STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TIMOTHY BUSH,

Petitioner,

vs.

NO: 08 WC 44502
12 WC 21131

THYSSEN KRUPP ELEVATOR CORP.,

16IWCC0233

Respondent.

DECISION AND OPINION ON REMAND

This matter had previously been heard and the Decision of the Arbitrator had been filed August 9, 2013. Petitioner timely filed a review. The Commission affirmed the Decision of the Arbitrator, finding that there was no abuse of discretion by the Arbitrator in granting Respondent's Motion to Set Aside the April 16, 2013 Order. On appeal the Circuit Court remanded the case to the Commission with instructions to clarify the misrepresentation engaged in by Petitioner's Counsel, to provide a basis for disallowing any future Motion to Substitute and to set forth how the Motion to Substitute came before the Arbitrator on April 16, 2013.

FACTUAL BACKGROUND

Commission records reflect that Petitioner's cases were set for April 19, 2013 at the April status call. However, three days prior, on April 16, 2013, Petitioner's Counsel in the 12 WC 21131 case presented to the Arbitrator, unaccompanied by Respondent's Counsel. On that date, Petitioner's Counsel presented the Motion to Substitute Petitioner. Petitioner's Counsel sought to substitute the deceased injured worker with his widow. The motion was granted by the Arbitrator on that date. The Arbitrator made note on the Order that Petitioner's Counsel in 12 WC 21131 represented that there was no objection by either other attorney to his Motion.

On April 19, 2013 Respondent's Counsel appeared with Petitioner's Counsel in the 08 WC 44502 case. Petitioner's Counsel in the 12 WC 21131 case was not present. Respondent's Counsel indicated that he did, in fact, object to the Motion to Substitute.

On April 25, 2013 Respondent filed a Motion to Set Aside the April 16, 2013 Order. Eventually a hearing date of July 8, 2013 was noticed, and the matter was set for trial on July 25,

16IWCC0233

2013, along with Respondent's Motion to Set Aside. On that date the Arbitrator denied Petitioner's request to proceed to trial. On August 8, 2013 the Arbitrator deliberated and subsequently granted Respondent's Motion to Set Aside the Order of April 16, 2013.

DECISION ON REMAND

In keeping with the Circuit Court instructions, the Commission finds that Petitioner's Counsel in the 12 WC 21131 case misrepresented to the Arbitrator that Respondent's Counsel had no objections to Petitioner's Counsel's Motion to Substitute Petitioner. This was noted by the Arbitrator on the Order granting said Motion. When Respondent's Counsel learned of the granting of said motion three days later, he immediately expressed that he in fact did object to the motion. The apparent inappropriateness of Petitioner's Counsel actions is bolstered by the fact that the Order itself was granted on April 16, 2013; yet there is no evidence in Commission records that either case was set to be heard by the Arbitrator on that date. In fact, the *Notice of Motion and Order* lists no scheduled date for hearing on Petitioner's motion.

Next, the Commission carefully points out that neither the Commission, nor the Arbitrator, ruled to disallow any future Motion to Substitute filed by Petitioner's Counsel. The only effect of the Order filed August 9, 2013 was to strike the Motion to Substitute that was granted on April 16, 2013. This ruling does not preclude any subsequent, and properly noticed, motions seeking substitution of Petitioner.

Lastly, the Commission is unclear how the Motion to Substitute came before the Arbitrator on April 16, 2013. As stated above, Commission records indicate that there were no hearings pertaining to Petitioner's claims that were set to be heard on that date. That being said, the Commission can only wonder if Petitioner's Counsel unilaterally chose April 16, 2013 to seek out the Arbitrator in an attempt to receive a favorable outcome on its' motion, while inaccurately representing Respondent's position on the motion.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Order of the Arbitrator filed August 9, 2013 is hereby affirmed and adopted.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 3 1 2016
O: 2/11/16
DLG/wde
45

David L. Gore

Mario Basurto

Stephen Mathis

STATE OF ILLINOIS)
) SS.
COUNTY OF ST. CLAIR)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cynthia Lynn Rudelic,

Petitioner,

vs. NO: 09 WC 04986

Schnuck Markets INC.,

16IWCC0231

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical, temporary total disability, permanent disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner is entitled to a permanent disability of 25% of a person as a whole as a result of her injuries on September 4, 2008.

At a hearing on May 9, 2010, the Arbitrator found that the Petitioner's condition of ill-being in regard to her right shoulder was causally related to a repetitive trauma on or about September 24, 2008. The Arbitrator ordered the Respondent to pay for the surgery to the right shoulder, which was recommended by Dr. Yagamuchi.

This matter came to a hearing on permanency on November 24, 2014. Since the first hearing, Petitioner underwent an arthroscopic surgery on her right shoulder with Dr. Yagamuchi. After that surgery, she still had complaints to her neck area. Yagamuchi referred the Petitioner to Dr. Labore who ordered a cervical MRI and cervical blocks. Petitioner was then referred to Dr. Riew. On August 17, 2011, he performed surgery consisting of an anterior cervical corpectomy of C5, removal of anterior cervical plate, placement of new cervical plate at C4-6. He also performed a cervical fusion at C4-5 and a cervical fusion at C5-6. This surgery was to repair a non-union of the fusion surgery Petitioner had in 2005. (Petitioner Exhibit 3)

After the shoulder surgery Dr. Yagamuchi, in a letter dated February 21, 2011, advised that her thickness tear was not as large as suggested on the pre-op imaging and "in fact, did not require treatment." He concluded that Petitioner might have a cervical or nerve problem in her

neck contributing to her symptoms. (Petitioner Exhibit 3) He had a high suspicion that she has a neurogenic source of pain probably from her neck. Dr. Riew agreed that the pain in Petitioner's shoulder was probably a neck problem and misdiagnosed as a shoulder problem. (Petitioner Exhibit 13 Pgs. 34-38)

Petitioner returned to her regular job on December 5, 2011. (Transcript Pgs. 33-35)

The Commission therefore awards the Petitioner 25% loss of use of the person as a whole for her injuries sustained due to repetitive trauma on or about September 4, 2008.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $343.72 per week for a period of 47 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $309.35 per week for a period of 125 weeks, as provided in §8(d) 2 of the Act, for the reason that the injuries sustained caused the loss of use of the person as a whole to the extent of 25%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $129,243.44 for medical expenses under §8(a) and 8-2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 3 1 2016

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

HSF
O: 2/10/16
049

[illegible]

[illegible]

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RUDELIC, CYNTHIA LYNN
Employee/Petitioner

Case# **09WC004986**

SCHNUCK MARKETS INC
Employer/Respondent

16IWCC0231

On 2/25/2015, 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 0.06% 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:

0000 RICE LAW OFFICES LTD
PHIL RICE
110 E LINCOLN ST
BELLEVILLE, IL 62220

0180 EVANS & DIXON LLC
MARILYN C PHILLIPS ESQ
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

16IWCC0231

STATE OF ILLINOIS)
)SS.
COUNTY OF St. Clair)

☐ 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

Case # 09 WC 04986

Consolidated cases: None

Cynthia Lynn Rudelic
Employee/Petitioner

v.

Schnuck Markets, Inc.
Employer/Respondent

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 **Michael Nowak**, Arbitrator of the Commission, in the city of **Belleville**, on **11/24/14**. 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 _____

16IWCC0231

FINDINGS

On **9/24/08**, 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 $**26,810.26**; the average weekly wage was $**515.58**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **0** 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 $5,733.42 for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $5,733.42.

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 $343.72/week for 47 weeks, commencing 1/10/11 through 12/4/11, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $5,733.42 for TTD.

