ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GARWOOD, JEFFREY N
Employee/Petitioner

Case# **12WC004194**

LAKE LAND COLLEGE
Employer/Respondent

On 1/3/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0834 KANOSKI & ASSOCIATES
CHARLES N EDMISTON
129 S CONGRESS
RUSHVILLE, IL 62681

RUSIN MACIOROWDKI & FRIEDMAN LTD
TERRY SCHROEDER
2506 GALEN DR SUITE 104
CHAMPAIGN, IL 61821-7047

STATE OF ILLINOIS)
)SS.
COUNTY OF ADAMS)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jeffrey N. Garwood
Employee/Petitioner

v.

Lake Land College
Employer/Respondent

Case # 12 WC 4194

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Quincy**, on **November 8, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☐ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other

FINDINGS

On **September 12, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$40,520.00**; the average weekly wage was **$779.23**.

On the date of accident, Petitioner was **54** years of age, ***married*** with **no** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$1,595.33** for TTD, $ **0** for TPD, $ **0** for maintenance, and $ **0** for other benefits, for a total credit of $ **1,595.33**.

Respondent is entitled to a credit of $ **0** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$519.44/week** for **4 4/7** weeks, commencing **12/2/11** through **1/3/12**, as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$1,595.33** for temporary total disability benefits that have been paid.

As stipulated, Respondent shall pay reasonable and necessary medical services of **$113.00**, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$467.54/week** for **43** weeks, because the injuries sustained caused the **20%** loss of the **left leg**, as provided in Section 8(e) of the Act.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Nancy Lindsay
Signature of Arbitrator

12/28/12
Date

JAN 3 - 2013

The Arbitrator finds:

Petitioner testified he began working for Respondent on January 30, 2006 as a vocational computer instructor. Petitioner testified that in June of 2010 all business and computer vocational classes were done away with; however, he was later brought back as an adjunct instructor (part-time instructor). Petitioner testified that as an adjunct instructor, he was paid per class. Petitioner testified he came back and taught computer-related classes, including introductions to computers and various other application, software, and keyboarding classes. Petitioner testified he was paid a different amount for each class based upon the number of credit hours for each class. Petitioner confirmed that for the wage periods shown on the wage statement beginning during November of 2010 and ending in June of 2011 he was working as an adjunct instructor (RX 3).

Petitioner further testified that beginning July 1, 2011 he became the vocational correctional occupational instructor at Western Illinois Correctional Center in Mt. Sterling, Illinois. This position was a full-time salaried position. When asked how he came to change his employment status he explained that when he was let go in June of 2010 he was on a "two-year recall," and when a previous instructor retired he was offered the job. Petitioner testified the difference in the job was that full-time employment included additional employment benefits such as healthcare and life insurance.

At arbitration, the parties stipulated that when Petitioner went to work as a full-time employee on July 1, 2011, he entered into an employment contract with Respondent and his annual salary payable under that contract is $40,519.48.

Petitioner testified that on 9/12/11 he was still working for Respondent as a full-time vocational instructor at the Western Illinois Correctional Center in Mt. Sterling, Illinois.

Accident and causation were undisputed. Petitioner testified that on September 12, 2011, he was walking to his vehicle after work when he tripped and fell in an area where concrete was in the process of being ground down to allow wheel chair access, landing first on his left knee and then onto his left hand, elbow and side. Petitioner testified that stood up on his own but noticed pain in his left knee, left elbow, ribs and left wrist. He continued home and that evening continued to experience increasing pain and swelling in his left knee. Petitioner testified that he reported the fall the next morning to his immediate supervisor, Tom Theiss, and to Tom Kerkhoff, Respondent's Executive Dean of Corrections.

Records show that Petitioner first sought medical care from his family doctor, Dr. Jennifer Schroeder, on September 13, 2011. Petitioner reported a consistent history of the accident and complained of pain in his left knee, as well as his left rib area and left elbow. (Pet. Ex. 3, p. 94) Petitioner was walking stiff legged and reported a sensation as if his leg would give way. He acknowledged having undergone a left knee arthroscopy previously but denied any further knee problems until his recent work accident. (Pet.

