusive" or "combinable" categories of Minn.R. 5223.0510, the condition is normally rated solely under the loss of function categories in Minn.R. 5223.0510, subp. 4. As a rating is thus provided for the employee's condition, a supplemental Weber rating was inappropriate.

Reversed.

Determined by Johnson, J., Pederson, J., and Wheeler, C.J.
Compensation Judge: Donald C. Erickson

OPINION

STEVEN D. WHEELER, Judge

The employer and insurer appeal from that portion of the employee's permanent partial disability rating which the compensation judge made pursuant to Minn. Stat. §176.105, subd. 1(c). We reverse.

BACKGROUND

The employee, Mark Stenhammer, sustained an admitted work injury to the right knee on July 27, 1998, when he twisted his knee while pulling a pallet in the course of his job with the employer as a delivery truck driver. (T. 16.)

The employee was treated the same day by Dr. Kenneth L. Kaylor, M.D., at the Department of Orthopedics at the Duluth Clinic, where he was diagnosed with an internal derangement of the right knee apparently related to delamination or dislodgement of a 1 x 2 centimeter osteochondral defect on the medial femoral condyle. Dr. Kaylor recommended that the employee undergo arthroscopic surgery to attempt to reattach the displaced fragment or, should that prove impossible, for osteochondral grafting to the lesion because of its large weight-bearing surface. (Exh. A: 7/28, 29/98.)

On July 30, 1998, the employee underwent diagnostic arthroscopy. A large 1 x 2 centimeter condylar lesion of an osteochondral nature was identified, with a large piece of the defect displaced in the notch of the knee. The employee's knee was otherwise normal. The

operating physician then pinned the osteochondral defect back into place using Orthosorb pins. On August 21, 1998, the employee resumed some weight-bearing with the right knee and began physical therapy treatment to restore range of motion and assist in the return to full weight-bearing. (Exh. A: 7/27/98 operative report; 8/21/98 physical therapy report.)

On September 3, 1998, the employee again returned to Dr. Kaylor, his treating orthopedic physician, who noted that the employee had been doing well, with decreasing knee pain and increasing range of motion. He recommended that the employee's weight-bearing be increased to near full over the next four weeks. On November 18, 1998, Dr. Kaylor noted that the employee's right knee range of motion was now 0 to 110 degrees with no pain. There was no crepitation or effusion. The employee reported that he had been able to resume skating and other recreational activity. Dr. Kaylor believed that the employee was now probably able to return to work. He prescribed a work hardening program. (Exh. A.)

On January 5, 1999, the employee returned to Dr. Kaylor, who recorded that the employee had returned to near full motion until a month previously when he "began to back slide just a bit" with "just some increasing pain and a little loss of motion." Range of motion was noted to be 5 to 115 degrees with no effusion. Dr. Kaylor suggested that the employee undergo a repeat arthroscopy. While the doctor did not think the employee's lesion had again become displaced, he thought the employee might have built up a slight cartilage ridge. The employee was seen by another orthopedic physician, Dr. David R. Webb, M.D., for a second opinion on the proposed repeat procedure. Dr. Webb concurred with Dr. Kaylor's recommendation. (Exh. A.)

The repeat arthroscopy was performed on January 26, 1999. The employee's osteochondral lesion was found to have healed well, but arthrofibrosis and scarring had formed which was preventing full extension. This was debrided during the arthroscopic procedure. (Exh. A.)

The employee returned to Dr. Kaylor on February 4, 1999. Dr. Kaylor recorded that the employee's extension at that time was excellent and that his surgical wounds were well-healed. Dr. Kaylor kept the employee off work until February 14, 1999, at which time he anticipated returning the employee to full duties. On March 23, 1999, the employee was seen by Dr. Webb, who noted that the arthroscopic procedure had confirmed solid bony union of the osteochondrosis lesion. However, the employee had lost some range of motion post-operatively. The employee was noted to have returned to work, although he reported some pain on walking and on ascending and descending stairs. Dr. Webb suggested that the employee undergo an interarticular corticosteroid injection to help prevent inflammation and further scar formation, as well as further physical therapy to regain knee motion. He noted that if these measures failed, the employee might need to undergo further surgical intervention in the future in the form of laser ablation, shaving or incising of scar tissue after any scarring had matured. (Exh. A.)