Respondent shall pay reasonable and necessary medical services of $129,243.44, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $309.35/week for 50 weeks, because the injuries sustained caused the 10 % loss of the person as a whole relative to the shoulder injury, and $309.35/week for 175 weeks, because the injuries sustained caused the 35 % loss of the person as a whole relative to the cervical spine injury as provided in Section 8(d)2 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.

Signature of Arbitrator

2/14/15
Date

ICArbDec p. 2

FEB 25 2015

16IWCC0231

BACKGROUND

On September 24, 2008 Petitioner was 46 years of age. She was employed by Respondent as a stocker. Her duties required her to stock items of different weights and sizes onto shelves above and below shoulder level for 32 to 38 hours a week. While stocking shelves she primarily used her right upper extremity. This required repetitive use of her right upper extremity. Petitioner is right handed. She testified that Respondent expected stockers to be able to go through approximately forty (40) cases per hour with each case containing, on the average, twelve (12) to twenty-four (24) items.

In May 2008 Petitioner developed right shoulder and upper arm pain. She initially saw her family doctor, Dr. McDermott on June 18, 2008. She complained of right shoulder and arm pain for two (2) weeks. (PX 1, p. 6) Dr. McDermott referred her to Dr. Donald Weimer, an orthopedic surgeon. When she saw Dr. Weimer on July 29, 2008 he noted "Right shoulder pain since June.... Complaint of some lateral deltoid pain with some radiation up into her neck – does hurt when she lifts or holds anything." (PX 2, p. 5) Dr. Weimer recommended that Petitioner undergo right shoulder arthroscopy with decompression and rotator cuff repair. (PX 2, p. 14) Dr. McDermott then referred Petitioner to Dr. Ken Yamaguchi at Barnes Hospital. (PX12, p. 6) Petitioner began treating with Dr. Yamaguchi on September 24, 2008. Dr. Yamaguchi's diagnosis, as of August 26, 2009, was "severe chronic rotator cuff tendinitis...." (PX 12, pp. 14-15) When conservative measures failed to alleviate the symptoms, Dr. Yamaguchi recommended arthroscopic surgery on her shoulder. (PX 12, pp. 16-18) Respondent refused to authorize the surgery. A 19(b) Petition was filed and a hearing was conducted on May 19, 2010. The decision issued on June 2, 2010 held that Petitioner's condition of ill-being is causally related to the accident and ordered Respondent to authorize the right shoulder surgery recommended by Dr. Yamaguchi. (PX 17) No appeal was taken and that decision became final.

FINDINGS OF FACT

Dr. Yamaguchi performed "Right rotator cuff debridement, subacromial decompression, extensive debridement of the glenohumeral joint, and acromioplasty" on January 10, 2011. (PX 3, pp. 40-41) His preoperative and postoperative diagnosis was Right partial thickness rotator cuff tear. (*Id.*)

Petitioner testified that within a few days of the surgery, as the medication wore off, she began experiencing pain in her neck. She described the pain as severe and constant, unlike any pain she had prior to the surgery. Petitioner testified that she had a cervical fusion performed in October 2005 and that she returned to work some thirteen weeks thereafter in early 2006. During the period from early 2006 until May 2008, she had no problem with her neck or right shoulder. She required no medical care for her neck or right shoulder during that period and was able to work her regular job as a stocker at Schnucks without difficulty. Petitioner also testified that during the period from May 2008 until she had the shoulder surgery on January 10, 2011, her main problem with pain was in the right shoulder with occasional pain going up to the side of her neck. After the shoulder surgery she suffered severe, constant pain in her neck. The neck pain continued through 2011. The Arbitrator finds Petitioner's testimony to be to be forthright and credible.

Petitioner saw her family doctor, Dr. McDermott, several times between early 2006 and May 2008. The records corresponding to this period are consistent with Petitioner's testimony, in that no neck complaints are noted. (PX 1, pp. 6-14) Following the May onset of shoulder symptoms she complained of right shoulder and arm pain on June 18, 2008 and July 8, 2008. She made mention of pain radiating to her neck on July 14, 2008. (PX 1, pp. 5-6) On July 29, 2008, she told Dr. Weimer about right shoulder

pain and lateral deltoid pain with some radiation up into her neck. (PX 2, p. 5) When she saw Dr. Burrows on August 7, 2008, she indicated that her main complaint involved right shoulder aching into arm. She denied any current neck pain. (PX 2, p. 9) Likewise, the pre surgery records of Dr. Yamaguchi are consistent with Petitioner's testimony. (PX 3, pp. 17-39)

Following her shoulder surgery Petitioner saw Dr. Yamaguchi on January 19, 2011. At that point he noted that she is in more pain than before surgery. She had stiffness in the neck radiating down over the top of the shoulder and down the arm. He stated "We are concerned that she may, in fact, have a cervical myeloradiculopathy." (PX 3, p. 46) When she returned on February 3, 2011 he noted a lot of pain and trouble swallowing. (PX 3, p. 48) On February 21, 2011, Dr. Yamaguchi stated "I have a high suspicion that she has a neurogenic source of her pain probably from her neck." (PX 3, p. 54)

Dr. Yamaguchi referred Petitioner to Dr. Adam Labore. She was seen on April 27, 2011. Her chief complaint was neck pain radiating into the right shoulder, arm and scapula. She told the doctor that following shoulder arthroscopy in January, she experienced the onset of these symptoms. Dr. Labore ordered a cervical MRI. When she returned on May 11, 2011, Dr. Labore noted that she continues to have persistent right sided neck and tropezius area pain that is severe and constant, significantly activity limiting. Dr. Labore opined "[c]urrent symptoms were absent prior to her shoulder surgery which was necessitated because of a work injury. Although her current symptoms were not acquired in the event of a work injury they have arisen through the course of treatment for her work injury. This represents the exacerbation of an underlying condition that was doing very well until the time of her surgery, by her report." (PX 3, p. 61) Dr. Labore performed nerve root block on May 16, 2011.

Petitioner saw Dr. Riew on June 30, 2011 at the referral of Dr. Labore. Her chief complaint was neck and arm pain; 90% neck pain/10% arm pain. Dr. Riew testified that Petitioner had a non-union from her 2005 cervical fusion at the C5-6 and the C6-7 levels, and that she had increased pain with palm down abduction that was indicative of a right shoulder problem. Dr. Riew testified "I felt that she had a non-union of the previous fusions that she had at C5-6 and C6-7, and I also felt that in addition to that causing the neck pain and some of the shoulder pain, that I felt that she also had a primary shoulder problem. So- I felt that she had two different and separate problems." (PX 13, pp. 5, 8)

Dr. Riew performed surgery on Petitioner on August 17, 2011. That surgery involved: Complex anterior cervical corpectomy of C5; Complex removal of anterior cervical plate, C5-7: Placement of a new anterior cervical plate, C4-6 with a Biomet Max An green plate; Anterior cervical fusion, C4-5; Anterior cervical fusion at additional level at C5-6; Structural allograft plus local autograft, plus demineralized bone Matrix grafting, plus extra-extra-small BMP grafting; and Microscope visualized corpectomy. (PX 3, pp. 103-106)

Petitioner continued to follow up with Dr. Yamaguchi for her shoulder and was ultimately released without restriction with respect to the shoulder on November 29, 2011. (PX 3, p. 158) Petitioner remained under the care of Dr. Riew and he ultimately released Petitioner to return to light duty work as of December 5, 2011. (PX 3, p. 160)