Ex. 3, p. 94)

On physical examination, Dr. Schroeder noted tenderness and abnormal range of motion of the left elbow and that Petitioner was walking stiff and not bearing weight on his left knee. She noted that x-rays of the left elbow and knee did not demonstrate any bony injury. (Pet. Ex. 3, p. 95, 99-100) Dr. Schroeder recommended the use of ice and heat, NSAIDS, range of motion exercise and a left knee immobilizer for comfort. (Pet. Ex. 3, p. 96) Petitioner returned to Dr. Schroeder on September 23, 2011, reporting continued concern regarding left knee pain and requesting a referral to Dr. Ronald Wheeler, an orthopedic surgeon. Petitioner also reported pain in his left chest wall while deep breathing or rubbing the chest wall and requested that it be x-rayed. (Pet. Ex. 3, p. 91) A rib and chest x-ray was taken but did not show any fracture. (Pet. Ex. 3, pp. 93, 98) Noting that Petitioner's left knee had not improved, Dr. Schroeder referred Petitioner to Dr. Ronald Wheeler. Petitioner's left elbow was not causing any problems.(Pet. Ex. 3, p. 93)

Petitioner initially saw Dr. Wheeler on October 3, 2011, reporting an onset of left knee pain after a fall at work about three weeks earlier with persistent discomfort thereafter. (Pet. Ex. 1, p. 16) On examination, Dr. Wheeler noted some swelling in the knee and vague tenderness and diagnosed pes anserine bursitis. He recommended adjustment of activities and consideration of therapy. (Pet. Ex. 1, p. 16)

Petitioner returned to see Dr. Wheeler a week later on October 10, 2011, reporting continued discomfort. (Pet. Ex. 1, p. 15)

Petitioner underwent an MRI of his left knee on October 10, 2011 at Blessing Hospital. The report of Dr. Stanton indicated mild chondromalacia of the patellofemoral compartment and mild thinning of the articular cartilage of the medial and lateral tibiofemoral compartments. Petitioner's medial meniscus appeared normal without tear. There was an oblique tear involving the posterior horn of the lateral meniscus with truncation of the inner third zone body of the lateral meniscus. It was Dr. Stanton's impression there was mild chondromalacia and arthritis involving the patellofemoral compartment and a complete tear of the posterior horn of the lateral meniscus. (RX 2,

Dr. Wheeler recommended therapy but noted that surgery might be required if Petitioner did not improve. (Pet. Ex. 1, p. 15) Records from Quincy Medical Group show that Petitioner began therapy on October 13, 2011, reporting a consistent history of accident and worsening pain in his left knee since that time. (Pet. Ex. 3, p. 86-87) Petitioner attended 8 sessions of therapy through October 27, 2011. (Pet. Ex. 3, pp. 76 – 85) At the final session, Petitioner continued to report pain of a level of 6-8/10 in all positions most of the time. Petitioner did not feel that he had experienced any improvement with therapy and showed no objective improvement in range of motion or strength. Petitioner reported difficulty with functional tasks as well as work tasks requiring prolonged standing and walking which would increase his left knee pain. The therapist opined that further functional improvement would be limited by worsening symptoms. (Pet. Ex. 3, p. 76)

Petitioner returned to Dr. Wheeler on October 31, 2011, reporting increasing pain in his left knee that was aggravated by activity. (Pet. Ex. 1, p. 14) On examination, Dr. Wheeler noted diffuse tenderness, positive McMurray testing and tenderness both medially and laterally. Dr. Wheeler therefore recommended surgery on the knee after clearance by Dr. Schroeder. (Pet. Ex. 1, p. 14)

Petitioner proceeded with arthroscopic surgery on December 2, 2011, at Blessing Hospital. (Pet. Ex. 1, pp. 11-13, Pet. Ex. 2, pp. 17-18) In the course of arthroscopic surgery, Dr. Wheeler confirmed his pre-operative diagnosis of medial and lateral meniscus tears and debrided those tears. He also found Class II chondromalacia of the medial femoral condyle and the medial tibial plateau and chondroplasty was performed. Some chondromalacia of the lateral tibial plateau was also noted and chondroplasty was performed. Synovectomy was also performed and a synovial plica was removed. (Pet. Ex. 2, pp. 17-18) Petitioner followed up with Dr. Wheeler on December 8, 2011, when sutures were removed and therapy was ordered. (Pet. Ex. 1, p. 10)