In a letter report dated June 23, 1999, the Dr. Kaylor and Dr. Webb opined that the employee's loss of range of motion was rated at four percent under Minn. R. 5223.0510, subp. 4A(2)(b). Noting that the employee's condition, which they described as "a severe osteochondral fracture," was not specifically addressed in the Minnesota workers' compensation disability schedules, they suggested that it might be rated at three percent by analogy to Minn. R. 5223.0510,

subp. 3B(2). Accordingly, they reasoned, the employee had a seven percent permanent partial disability as a result of the 1998 work injury.

The employee was seen at the walk-in clinic at St. Mary's Medical Center on July 11, 2000, complaining that he had experienced a gradual onset of right knee pain, stiffness and locking at home that morning. He was seen the next day by Dr. Kaylor, who noted that the employee had done very well following the repair of his osteochondral defect, "although he did lose a little bit of motion recovering from that." The employee told the doctor that he had been doing a lot of bicycling, including competing in a "very hard" mountain-bike race, and had some increasing knee pain. Dr. Kaylor thought that the employee had "just overdone it a little bit." He recommended that the employee resume taking anti-inflammatories and reduce his activities. On August 3, 2000, the employee was also seen by Dr. Webb, who diagnosed an activity related synovitis and effusion of the right knee, "most likely attributable to egregious overuse." Dr. Webb advised the employee that while bicycling could be beneficial to the employee, "carrying a bicycle on one's shoulder while running through mud up steep hills would [not] be expected to be equally benign/beneficial." He suggested that the employee limit his bicycling to "on-road or gentle terrain off-road fitness cycling." (Exh. 1.)

On August 31, 2000, Dr. Webb again saw the employee, who was very much improved and "perceives he has returned to his usual post-operative baseline." The employee had refrained from bicycling since his last visit. The employee reported that he was no longer having any episodes of the knee giving way, and that his knee pain and swelling had subsided. Measurement of his right knee range of motion showed a 15 degree flexion contracture with further flexion to 110 degrees. An MRI taken the previous day was reviewed, and read as showing that there was ossification separated from the main part of the femoral condyle by fluid density signal in part, but also an area of bony continuity. The employee was authorized to return to his usual and customary work. He was encouraged to use regular exercises involving less high impact and torsional stress on the knee.

The employee had no further medical care through February 19, 2001, on which date he was seen for an examination on behalf of the employer and insurer by Dr. Stephen E. Barron, M.D., an orthopedic surgeon. Dr. Barron recorded that as of that date the employee was back at work for the employer as a warehouseman with no restrictions driving a forklift and lifting up to 90 pounds. In Dr. Barron's opinion, the employee's recent loss of range of motion in the right knee was the result of "his outside physical activities," and the employee had sustained no permanent partial disability as a result of the 1998 work injury. (Exh. 2.)

A hearing was held before a compensation judge of the Office of Administrative Hearings on February 23, 2001, on the employee's claim for a seven percent permanent partial disability rating. The employer and insurer appeal from the compensation judge's award of a seven percent rating.

STANDARD OF REVIEW

Question of law. The issues on appeal in this matter involve the interpretation and application of case law to undisputed facts. While this court may not disturb a compensation

judge's findings of fact unless clearly erroneous and unsupported by substantial evidence in the record as a whole, Minn Stat. § 176.421, subd. 1(3) (1992), a decision which rests upon the application of the law and regulations issued under a statute to undisputed facts involves a question of law which this court may consider *de novo*.

DECISION

The compensation judge found that the employee has a 15 degree flexion contracture with further flexion limited to 110 degrees and that he accordingly was entitled to a four percent permanency rating pursuant to Minn. R. 5223.0510, subp. 4A(2)(b). (Findings 14, 15.) That rule provides a four percent rating where "extension is limited to between ten degrees and 20 degrees flexion, that is, there is a flexion contracture, and flexion is . . . limited to between 91 degrees and 120 degrees . . . ." The employer and insurer have not appealed from these findings.

In addition, the compensation judge found that the employee is entitled to an additional three percent permanent partial disability rating pursuant to Weber v. City of Inver Grove Heights, 461 N.W.2d 918, 43 W.C.D. 471 (Minn 1990). (Finding 17.) The compensation judge, in his memorandum, explained his reasoning: "the Compensation Judge agrees [with the opinion expressed by the employee's treating physicians] that the pinning of the osteochondral defect is at least as serious as the removal of 50% of the meniscus. In this case, the most recent MRI indicates that the pinned defect has only a small area of connection to the weight bearing surface of the medial femoral condyle. The analogy to a meniscal tear is most appropriate." (Mem. at 5.)