Dr. Riew agreed with Dr. Labore in that Petitioner's current symptoms had arisen through the course of treatment for her work injury which "represents the exacerbation of any underlying condition that was doing very well until the time of her surgery, by her report." Dr. Riew further indicated that the course of treatment for her shoulder was: a cause of the neck pain for which he provided treatment; a

contributory factor in the neck pain he treated; and a contributing factor or cause for the surgery he eventually performed. He further indicated that the course of treatment for her shoulder caused an exacerbation and an aggravation of an underlying condition in her neck. (PX 13, pp. 15-16) Dr. Riew explained that he is familiar with the shoulder surgery performed by Dr. Yamaguchi and that the surgery involves yanking on the shoulder while the head is turned away and taped down. (PX 13, pp. 33-34, 39-41) Dr. Riew testified that he is 90% confident that it was the shoulder surgery that aggravated the neck pain, and were it not for the shoulder operation, she would not have been symptomatic and she would not have needed the treatment he provided. (PX 13, pp. 63, 61) Dr. Riew also testified that Petitioner's work duties as a stocker accelerated the degenerative conditions in her neck going back to 2005. (PX 13, p. 60)

After being released to return to work, Petitioner continued under the care of Dr. Riew. Following her return to work Petitioner experienced periodic increases in her symptoms and noted when she was away from work the symptoms decreased. Post-surgery medical care for Petitioner's neck included medication, various radiographs (MRI, x-rays, CT scan), physical therapy, work hardening, and epidural injections by Dr. Swarm in September, October and November 2012. When asked if he had an opinion as to whether or not Petitioner's job duties involving stocking was a cause of the ongoing neck pain for which he had been treating her in 2012, Dr. Riew testified "Yeah, I would say that it's a combination of the fact that they're aggravated by the kind of duties that she has to perform." He further testified that it would be fair to say that the job duties she performed caused an aggravation of an underlying condition in her neck which was related to the pain for which he had been treating Petitioner. (PX 13, pp. 21-22) He also felt that the shoulder surgery of January 10, 2011 was a contributing factor to the current problems Petitioner is having with her neck when he last saw her on March 6, 2014. (PX 13, pp. 27-28)

Petitioner was examined by Dr. James Coyle, pursuant to §12, on May 25, 2011. Dr. Coyle testified that the sudden onset of severe neck pain following the shoulder surgery was merely coincidence. He stated that he cannot imagine how having shoulder surgery could cause an injury to the cervical spine. (RX 1, pp. 15-16) In his opinion the cause of Petitioner's neck pain was a nonunion of the prior cervical fusion, a fracture of the hardware below and erosion of the hardware above into the disc space, which he diagnosed as "pseudoarthosis" and "severe juxtafusional degenerative changes at C4-5." (RX 1, pp 28-29) When asked what causes fracture of the hardware, Dr. Coyle testified that "any stress to it will cause failure over time. Just normal activities of daily living can cause it." (RX 1, p. 32) He further elaborated that such normal activities of daily living would include flexion, extension, rotation and lateral bending

Dr. Riew testified that Petitioner's injuries are permanent. The fusion from C4 to C7 is solid so she has permanently lost 30 degrees of flexion and extension, and about 20 degrees of left and right rotation. The fusion will permanently increase the load stress at the other levels of her cervical spine, making them break down just a little faster than they would have had she not had the operation, and that it is more likely than not she will require surgery at the levels above and below the current fusion in the future resulting in still more loss of motion. (PX 13, pp. 26-27, 60) Finally, Dr. Riew indicated that Petitioner should avoid activities such as "...stocking shelves, looking up, looking down, and having to constantly shift her neck left and right." (PX 13, pp. 25-26)

Petitioner testified that she continues to suffer the effects of these injuries. She continues to have pain which is activity related. When she is stocking frozen products she eels increased pain and there is little she can do to alleviate it. If she is involved in activities that involve little repetitive movement (i.e. working as a checker), her pain is less. Work activities involving stocking cause the most pain. Other

activities which cause a significant problem include driving for long distances and turning her head to check other lanes for traffic when driving and changing lanes.

CONCLUSIONS OF LAW

Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?

Based upon the previous decision of Arbitrator Teague, Petitioner's shoulder condition and the surgical procedure which it necessitated are causally related to Petitioner's work related accident of September 24, 2008.

Although an independent intervening cause can break the chain of causation between a work-related injury and subsequent disability, the chain remains intact when the subsequent disability results from treatment for the first injury. *Tee-Pak, Inc. v. Industrial Commission of Illinois*, 95 Ill.Dec. 697, 702, 490 N.E.2d 170, 175 (4th District 1986). See also, *McNeil v. Diffenbaugh,* 61 Ill.Dec. 224, 434 N.E.2d 377, 380 (1st Dist. 1982) (Act applies to aggravation of an injury caused by medical treatment).

Petitioner had a prior cervical fusion performed in October 2005. She returned to work thereafter in early 2006. From that time until her January 11, 2011 surgery she had no problem with her neck. She required no medical care for her neck during that period and was able to work her regular job as a stocker at Schnucks without difficulty. Following the onset of shoulder symptoms in May 2008 she experienced some slight radiation of pain into the neck. Petitioner testified her "extreme" neck pain began after her January 10, 2011 shoulder surgery. The Arbitrator notes Petitioner's testimony was both credible and consistent with the medical records in evidence.

Both Dr. Riew and Dr. Labore agreed that Petitioner's neck symptoms had arisen through the course of treatment for her work related shoulder injury. They opined that the surgery exacerbated an underlying condition that was doing very well until the time of her surgery. Dr. Riew further indicated that the course of treatment for her shoulder was: a cause of the neck pain and the surgery he eventually performed to treat that pain. Dr. Riew testified that he is 90% confident that it was the shoulder surgery that aggravated the neck pain, and were it not for the shoulder operation, she would not have been symptomatic and she would not have needed the treatment he provided. Dr. Coyle testified that the sudden onset of severe neck pain following the shoulder surgery was mere coincidence. He stated that he cannot imagine how having shoulder surgery could cause an injury to the cervical spine. Dr. Riew explained, however that he is familiar with the shoulder surgery performed by Dr. Yamaguchi and that the surgery involves forceful manipulation of the shoulder while the head is turned away and taped down.

The Arbitrator finds the testimony and opinions of Dr. Riew and Dr. Labore are more persuasive. Based upon the foregoing and the record taken as a whole, the Arbitrator finds that the condition of ill-being of Petitioners cervical spine which, required additional surgery by Dr. Riew in August of 2011, resulted from an exacerbation and aggravation of Petitioner's previously asymptomatic preexisting cervical spine condition and is therefore causally related to the compensable accident of September 24, 2008.

Issue (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?

Petitioner submitted only medical bills related to the treatment of her cervical condition. The Arbitrator presumes that all charges related to the treatment of the shoulder have been paid by Respondent pursuant to the prior decision and order of Arbitrator Teague. The bills submitted relative to treatment of the cervical spine are as follows:

Barnes-Jewish Hospital	$ 68,756.94
Memorial Hospital (Physical Therapy)	$ 2,812.00
St. Elizabeth's Hospital	$ 3,609.50
Washington University Physicians	$ 54,245.00
	$129,243.44

These charges correspond to the bills admitted into evidence as PX 8 through PX 11 respectively.

The parties do not dispute the reasonableness and necessity of the treatment Petitioner underwent for her cervical spine nor do they dispute the amount of the charges. Rather, Respondent disputed its liability for the treatment based upon their denial of causal connection between the condition of the cervical spine and the accident. Having found Petitioner's current condition of ill-being to be causally related to the accident, and based upon the record taken as a whole, the Arbitrator finds that the treatment rendered to Petitioner's cervical spine to be necessary, reasonable and related to this accident. Respondent shall pay the incurred expenses of $129,243.44 pursuant to the fee schedule. The Arbitrator notes that the UFCW Local 655 Health & Welfare Fund has paid $42,445.30 toward the medical bills in this case for which they claim a lien. Respondent further shall hold Petitioner harmless with regard to said lien.