Records show that Petitioner began post-operative therapy on December 12, 2011, and attended 30 sessions through February 6, 2012. (Pet. Ex. 3, pp. 28-59) Petitioner continued to follow up with Dr. Wheeler on December 29, 2011, January 26, 2012 and February 6, 2012. (Pet. Ex. 1, pp. 7-9) At these visits, Dr. Wheeler noted some ongoing soreness, though improved, and some improvement in strength, though he noted a continued imbalance in the quads and hamstrings. (Pet. Ex. 1, pp. 8-9) In her last physical therapy note, Petitioner's therapist noted that the focus of treatment had been on normalizing Petitioner's left knee range of motion and progressive strengthening as tolerated. Petitioner's response had been good with only minimal complaints of pain with prolonged weightbearing activities. All goals were achieved and Petitioner was discharged to an established home exercise program per Dr. Wheeler's discretion. (Pet. Ex. 3, p. 28)

Petitioner returned for a final appointment on May 7, 2012, reporting that he was doing fairly well but was continuing to experience some soreness. (Pet. Ex. 1, p. 5) Dr. Wheeler noted "improved" range of motion and good strength in Petitioner's knee. There was no tenderness, effusion, or swelling noted. There was balance between Petitioner's quads and hamstrings. Dr. Wheeler released Petitioner from care finding him to be at maximum medical improvement. Dr. Wheeler did not anticipate any permanent disability. (Pet. Ex. 1, p. 5)

Petitioner was examined by Dr. Joseph T. Monaco at Respondent's request on August 3, 2012, in Bloomington, Illinois (Resp. Ex. 1) Dr. Monaco provided an impairment rating of Petitioner's injury under the 6th Addition of the AMA Guides. Dr. Monaco reviewed Petitioner's medical records, met with Petitioner and took a history and summary of his complaints. He also performed a physical examination. At the time of the exam, Petitioner reported he liked to walk for exercise and was doing so for about thirty minutes two to three times per week. Petitioner also reported taking two Aleve tablets about three times per week for arthritic knee pain. Petitioner provided the doctor with a typed report regarding his ongoing complaints. Petitioner reported pain from six inches above the knee to six inches below the knee. He described this pain as mild to moderate most of the time but getting as bad as 5/10 on occasion. Petitioner also reported that his knee would stiffen up if he sat for more than twenty minutes at a time with his knee bent, that he felt weak when arising from a sitting position or turning to his left, and occasionally he loses his balance while walking down a hallway. Petitioner also reported increasing pain

and stiffness when driving a car, walking in a store or on any concrete surface for a long period of time. Petitioner noted that his knee would also hurt when lying in bed at the end of the day. Petitioner explained that he could help lessen the pain and stiffness by elevating his leg during the day.

In his report Dr. Monaco noted that Petitioner walked with a slight left antalgic gait. Petitioner had seven degrees of valgus in both knees when supine and standing. Petitioner had full extension with 135 degrees of flexion, equal to the right knee. There was good straight leg raise and no extensor lag. There was trace patellofemoral crepitus bilaterally. There was no patellofemoral pain with ballottement of the left knee. Petitioner's left knee was stable to varus and valgus stress and anterior and posterior drawer sign. Lachman's test and Pivot-shift test were negative. McMurray testing revealed mild discomfort. He noted that Petitioner's left knee was slightly larger than the right (44 cm vs 43.2 or 43.5 cm) and that there was some discomfort with McMurray's testing, though there was no pop or click. Deep tendon reflexes were 2+ and equal bilaterally at both the knees and ankles. Motor function was graded 5/5 in all muscles tested in the lower extremities. Homan's sign was negative. Petitioner exhibited good dorsalis pedis pulses. Dr. Monaco also reviewed Petitioner's diagnostic studies. He concurred with Dr. Wheeler's earlier diagnoses and believed petitioner had reached maximum medical improvement as a result of his work accident. Dr. Monaco only believed the tears were due to the accident; Petitioner's chondromalacia pre-dated the accident and was not related. Based upon the AMA Guides (Sixth Edition), Petitioner's impairment was rated at 3% whole person impairment or 8% loss of the lower extremity. (RX 1 and RX 2, exhibit 2)