The employer and insurer appeal from the compensation judge's additional three percent rating under Weber. They argue that the employee's impairing condition is fully rated by the four percent rating for loss of motion under Minn. R. 5223.0510, subp. 4A(2)(b), and an additional rating under Weber is legally erroneous. We agree.

In Weber v. City of Inver Grove Heights, 461 N.W.2d 918, 43 W.C.D. 471 (Minn 1990), the Minnesota Supreme Court recognized that the permanency schedules could not cover every possible rateable disability. Accordingly, the court held that non-scheduled injuries resulting in functional impairment may not be excluded from coverage. Subsequently, in 1992, the legislature enacted Minn. Stat. § 176.105, subd. 1(c), which provides, "If an injury for which there is objective medical evidence is not rated by the permanent partial disability schedule, the unrated injury must be assigned and compensated for at the rating for the most similar condition that is rated." The statute allows thus a Weber rating for an injury not addressed in the disability schedules. However, a Weber rating is not intended to be used in cases where a rating for an employee's impairment is provided for in the schedules.

The disability schedule covering the employee's knee injury is Minn. R. 5223.0510. The first subpart of that rule sets out the specific instructions for its application:

> Subpart 1. General. For permanent partial impairment to the knee and lower leg, disability of the whole body is as provided in subparts 2 to 4. The percent of whole body disability under this part may not

> exceed the percent of whole body disability for amputation of the leg at the knee under part 5223.0550. Each mutually exclusive impairing condition must be rated separately and the ratings must be combined as described in part 5223.0300, subpart 3, item E.
>
> If an impairing condition is represented by a category designated as exclusive under subpart 2, it must be rated by that category only and that rating may not be combined with a rating under any other category of this part for that impairing condition.
>
> If an impairing condition is represented by a category designated as exclusive under subpart 3, it must be rated under that category and under the appropriate categories describing loss of function under subpart 4. The ratings obtained must be combined as described in part 5223.0300, subpart 3, item E.
>
> If an impairing condition is not represented by a category designated either exclusive or combinable, it must be rated only under the appropriate categories describing loss of function under subpart 4.

In their letter report dated June 23, 1999, the employee's physicians opined that the employee's loss of function was properly rated at four percent under Minn. R. 5223.0510, subp. 4A(2)(b). The rating under this part was accepted and awarded by the compensation judge. In the same report, the doctors noted that the employee's impairing condition, which they described as "a severe osteochondral fracture," is not among the specified conditions listed in subparts 2 and 3 of the knee schedule. They further suggested that the employee's specific unlisted *condition* of an osteochondral fracture is most functionally analogous to the condition rated at three percent in Minn. R. 5223.0510, subp. 3B(2). This subpart provides a three percent rating for a meniscectomy or excision of more than 50 percent of the semilunar cartilage in either knee. (Exh. A.) Accordingly, they reasoned, the employee is seven percent permanently and partially disabled from the effects of the work injury.

The employer and insurer argue that this amounts to rating the employee twice for one condition. The employee argues in response that Minn. R. 5223.0510, subp. 3B(2), covering a condition which the employee's doctors thought analogous to the employee's condition, is in a combinable category under the rule and that if the analogy is proper, then the rating under subpart 3B(2) is appropriately to be combined with four percent rating under subpart 4 for loss of function.

Here, however, subpart 1 of the rule expressly sets forth that "[i]f an impairing condition is not represented by a category designated either exclusive or combinable, it must be rated *only* under the appropriate categories describing loss of function under subpart 4." (Emphasis added.) This is precisely the case here. It is undisputed that the employee's condition is not listed under either the exclusive or combinable categories. As such, the rule specifically provides that the condition is to be rated only for loss of function under subpart 4. In essence, the rule can be seen as providing that knee conditions are generally rated on the basis of loss of function, as provided in subpart 4, with the exception of the "exclusive" categories in subpart 2, which receive

a condition-specific rating only. A further rating in addition to the functional loss rating of subpart 4 is added solely in the case of the specific named conditions of subpart 3. Thus, the rule simply rates the employee's knee condition on the basis of functional loss in the usual fashion. The employee's condition is not excepted from this rating method by inclusion in subpart 2, nor is it specifically listed in subpart 3 so as to warrant a supplemental rating. Since the rules do provide a specific rating for the employee's condition, application of the Weber doctrine is not permissible.

We therefore reverse the award of a supplemental three percent permanent partial disability under Weber.