Issue (K): What temporary benefits are in dispute?

Again, the parties do not dispute the period of incapacity. Rather, Respondent disputed its liability for benefits following February 21, 2011 based upon their denial of causal connection between the condition of the cervical spine and the accident. Petitioner was allowed to return to work with restrictions as of December 5, 2011 by Dr. Riew. Having found Petitioner's current condition of ill-being to be causally related to the accident, and based upon the record taken as a whole, the Arbitrator finds that Petitioner was temporarily totally disabled for the 47 week period from January 10, 2011 through December 4, 2011. Respondent shall pay Petitioner temporary total disability benefits of $343.72/week for 47 weeks, as provided in Section 8(b) of the Act. Respondent has already paid $5,733.42 in temporary total disability benefits and shall have a credit in that amount.

Issue (L): What is the nature and extent of the injury?

As a result of the accident of September 24, 2008, Petitioner sustained a right partial-thickness rotator cuff tear. On January 10, 2011, she underwent a right rotator cuff debridement, subacromial decompression, extensive debridement of the glenohumeral joint and acromioplasty. Petitioner began to experience "extreme" neck pain following her January 10, 2011 shoulder surgery. It was determined that Petitioner had sustained an exacerbation and aggravation of her previously asymptomatic preexisting cervical spine condition which ultimately required additional surgery. Dr. Riew performed surgery on Petitioner on August 17, 2011. That surgery involved: Complex anterior cervical corpectomy of C5; Complex removal of anterior cervical plate, C5-7: Placement of a new anterior cervical plate, C4-6 with

a Biomet Max An green plate; Anterior cervical fusion, C4-5; Anterior cervical fusion at additional level at C5-6; Structural allograft plus local autograft, plus demineralized bone Matrix grafting, plus extra-extra-small BMP grafting; and Microscope visualized corpectomy.

Petitioner continues to have pain which is activity related. When she is stocking frozen products she feels increased pain and there is little she can do to alleviate it. Work activities involving stocking cause the most pain. Other activities which cause a significant problem include driving for long distances and turning her head to check other lanes for traffic when driving and changing lanes.

Dr. Riew testified that Petitioner's injuries are permanent. She has decreased range of motion in her neck. In addition, the fusion will permanently increase the load stress at the other levels of her cervical spine, making them break down faster than they otherwise would. Dr. Riew indicated that Petitioner should avoid activities such as stocking shelves, looking up, looking down, and having to constantly shift her neck left and right.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds the injuries sustained caused the 10% loss of the person as a whole, as provided in Section 8(d)2 of the Act related to the injury to Petitioner's right shoulder, and 35% loss of the person as a whole, as provided in Section 8(d)2 of the Act related to the injury to Petitioner's neck injury. The Arbitrator notes that this award is consistent with, albeit slightly more conservative, the Commission decision in *Strader v. State of Illinois- CMS*, 13 IWWC 0200 [Commission modified award of Arbitrator and awarded 47% MAW Claimant had shoulder and cervical spine injuries and surgeries]

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Arturo Escobar

Petitioner,

vs.

NOS. 11WC 10278
13WC 14702

Meyer Steel & Drum Inc.,

16IWCC0234

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review under §19b having been filed by both parties herein and proper notice given, the Commission, after considering the issues of accident, temporary disability, permanent disability, medical expenses, causal connection, prospective medical care, penalties and fees, and being advised of the facts and law, affirms and adopts the Decisions of the Arbitrator, which are attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decisions of the Arbitrator filed May 7, 2015 are hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of

expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 3 1 2016
SJM/sj
o-3/17/16
44

Stephen J. Mathis

Maria Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

ESCOBER, ARTURO
Employee/Petitioner

Case# **11WC010278**

13WC014702

MEYER STEEL & DRUM INC
Employer/Respondent

16IWCC0234

On 5/7/2015, 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 0.07% 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:

1922 SALK, STEVEN B & ASSOC LTD
DAMON FLORES
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

1109 GAROFALO SCHREIBER HART ETAL
DAVID HANSON
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS) 16IWCC0234

)SS.

COUNTY OF COOK)

☐ 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
19(b)

ARTURO ESCOBAR
Employee/Petitioner

v.

MEYER STEEL & DRUM, INC
Employer/Respondent

Case # 11 WC 10278

Consolidated cases: 13 WC 14702

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 **Ketki Steffans**, Arbitrator of the Commission, in the city of **Chicago**, on **12/11/14 & 2/2/15**. 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. ☒ Is Petitioner entitled to any prospective medical care?

L. ☒ What temporary benefits are in dispute?
☒ TPD ☐ Maintenance ☒ TTD

M. ☒ Should penalties or fees be imposed upon Respondent?

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

16IWCC0234

FINDINGS

On the date of accident, **2/16/11**, 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 **$14,699.81**; the average weekly wage was **$376.92**.

On the date of accident, Petitioner was **33** years of age, ***married*** with **3** dependent children.

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

Respondent shall be given a credit of **$15,504.75** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$17,912.85** for other benefits, for a total credit of **$33,417.60**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $330.00/week for 164 & 6/7th weeks, commencing 3/2/11 – 3/14/11 & 8/8/11 – 9/21/14, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of in the amount of $2,346.16 for the time period commencing 2/17/11 – 3/1/11 & 3/15/11 – 8/7/11, as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical services of $290,200.43, as provided in Section 8(a) of the Act.

Respondent is not liable for penalties under Section 16, Section 19(k) or Section 19(l) of the Act.

Respondent shall authorize surgery as prescribed by Dr. Ronald Michael on 9/4/14.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

Kelli Stetten
Signature of Arbitrator

5/6/15
Date

ICArbDec19(b)

MAY 7 - 2015

Procedural History

This matter was tried as consolidated cases before Arb. Ketki Steffen on 12/11/14, 2/2/15 and 3/2/15 as an 19(B)/8(a) hearing. 11WC10278 is an Application for Adjustment of Claim for a low back injury for a date of accident of 2/16/11. 13WC14702 is a claim for the same back injury with the same accident date but under the theory of repetitive trauma. The same opinion and findings are being given by Arbitrator Steffen with separate case captions.

Factual History

It has been stipulated by the parties that on 2/16/11, Petitioner and Respondent were operating under the Act and that the accident in question was reported within the time limits of the Act. It has also been stipulated that on the date of accident, Petitioner was thirty-three (33) years of age, married, and had three (3) dependent children. The parties also stipulated that through the date of arbitration, Respondent paid Petitioner $15,504.75 in TTD benefits and $17,912.85 in PPD advances. The issues in dispute at arbitration were accident, causal connection, reasonableness and necessity of accrued medical, TTD, TPD, prospective medical, and penalties and attorneys' fees.

As of the date of accident, Petitioner had been employed by Respondent, working eight hour shifts as a laborer on the production line for approximately five (5) years (T1 at 11 & 19). Respondent is in the business of reconditioning metal drums/barrels. Petitioner testified these drums are four (4) feet high, two and half (2 ½) to three (3) feet in diameter and varying in weight from forty to sixty (40 – 60) pounds (T1 at 12). It was Petitioner's responsibility to straighten out dented drums with the use of a machine. The drums arrived to Petitioner's station atop a conveyor line which was

one (1) foot above the ground. Petitioner would bring the drum down off the conveyor line by bending over, slightly bending his knees and placing his left hand below and the right hand atop as he brought the drum down (T1 at 18). Once on the ground, Petitioner would roll the bottom edge of the drum two to three (2-3) feet to the straightening machine (T1 at 79). Petitioner would then tilt and pick up the end of the drum to feed it into the straightening machine for approximately twenty (20) seconds. The completed drum was then removed from the machine and placed back on the conveyor line. Petitioner estimated that this process was completed two to three (2 – 3) times per minute; this process was repeated throughout Petitioner's entire eight hour shift (T1 at 19). Aside from his drum straightening duties, Petitioner was also occasionally instructed to place metal seals on the drums. Petitioner used similar lifting body mechanics when completing this task (T1 at 20).