Dr. Monaco's deposition was taken on November 1, 2012. Dr. Monaco, a board certified orthopedic surgeon, testified consistent with his report.

Dr. Monaco testified that he diagnosed Petitioner with tears of the medial and lateral meniscus of the left knee and chondromalacia of the patellofemoral joint of the left knee. He further opined that the meniscus tears were causally related to Petitioner's fall but not the chondromalacia. (Resp. Ex. 2, pp. 20-21) In reaching an impairment rating, Dr. Monaco testified that he did not consider the chondromalacia to be related to the work injury but he did consider the medial and lateral meniscus tears to be related. (Resp. Ex. 2, p. 29). Accordingly, he looked to Table 16-3 of the AMA Guides, and used the Diagnostic Criteria (Key Factor) to be "Meniscal Injury" and assigned the injury to Class 1 as a "Partial (medial and lateral)". (Resp. Ex. 2, pp. 29-30) He noted that the Class assignment is based upon a tear of the meniscus and that the rating is not affected by whether it was treated surgically or not. (Resp. Ex. 2, p. 30) He testified that under the Guides he would initially assign the injury to Class C within that class, providing a default impairment of 10% of the lower extremity subject to grade modifiers and adjustment grids. (Resp. Ex. 2, p. 31) Dr. Monaco testified that generally there are three categories of modifiers – functional history, physical examination and diagnostic studies. (Resp. Ex. 2, p. 24) In considering Functional History Adjustment, Dr. Monaco looked to Table 16-6 of the Guides which shows five levels of Grade Modifier ranging from "no problem" to "very severe problem". Under the class definition of "Gait Derangement", Dr. Monaco assigned a Grade Modifier of 1 (Mild Problem) as Petitioner did have a limp. This Adjustment table also refers to the "AAOS Lower Limb Instrument", though Dr. Monaco stated that he used the "PDQ" (pain disability questionnaire) assessment tool instead as he felt it was a more reliable tool. He acknowledged that the Guides recommend use of the AAOS Lower Limb Instrument (outcome measure). (Resp. Ex. 2, p. 32, 27, 46-48)

On cross-examination, Dr. Monaco admitted that Petitioner's score on the PDQ would be classified as a "moderate" rather than "mild" (as indicated in his report) and a Grade Modifier "2" rather than the Grade Modifier "1" that he had assigned, but testified that he would reject that higher Modifier because it seemed inconsistent with the Gait Derangement modifier and because the Guides provide that if the Functional History modifier deviates two or more grades from any other modifier it should be considered unreliable and should not be used. (Resp. Ex. 2, pp. 49-52) Dr. Monaco next considered the Physical Examination Adjustment found in Table 16-7 of the Guides and concluded that all of Petitioner's physical findings were under Grade Modifier 0. Finally, he looked to the Clinical Studies Adjustment grade modifiers in Table 16-8 of the Guides, but did not use this table as he felt that the clinical studies were used to define the diagnosis and, as he interpreted the Guides, should not then be used to make a further adjustment. (Resp. Ex. 2, p. 35) However, he testified that if he did consider the fact that the clinical studies confirmed the diagnosis, the result would not change the impairment rating. (Resp. Ex. 2, p. 35-37) Dr. Monaco then testified that under the Guides, he would then subtract each grade modifier from the class of diagnosis resulting here in a net adjustment of minus 1. (Resp. Ex. 2, pp. 38-39) He testified that this would reduce the impairment rating to Class B within Class 1 in Table 16-3 of the Guides, resulting in a final impairment rating of 8% of the lower extremity. (Resp. Ex. 2, p. 39)