Prior to commencing his employment with Respondent, Petitioner had never sought treatment for low back pain. Up through the date of accident in question, he had never injured his low back, sought treatment for his back, or missed work due to low back pain (T1 at 21). On Wednesday, 2/16/11, Petitioner reported to work at 5:30 a.m. in his same general state of good health (T1 at 22). While performing his lifting duties, Petitioner noticed a strong right sided low back pain which he had never experienced before. Petitioner reported the pain to his supervisor, Francisco, at about noon that day (T1 at 24). Francisco told Petitioner that he complained too much and that he had low back pain because he was fat. Petitioner continued working, noticing increased pain as he completed his shift. He reported to work the following Thursday, Friday, and also again on Monday. As he continued working, Petitioner realized the pain would not go

away on its own (T1 at 25). On Tuesday, 2/22/11, Petitioner reported to work but was unable to complete his shift due to increased pain. He once again discussed the pain with Francisco and also spoke with Ornela Joyner (OJ), Respondent's Human Resource manager. Petitioner decided not to file a written accident report because he hoped the pain would improve (T1 at 96). Upon discussing the pain with OJ, Petitioner was instructed to seek treatment at Concentra Medical Center.

The initial examination at Concentra took place that same morning at 10:20 AM (PX1). The first report by Dr. Bunting documented the following:

> CHIEF COMPLAINT: Patient is a 33 year old male employee of Meyer Steel & Drum who complains about his Back which was injured on 2/16/11
>
> PATIENT STATEMENT: Patients states: "lifting heavy containers, I felt pain in my lower back."
>
> HISTORY OF PRESENT ILLINESS: "The mechanism of injury was lifting of [sic] many 40-50# barrels in a day and he noticed his back begin hurting almost a week ago. He thought the pain would get better but did not (PX 1)."

Dr. Bunting diagnosed Petitioner with a back sprain, prescribed pain medication with physical therapy and further instructed Petitioner to report to work with ten (10) pound lifting restrictions. Petitioner testified that he did not attend physical therapy because OJ told him it was not necessary (T1 at 27). Petitioner's testimony regarding OJ's medical advice is supported by Dr. Bunting's chart in which he documents a troublesome conversation he had with Respondent's HR manager, noting:

> "OJ called and asked if PT was necessary. I indicated I thought it would aid him and speed his recovery; **but, she requested he just take it easy and maybe get a day off.** I told her I would reevaluate him on Friday and placed him on light duty (PX 1)."

Without Respondent's permission to attend physical therapy, Petitioner continued working and did not improve.

Approximately two days after this first date of service, Petitioner once again met with OJ. During the second meeting, OJ informed Petitioner that she reviewed his social security number and that she was going to send a report to the IRS (T1 at 92). Respondent knew he was working with a invalid social security number; nevertheless, following this meeting, Petitioner continued working for Respondent for another six (6) months through August of 2011 (PX 31 and RX 4).

Dr. Bunting's 2/25/11 follow up note documents exacerbated symptoms with bending, squatting, lifting, carrying and twisting; nevertheless, instead of decreasing the restrictions to avoid further aggravation, Petitioner's work restrictions were increased to twenty-five (25) pounds (PX 1). Petitioner never followed up with Concentra Medical after the second date of service. Petitioner testified that he decided to seek a second opinion because he was frightened when he noticed his feet and legs started to feel asleep and numb (T1 at 28).

On 3/2/11, Petitioner sought treatment with Dr. Bermudez at Herron Medical Center (a/k/a Alivio Physical Therapy); he reported complaints of low back pain which traveled down both legs with some tingling and numbness (PX 2). Petitioner informed his new medical provider that the low back pain was due to the repetitive lifting of steel drums weighing forty to fifty (40–50) pounds (PX 2). Dr. Bermudez requested an MRI of the low back and instructed Petitioner to remain off work. The 3/2/11 MRI was read by Dr. Payvar to identify grade I anterior spondylolisthesis of the L5 with respect to S1,

most likely as a result of underlying spondylosis; at L5-S1 there was disc dehydration with moderate bilateral foraminal stenosis (PX 2).

Post MRI, Petitioner was referred to Dr. Suneela Harsoor who on 3/10/11 reviewed the films and identified grade I L5 on S1 lumbar spondylosis and spondylolisthesis with mild arthritis; she also identified mild facet arthritis with stenosis (PX 3). The clinical exam revealed right lateral flexion pain anterior flexion pain and left later flexion pain. Dr. Harsoor prescribed physical therapy and lumbar epidural steroid injections at L5/S1 which took place on 3/22/11. The physical therapy took place at New Life Medical Center (PX 4). Petitioner testified that he returned to work with restrictions while under the care of Dr. Harsoor (T1 at 32). On 4/7/11, Petitioner reported mild relief of pain with the injection (PX 3); he testified the injection calmed his pain, but the returned after a week (T1 at 33). On 4/19/11 Dr. Harsoor administered a lumbar facet joint block to address the facet arthropathy symptomology; Petitioner once again reported mild relief with the procedure. Dr. Harsoor's 5/3/11 dictation documents worsening pain at work on 4/29/11 (PX 3). On 6/14/11, Dr. Harsoor administered epidural steroid injections at L5/S1. Post injection, on 6/2/11, Petitioner reported mild relief, pain at a 7/10 with continued numbness down both legs (PX 3). Petitioner was allowed to continue working with restrictions and was referred to a surgeon for further evaluation.

Petitioner was examined by Dr. Ronald Michael on 7/18/11 at the Illinois Nuerospine Institute (PX 6). The initial dictation documents a consistent accident history with low back pain and bilateral leg pain with numbness' and tingling. Dr. Michael reviewed the MRI scan and noted a broad-based subligamentous disk

herniation at L5/S1 with possible small extruded fragments. Dr. Michael advised Petitioner he could either learn to live with the pain or undergo an lumbar diskography to define the pain generator (PX 6). The 8/4/11 diskography with Dr. Harsoor documented 5/5 concordant pain at the L5/S1 level (PX 6). The post diskogram CT identified a grade IV radial tear at L5/S1; Dr. Payvar also noted grade I anterior spondylolisthesis of L5 with respect to S1 which appeared to be the result of associated underlying spondylosis at L5 (PX 6).

On of 8/8/11 Dr. Michael prescribed Soma, Ultram, Mobic and Zantac; he further instructed Petitioner to remain off work pending receipt and review of the diskography report.

On 8/15/11, Dr. Michael diagnosed Petitioner with a herniated nucleus pulposus at L5/S1 with an annular tear, grade I spondylolisthesis at L5/S1, and bilateral L5 spondylosis. Dr. Michael stated, "There is clearly a causal relationship between his current condition of ill-being and the work related injury described previously. The patient did not have low back problems prior to this. Indeed, he used to carry heavy weight with no problems whatsoever (PX 6)." Dr. Michael instructed Petitioner to remain off work and advised Petitioner he could either live with the pain or consider a lumbar fusion. Petitioner decided to move forward with surgery because he was in a lot of pain and felt he was unable to do anything (T1 at 40).

On 10/3/11, Petitioner sent an email correspondence with medical records to Respondent's counsel supporting the request for payment of TPD through 8/7/11 and TTD through the date of the correspondence (PX 35). At Respondent's request, Petitioner was examined by Dr. Jesse Butler on 11/7/11 (RX 1 at 6). Upon examination

of Petitioner, review of the diagnostic tests, and also the notes from Dr. Harsoor and Dr. Michael, Respondent's expert diagnosed Petitioner with spondylolisthesis spondylosis at L5/S1 (RX 1 at 8). He opined that the initial epidural injection was reasonable and necessary (RX 1 at 37). He further opined that the follow-up epidural injection was not indicated because the first did not provide much relief; Dr. Butler also disputed the necessity of the diskogram and the medial branch block (RX 1 at 10). Dr. Butler found Petitioner to be a candidate for a spinal fusion due to the failure of conservative care (RX 1 at 8). Post operatively, Respondent's expert opined that Petitioner would remain off work for six months (RX 1 at 38). Dr. Butler withheld his causation opinion because Respondent failed to provide the initial clinic notes from Concentra Medical Center (RX 1 at 9).

Dr. Butler authored a second report on 2/23/12 after receipt of the treatment records from Alivio Physical Therapy. Within the addendum report, Dr. Butler was of the opinion that the records from Alivio provided additional support to establish causality (RX 1 at 34). Respondent's expert noted that Petitioner reported progressive intolerance; he surmised that "unless the Concentra records contradict this report of Dr. Bermudez, there appears to be causal connection (RX 1 at 34)."

On 5/16/12, Karen Collier from Alternative Risk Management (ARM) sent a correspondence to Dr. Michael indicating the lumbar fusion would be covered by ARM; in-network services would be covered at 80% while out of network services were to be covered at 60%; Dr Michael was also informed that there would be an out of pocket deductible (PX 37). On 5/18/12, Petitioner sent an email correspondence to Respondent's counsel requesting confirmation that Respondent would cover the

deductible (PX 37). Petitioner sent a facsimile to Respondent's counsel on 8/20/12 asking for status of TTD benefits and reminding Respondent that surgery was set for 9/5/12 (PX 44).

Dr. Michael performed a L5/S1 posterolateral discectomy and fusion on 9/5/12 at Metro South Medical Center (PX 6 & PX 7). Post-surgery Petitioner was prescribed a bone growth stimulator to enhance bony fusion and healing (PX 6). As of 10/16/12 Petitioner reported 50% improvement to Dr. Michael. Physical therapy was prescribed on November 27, 2012.

Dr. Butler examined Petitioner for a second time on 12/17/12; it was during this second examination that he was finally provided the initial treatment records from Concentra Medical Center (RX 1 at 14). Despite the reported accident described within the Concentra Records (PX 1), as of 12/17/12, Dr. Butler opined that there was no causal connection between Petitioner's work activity and a specific incident that caused an injury (RX 1 at 18). Instead, Dr. Butler opined that there was a gradual deterioration that manifested and that his pain complaints seemed to reflect the natural history in a morbidly obese deconditioned young man (RX 1 at 24). Dr. Butler also testified Petitioner could return to work with twenty-five (25) pound lifting restrictions.

Petitioner continued his post-operative treatment with Dr. Michael. Upon completion of eight (8) weeks of physical therapy, as of 1/22/13, Petitioner reported minimal low back pain with occasional right leg pain and 60% overall improvement (PX 6). Dr. Michael instructed Petitioner to remain off work as he completed an additional course of physical therapy.

At Respondent's request, on 2/18/13 Dr. Butler authored a final report in which he opined that the records depicted vague if not conflicting descriptions of an injury. He summarized that Petitioner had pre-existing spondylolisthesis that pre-dated the accident date at hand. Dr. Butler set forth his own legal definition of causation, stating, "In order to establish causality, there needs to be an event or series of events that led to an aggravation of [Petitioner's] condition (RX 1 at 26)."

Petitioner continued physical therapy at New Life Medical Center through 4/26/13 (PX 4A). On 7/12/13 an FCE performed at New Life Medical Center found Petitioner capable of returning to work at a light physical demand level (PX 4A).

On 7/24/13 Dr. Michael noted continued complaints of low back and bilateral leg pain. Petitioner reported 60% overall improvement as compared to his pre-surgical state (PX6). Dr. Michael prescribed Mobic, Protonix, Ultram, Topamax, and Flexeril; he found Petitioner to be at MMI per the FCE with a weight limit of five (5) pounds and avoidance of bending, twisting, and lifting to the extent possible (PX 6).

On August 15, 2013, Petitioner sent Respondent's counsel an email correspondence requesting past due benefits and reminding Respondent that Petitioner had been discharged with permanent restrictions; Respondent was also reminded that the medical providers had yet to receive payment (PX 45). A follow-up correspondence was sent by Petitioner on 8/23/13 requesting authorization of vocational rehab and maintenance benefits (PX 46). On 8/30/13, Petitioner sent copies of all outstanding medical bills to Respondent (PX 47).

Petitioner testified that he attempted to return to work for his employer; however, Respondent did not give him his job back (T1 at 46). Petitioner took it upon himself to

look for work with other employers. With the use of his documented job search diary (PX32), Petitioner testified that he contacted approximately thirty (30) employers from 7/29/13 through 10/17/13 (*Note: PX 32 actually identifies thirty-two potential employers*). Petitioner testified the employers were unable to give him work because of his work restrictions (T1 at 47). Petitioner testified he contacted from eighty to ninety (80-90) employers from October 2013 through September 2014. He stopped documenting the employers contacted because he felt it was no longer helping (T1 at 51).

Petitioner received a check from ARM in the amount of $3,353.25 dated 9/25/13, (PX 51). Karen Collier testified that this check was sent to Petitioner at the request of Ornela Joyner (T2 at 20). Ms. Collier testified she sent a check to Petitioner in the amount of $2,419.60 at Ms. Joyner's instruction; this check is dated 5/13/14 and is also from ARM Insurance Services (PX 51).

Although he was discharged with permanent restrictions, Petitioner continued following up with Dr. Michael to refill his pain medication. Dr. Michael's dictations document increased symptoms of low back pain and lower extremity complaints. As of 7/22/14, Dr. Michael noted complaints of low back pain with bilateral lower extremity numbness and tingling; a CT scan of the lumbar spine was ordered and completed on 7/28/14 (PX 6). The study demonstrated post-operative changes at L5/S1 with grade 1 anterolisthesis at L5/S1 and no evidence of hardware complication (PX 6). As of 8/5/14, Dr. Michael identified three possible causes of Petitioner's ongoing complaints: 1) pseudoarthrosis; 2) hardware irritation; or 3) adolescents level disc disease. Dr. Michael recommended a lumbar diskogram to rule out the cause of the ongoing complaints.

The 8/26/14 diskogram administered by Dr. Michael failed to demonstrate any concordant discs superior to the fused L5/S1 level (PX 6). Dr. Michael determined that the two remaining causes of pain were either pseudoarthrosis or hardware irritation at L5/S1 (PX 6). On 9/4/14 Dr. Michael recommended surgery to assess the fusion. If the fusion healed properly, this means that the hardware irritation is the reason for the ongoing pain and Dr. Michael simply seeks to permanently remove the hardware. If it is determined during the surgery that the fusion failed, Dr. Michael intends repeat the fusion surgery by reinserting new hardware (PX).