On further cross-examination, Dr. Monaco acknowledged that "impairment" is not synonymous with "disability" and that other factors than "impairment" must be considered to determine "disability". (Resp. Ex. 2, pp. 42-43) Dr. Monaco also acknowledged that the Guides note a difference between "legal" causation (judged at more than 50% probable) and "medical" causation (judged at 95% probable) and testified that in concluding that the chondromalacia was not related to the injury he was applying "medical" causation. (Resp. Ex. 2, p. 52) However, the testified that even if the chondromalacia were considered related, that fact would not affect the impairment rating because the Guides allow consideration of only one diagnosis in each part of the body. (Resp. Ex. 2, p. 53) Therefore, if an injury results in more than one diagnosis in one part of the body, the impairments related to each diagnosis are not added together and only the more serious diagnosis is taken into account. (Resp. Ex. 2, p. 53)

Dr. Monaco testified that he devotes 20 percent of his practice to performing IME examinations. (Resp. Ex. 2, p. 6) Dr. Monaco testified that he had performed 10 evaluations for impairment ratings since May or June 2012. (Resp. Ex. 2, p. 62-63) He testified that he performed his examination in Bloomington, Illinois (though his office is in Tinley Park, Illinois) through a vendor who "market[s] themselves to insurance companies for these kind[s] of services." (Resp. Ex. 2, p. 63) He testified that he travels to Bloomington about once a month for this vendor and sees four to six people over the course of a day. (Resp. Ex. 2, p. 63) Dr. Monaco further testified that all of the impairment ratings that he has done have been at the request of insurance companies or defense attorneys. (Resp. Ex. 2, p. 64-65) He testified that he also performs IMEs independent of impairment ratings and performs 10 to 12 per month and 95 percent of these are for insurance companies and defense firms. (Resp. Ex. 2, p. 65) Dr. Monaco testified that he does not do an impairment rating without doing a full medical examination, and that he charges $1,250.00 for the medical examination and an additional $250 for the impairment rating. He testified that he charges $650 per hour, with a minimum of two hours, for depositions and $325 for preparation time if there is a lot of preparation time. (Resp. Ex. 2)

At arbitration Petitioner testified that he is 54 years of age and remains employed as an instructor of Construction Occupations at the prison. Petitioner denied any problems with his left knee before his undisputed accident on September 12, 2011. Petitioner acknowledged that he is able to perform his present job duties but that he sits down whenever he can. He prefers to sit, rather than to stand, when teaching. Petitioner also testified that he occasionally puts his leg up on a desk and stretches it but doesn't do so when the students are around. Petitioner takes Aleve when the pain is "real bad." Petitioner also testified that he continues to experience the problems with his knee that he described in detail to Dr. Monaco. Petitioner further testified that he and his wife used to walk and that he is diabetic and they walk for exercise. He testified they walk less now because his knee will hurt and he just doesn't feel like it. Petitioner testified he and his wife used to walk four or five times per week. Petitioner is also diabetic.

Petitioner testified he is currently being paid under the collective bargaining agreement that was entered into evidence as Respondent's Exhibit 4 and that he has no reason to believe his employment with Respondent is in jeopardy or his salary might be reduced because of the injury. He further testified neither his work hours nor the number of classes he teaches have been reduced as a result of the injury.

Petitioner testified the payment of the $40,519.48 of his employment contract was paid out over 26 pay periods from July 1st forward.

Respondent called one witness, Mr. Ronald C. Frillmann, who is the associate dean at the Lake Land facility at Western Illinois Correctional Center.

Mr. Frillmann is Petitioner's direct supervisor. He testified he and Petitioner had been friends for some years. Mr. Frillmann identified the collective bargaining agreement that was entered into evidence as Respondent's Exhibit 4 and confirmed that it was signed 7/01/10 and involves a three-year contract expiring in June of 2014.

Mr. Frillmann testified that he has no knowledge of any complaints regarding Petitioner's performance of his job since he has been returned to work. He testified there are procedures included in the collective bargaining agreement for discipline and/or dismissal of employees. He further testified he has no reason as Petitioner's supervisor to think there is any reason that his position with Respondent might be terminated for any reason.

The Arbitrator concludes:

1. **Earnings.**

   Section 10 of the Illinois Worker's Compensation Act defines "average weekly wage" as the earnings of the employee "in the employment in which he was working at the time of the injury." The Arbitrator concludes that at the time of his undisputed accident Petitioner was working as a full-time instructor for Respondent at the stipulated salary of $40,520 per year, producing an average weekly wage of $779.23. Petitioner experienced a change in his employment status when

he was hired as a full-time instructor and, therefore, only the earnings during that employment should be considered. The Arbitrator finds significant that the manner of computing his earnings changed from being paid by the class to becoming salaried, and that he became eligible for employee benefits after becoming a full-time instructor. See, Walter vs. Jacksonville Developmental Center 99 IIC 1031 and Rios vs. United Parcel Service 01 IIC 860.

2. Nature and Extent of the Injury.

Petitioner suffered tears to the lateral meniscus and medial meniscus of his left knee. He was also diagnosed with synovitis and patellofemoral chondromalacia of the left knee. Petitioner's left elbow and chest complaints appear to have resolved.

The injuries to Petitioner's left knee were addressed in a timely manner and he appears to have had a good recovery as indicated in the medical treatment notes. Petitioner underwent one arthroscopic procedure from which he had a satisfactory recovery. Petitioner was last seen for his knee by Dr. Wheeler on May 7, 2012. At that time the doctor indicated that Petitioner had improvement in his range of motion, good strength and balance between the quads and hamstrings. There was no effusion, swelling, or tenderness. At that time the doctor's plans and recommendations indicate Petitioner should increase his activities. No permanent disability was anticipated." Petitioner was told to recheck as needed. The Arbitrator further notes Petitioner was seen again on May 31, 2012 and, according to his testimony at arbitration, had seen Dr. Wheeler several other times for treatment of a thumb injury. However, there was no additional medical documentation that would indicate Petitioner had seen Dr. Wheeler or any other medical professionals for complaints of his knee after the May 7, 2012 release date.

Pursuant to Section 8.1b of the Act, the following criteria and factors must be considered in assessing permanent partial disability:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion, loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:

(i) the reported level of impairment as assessed pursuant to the current edition of the AMA "Guides to the Evaluation of Permanent Impairment";
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records.

The Act provides that no single enumerated factor shall be the sole determinant of disability. With respect to these factors, the Arbitrator notes:

1. The reported level of impairment under the AMA Guides. With regard to the AMA impairment rating, the Arbitrator takes into account Dr. Monaco's rating of 8% impairment of a lower extremity. In determining that rating, Dr. Monaco acknowledged that he did not use the recommended "outcome measure" for lower extremity ratings and that he did not take into account any aggravation that Petitioner suffered to his pre-existing chondromalacia because he did not believe that condition was related to petitioner's accident. While Petitioner testified that Dr. Norregaard has told him he needs surgery that recommendation is not reflected in the doctor's office records. There is no August 31, 2012 office note setting forth any proposed treatment plan by Dr. Norregaard. (PX 6). The Arbitrator also notes that there were some other discrepancies between Petitioner's testimony and the medical records themselves with regard to Petitioner's care and treatment (for ex., physical therapy) While these discrepancies are not enough to undermine causation they create some "pause" regarding treatment recommendations and prospective care. Furthermore, looking at the "outcome measure" Dr. Monaco did utilize (albeit it was not the recommended one) Dr. Monaco agreed on cross-examination that Petitioner's score on the "PDQ" would place Petitioner in a "moderate" impairment category rather than a "mild" one as he indicated in his report.

As acknowledged by Dr. Monaco, "impairment" is not synonymous with "disability" and other factors must be considered to assess "disability." In assessing the weight to be assigned to the impairment rating as compared to the other enumerated factors, the Arbitrator notes these concessions by Dr. Monaco.