Subsequent to Dr. Michael's surgical recommendation, on 9/22/14 Petitioner found employment as a laborer through a temporary agency. From the date of hire through the initial date of arbitration, 12/11/14, Petitioner worked through this temp agency on a conveyor belt line as a packer. Petitioner described the work as light duty; he generally works forty hours per week and finds himself standing all day performing his packing duties (PX 63). Since the return to work, Petitioner has noticed increased pain which prevents him from standing all day. Petitioner testified that he was initially hesitant to move forward with surgery. Since his return to work, Petitioner has decided to proceed with surgery because he cannot stand the pain and the pills are no longer helping (T1 at 63). As of the date of arbitration Petitioner testified he was taking seven (7) different medications; Petitioner testified that the medication makes him feel sleepy and occasionally hurts his stomach (T1 at 52 & 94). Petitioner was unable to recall each medication he was taking on a daily basis. With the use of a hand written list, Petitioner identified Gabapentin, Topiramate, Cyclobenzaprine, Meloxicam, Tramadol, Pantoprazole, and Ketoprogen (EX 33). Petitioner testified that his family has suffered

since his work accident. He wants to undergo the surgery because he wants to work "the right way" and help his children (T1 at 65). On cross examination, Petitioner acknowledged he is not a US Citizen; nevertheless, he listed himself as a citizen when applying for employment for Respondent in order to support his family.

Petitioner's supervisor, Francisco Calderas, testified on Respondent's behalf and stated Petitioner had worked for Respondent for five years (T2 at 55). As a supervisor, Mr. Calderas was familiar with Petitioner's work station. According to the supervisor, Petitioner worked on the platform fixing drums (T2 at 40). The drums arrived at Petitioner's station atop a blaster or roller conveyor belt (T2 at 41). Petitioner would pull the drum off the roller, roll the drum to the (straightening) machine and then slides the drum into a machine that is a foot off the ground by tilting the drum and using force to push up the drum (T2 at 41 & 61-62). Mr. Calderas confirmed Petitioner's testimony that through the initial date of accident Petitioner completed his work duties without complaints of low back pain, that Petitioner reported the accident on 2/16/11 and continued working until 2/22/11 when the Petitioner could no longer stand the pain (T2 at 47, 52 & 54). On cross examination, Mr. Calderas confirmed that Respondent terminated approximately 80% of its workforce due to issues with their immigration status (T2 at 63).

Karen Collier, an employee from Alternative Risk Management (ARM) also testified on Respondent's behalf. Ms. Collier confirmed that Respondent is self-insured and as an employee of ARM, she processes checks and reviews both workers' compensation and group health claims for Respondent. (T2 at 7-8). According to Ms. Collier, OJ is the Respondent's HR manager who decides whether treatment is covered

by the Workers' compensation insurance (T2 at 22). During the time frame of Petitioner's treatment, Ms. Collier acknowledged it was especially common for Respondent to push treatment on injured workers through group heath when there is a pending Worker's compensation claim (T2 at 29-30). After being informed that Petitioners' claim was not work related, OJ instructed Ms. Collier to send the 5/16/12 correspondence to Dr. Michael which is is the subject of PX 37 (T2 at 9).

Findings/Analysis

With respect to accident, the Arbitrator finds as follows:

The Arbitrator took into account Petitioner's demeanor and found him to be a credible witness. The Arbitrator finds that Petitioner did sustain an accident that arose out of and in the course of employment.

An injury is accidental within the meaning of the Workers' Compensation Act when it is traceable to a definite time, place, and cause and occurs in the course of employment unexpectedly and without affirmative act or design of the employee. Matthiessen & Hegeler Zinco Co. v. Industrial Board, 284 Ill. 378 (1918). Even if the claimant has a preexisting condition, the injury is categorized an accident if "a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor." Laclede Steel Co. v. Industrial Commission, 6 Ill.2d 296 (1955).

Leading up through 2/16/11, there is no history of low back pain. Petitioner worked for the Respondent for five (5) years. Petitioner's testified that he had low back complaints. The Petitioner testimony regarding his work duties and the injury are of record. On 2/16/11 Petitioner was at work when he began to experience low back pain

which was non-existent prior to the date in question. Petitioner reported the pain to his supervisor, but continued working while hoping the pain would subside. Respondent's witness corroborated the fact that Petitioner reported the accident and continued working.

Petitioner completed his shift an worked and additional three days. Petitioner testified that his pain increased and he informed his supervisor of the increased complaints. After a brief discussion with OJ in HR, Petitioner reported to the company clinic and provided a consistent account of the mechanism of injury.

During the initial date of service at Concentra, Petitioner informed Dr. Bunting he hurt his back on 2/16/11 while lifting heavy containers (PX 1). The mechanism of injury was specifically identified as the repeated lifting of forty to fifty (40-50) pound barrels (PX 1). This is the same history provided to each medical provider.

Dr. Butler's opines that Petitioner did not sustain a work accident on the date in question, however, Petitioner has identified the time, place, and cause of his low back injury. The incident was reported immediately to a supervisor. The Arbitrator finds that the mechanism of injury remained consistent throughout the record. The Arbitrator therefore finds that Petitioner sustained a work accident on 2/16/11 that arose out of and in the course of employment, i.e. the repetitive lifting of metal drums.

With respect to causal connection, the Arbitrator finds as follows:

The Arbitrator finds Petitioner met his burden of proof and established that he sustained a low back injury on 2/16/11 which was causally related to the lifting of metal drums during the course of his employment.

It is well established law that proof of prior good health and change immediately following and continuing after an injury may establish that an impaired condition was due to the injury. Navistar International Transportation Corporation, 315 Ill. App. 3d 1197, 1206 (2000). The Court specifically stated that causal connection between work duties and a condition may be established by a chain of events including Petitioner's ability to perform duties before the date of the accident and inability to perform the same duties following that date. Id.

In the case at hand, Petitioner's testimony regarding the chain of events surrounding the injury is documented within the medical records and also supported by the testimony of Petitioner's supervisor. Prior to the incident in question, Petitioner never sought low back treatment was completely asymptomatic and he was able to complete his job duties without incident. Petitioner showed up to work on the date in question without low back discomfort. On 2/16/11, Petitioner reported to work in his same general state of good health, commenced his work activities, noticed the increasing low back pain, and reported the pain to his supervisor. Thinking the pain would subside, Petitioner continued working through 2/22/11, at which point he could no longer tolerate the pain. The chain of events demonstrates Petitioner's health deteriorated from a state which allowed him to work without issue through 2/16/16, to a state of disability after that date.

The Arbitrator is further convinced by the credible opinions of Dr. Michael who found Petitioner's condition of ill-being to be causally related to the work activities performed on 2/16/11 (PX 6; See dictation 8/15/11 & 1/22/13). The Arbitrator is unconvinced by the testimony of Respondent's expert. Dr. Butler authored a report on

2/23/12 in which he opined the medical records from Alivio Physical Therapy (a/k/a Herron Medical Center) provided additional support to establish causality (RX1 at 34). The initial dictation from Dr. Bermudez at Alivio Physical Therapy dated 3/2/11 states "[T]he patient noticed pain in the lower back due to repetitive lifting of steel drums. These drums weigh anywhere from 40-50 lbs [sic] and place them on machine lines. He noticed this on 2/16/11 and reported the injury on 2/22/11 (PX 2)." The 2/23/12 report was authored by Dr. Butler prior to his review of the initial treatment notes from Concentra medical records; he concluded that unless the Concentra records contradict the report of Dr. Bermudez, there appeared to be causal connection (RX 1 at 34).

It was not until 12/17/12 that Dr. Butler finally had the opportunity to review the notes from Concentra Medical Center (PX 1) and additional notes form New Life Medical Center (PX 4). Petitioner informed Concentra that he injured himself on 2/16/11; "the mechanism of injury was lifting of many 40-50# barrels in a day and he noticed his back begin hurting almost a week ago (PX 1)." Despite the consistent accident history documented within the initial note at Concentra on 2/22/11, Dr. Butler ignored his prior opinion and determined there was no causal connection between Petitioner's work activities and Petitioner's condition of ill-being (RX 1 at 25). Dr. Butler found the records to be conflicting and vague and therefore determined Petitioner's pre-existing spondylolisthesis was not aggravated by his work duties because there was no clear injury but a gradual deterioration that manifested itself (RX 1 at 24).