2. The occupation of the injured employee. Petitioner's current occupation is that of an instructor in Construction Occupations, a position he has held for a relatively short period of time. Previously, he was employed as a part-time instructor teaching computer-related courses. Prior to that Petitioner was employed as a dispatcher and he also had work experience in construction. This testimony was not rebutted by Respondent.

3. The age of the employee at the time of the injury. At the time of his accident, Petitioner was 53 years old. No evidence was presented as to how Petitioner's age might affect his disability.

4. The employee's future earning capacity. Petitioner testified that his current employer allows him to accommodate his ongoing problems in that he can sit and stand as desired and strenuous activity is not required. However, if he were to lose his current employment and be required to seek alternative employment, there could be issues with accommodation.

Petitioner's past skills are varied, however, which would theoretically present greater employment opportunities. No evidence was presented to show a diminishment in Petitioner's future earning capacity as a result of his injury.

5. Evidence of disability corroborated by the treating medical records. Petitioner testified credibly to ongoing problems with pain and stiffness in his injured left knee that limit his ability to stand and walk. These complaints are corroborated by medical records showing that he suffered medial and lateral meniscus tears as well as an aggravation of pre-existing chondromalacia, that these conditions were serious enough to require arthroscopic surgery as described above, and by references in Dr. Wheeler's treatment notes that Petitioner has suffered from persistent soreness through his last visit and had demonstrated muscle imbalance during his recovery. Though not a treating record, Petitioner's complaints are also objectively corroborated by Dr. Monaco's findings that Petitioner walked with a limp at the time of his evaluation and had swelling in his left knee, as well as the finding of "moderate" functional impairment on his "PDQ" evaluation.

Petitioner was off work for 4 4/7 weeks. He then resumed regular duty. Petitioner was released by Dr. Wheeler on May 7, 2012. At that time Dr. Wheeler anticipated no permanent disability.

After considering all of these factors, the Arbitrator concludes that Petitioner has sustained permanent partial disability of 20% loss of use of the left leg.

3. TTD Underpayment.

The period of temporary total disability was undisputed (December 2, 2011 through January 3, 2012); however, Petitioner claims an underpayment of TTD benefits based upon the average weekly wage/earnings dispute. The parties further stipulated that Petitioner was paid $1595.33 in TTD benefits. Based upon the Arbitrator's earnings determination there has been an underpayment of TTD benefits and Respondent shall pay same.

****

TABLE 16-3 Knee Regional Grid – Lower Extremity Impairments

Knee Regional Grid (LEI)

DIAGNOSTIC CRITERIA (KEY FACTOR)	CLASS 0	CLASS 1	CLASS 2	CLASS 3	CLASS 4
CLASS DEFINITIONS	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem
IMPAIRMENT RANGES	0% LE	1%–13% LE	14%–25% LE	26%–49% LE	50%–100% LE
GRADE		A B C D E	A B C D E	A B C D E	A B C D E
SOFT TISSUE					
Bursitis, plica, h/o contusion, or other soft tissue lesion	0 No significant objective abnormal findings on examination or radiographic studies at MMI	0 1 1 2 2 Significant consistent palpatory findings and/or radiographic findings 1 2 2 2 3 Consistent motion deficits			
MUSCLE / TENDON		**Do not use with PE range of motion**			
Strain; tendonitis; or ruptured tendon	0 No significant objective abnormal findings of muscle or tendon injury at MMI	1 2 2 2 3 Palpatory findings and/or radiographic findings 5 6 7 8 9 Mild motion deficits 7 8 10 12 13 Moderate motion deficits and/or significant weakness			
Myositis ossificans (hypertrophic ossification)		0 1 1 2 2 Small 3 4 5 6 7 Large, palpable mass with decreased knee motion			
LIGAMENT / BONE / JOINT		**Do not use with PE stability**	**Do not use with PE stability**		
Meniscal injury		1 2 2 2 3 Partial (medial or lateral) meniscectomy, meniscal tear, or meniscal repair 5 6 7 8 9 Total meniscectomy (medial or lateral) or meniscal transplant (allograft) 7 8 10 12 13 Partial (medial and lateral)	19 20 22 24 25 Total (medial and lateral)		

(continued)