Assuming arguendo that Petitioner experienced gradually increasing low back pain prior to 2/16/11 as as Dr. Butler indicated, it is undisputed that Petitioner never sought treatment for low back pain. He was able to complete his work duties without

issue up to through date of accident. It was not until 2/16/11 that Petitioner's pain became sufficiently bothersome that he reported the pain to Respondent and eventually sought treatment. Upon seeking treatment, Petitioner consistently told each provider that the back pain resulted from the repetitive lifting of metal drums/barrels at work. Taking into account the lack of prior history and the immediacy of his complaints, the Arbitrator finds that there exists a causal connection between Petitioner's work duties on 2/16/11 and his condition of ill-being. For the aforementioned reasons, the Arbitrator finds Petitioner satisfied his burden of proof and established causal connection.

With respect to reasonableness and necessity of accrued medical, the Arbitrator finds as follows:

The Arbitrator finds that all the treatment rendered prior to arbitration was reasonable and necessary to treat Petitioner's condition of ill-being. There is no dispute within the records as to the reasonableness and necessity of the majority of the treatment rendered. Dr. Butler agreed with the necessity of the first epidural steroid injection on 3/22/11 and Dr. Michael's recommendation of a lumbar fusion (RX1 at 10). Respondent's hired medical expert only negates the necessity of the lumbar facet block (4/19/11), the second epidural steroid injection (6/14/11) and the discogram (8/4/11) (RX 1 at 10). Aside from the three procedures isolated by Dr. Butler as unnecessary, the record is devoid of any dispute regarding reasonableness and necessity of the remaining treatment rendered through the date of arbitration.

The Arbitrator notes that Respondent failed to rely upon a utilization review to deny the reasonableness and necessity of the treatment rendered. Pursuant to Section 8.7(i)(3) of the Act, "An employer may only deny payment of or refuse to authorize payment of medical services rendered or proposed to be rendered on the grounds that

the extent and scope of medical treatment is excessive and unnecessary in compliance with an accredited utilization review program under this Section." This section of the Act is applicable to all treatment rendered on or after 9/1/11. Once a Petitioner meets its burden of proof and establishes causal connection, if Respondent fails to offer a utilization review opinion into evidence denying treatment, then all treatment is therefore deemed reasonable and necessary.

Through the date of Arbitration, the following balances remained outstanding pursuant to the fee schedule:

1. Alivio Physical Therapy	3/2/11 – 4/18/11	$793.30
2. Delaware Place MRI	3/2/11	$1,617.75
3. New Life Medical	3/19/11 – 7/12/13	$44,811.80
4. Rogers Park One Day Surgery (Fac)	3/22/11 – 8/4/11	$18,949.22
5. Rogers Park One Day Surgery (Phys)	3/22/11 – 8/4/11	$482.28
6. Paulina Anesthesia	3/22/11 – 8/4/11	$3,510.00
7. EQMD	3/30/11 – 7/26/13	$47,994.46
8. Dr. Ronald Michael	7/18/11 – 10/14/14	$36,333.68
9. Lakeshore Open MRI	8/4/11	$1,368.00
10. Pronger Smith Medical Center	5/17/12	$20.00
11. NW IND. Radiology	5/21/12	$27.36
12. OPTECH	5/22/12	$1,730.24
13. Metro South Medical Center	9/5/12 – 9/7/12	$114,939.51
14. BI Anesthesia	9/5/12	$3,597.95
15. BIOMET	9/18/12	$3,133.48
16. Archer Open MRI	1/12/12 – 7/29/14	$1,164.55
17. Walgreens	12/31/12 – 2/14/13	$70.00
18. G&U Orthopedics	3/18/13	$2,133.02
19. 900 North Michigan Surgical Center	8/26/14	$4,558.83
20. Northwestern Memorial Hospital	8/26/14	$2,965.00
	TOTAL BALANCE:	**$290,200.43**

The Arbitrator found accident and causal connection. The Arbitrator notes the absence of UR denying the necessity of treatment rendered and adopts the credible opinions of Petitioner's medical providers as it pertains to the procedures Dr. Butler found to be unnecessary. Accordingly, for the reasons noted, the Arbitrator finds all

medical treatment rendered through the date of arbitration to be reasonable, necessary, and causally related to the low back injury sustained on 2/16/11.

With respect to TTD & TPD, the Arbitrator finds as follows:

Respondent denies the accident and therefore denies Petitioner is entitled to any TTD/TPD benefits. Having established accident and causal connection, the Arbitrator finds Petitioner satisfied his burden of proof and is entitled to TTD benefits from 3/2/11 through 3/14/11 and 8/8/11 through 9/21/14 for a total of 164 & 6/7th weeks. Petitioner has also satisfied his burden of proof in establishing entitlement to TPD benefits from 2/17/11 through 3/1/11; 3/15/11 through 8/7/11, and 9/22/14 through 12/11/14.

During the time in question, Petitioner was either completely off work or capable of returning to work with restrictions. Petitioner testified that although off work for periods of time, he did return to work with restrictions for Respondent while treating at Concentra (2/17/11 - 3/1/11) and while he waited for approval of surgery (3/15/11 - 8/7/11). From 2/20/11 through 3/1/11, Petitioner had a net income of $484.95; he is therefore entitled $35.67 in TPD (PX 31 & RX 4). During the second return to work for Respondent, Petitioner had net income of $2,704.14 through 6/28/11 and gross income of $1,691.59 through 8/7/11 (PX 31 & RX 4). [*Note: The amendments to Section 8(a) of the Act became effective 8/28/11.]* Petitioner is therefore entitled to $2,310.49 for the second period of work with restrictions.

After undergoing surgery, Petitioner sought to return to work with restrictions for Respondent but was never provided light duty work. He then found work through a

temporary agency (9/22/14 - 12/11/14). Respondent failed to offer evidence negating Petitioner's testimony regarding his attempt to return to work or the necessity of Petitioner's work restrictions. Petitioner earned more while working for the new employer and therefore is not entitled to TPD during the final period of work with restrictions.

Aside from the TPD, Petitioner is also entitled to TTD benefits for the periods of time he was either off work completely, or able to work with restrictions but unable to find employment (3/2/11 - 3/14/11 & 8/8/11 - 9/21/14). Taking into account an AWW of $376.92 and a minimum TTD rate of $330.00, Petitioner should have been paid $54,402.86 in TTD benefits during the time period in question.

Through the date of arbitration, Petitioner should have been paid a total of $54,749.02 in TTD/TPD benefits. Respondent is entitled to a total credit of $33,417.60 (TTD paid = $15,504; PPD Advance = $17,912.85). Taking into account the credit, the Petitioner is awarded $21,331.42 in back due TTD/TPD benefits.

With respect to future medical, the Arbitrator finds as follows:

The Arbitrator finds the surgery prescribed by Dr. Ronald Michael to be reasonable, necessary, and causally related to the 2/16/11 work accident. As noted above, the Arbitrator finds Dr. Michael to be credible and therefore is persuaded by his opinions. The Respondent failed to offer into evidence any opinion which negates the necessity of the surgery prescribed by Dr. Michael on 9/4/14. Although hesitant to undergo surgery at first, Petitioner testified he wants to proceed with the surgery because he is still in pain, no longer want to continue taking medication, and wants to be able to properly provide for his children.

The Arbitrator further notes that Respondent failed to submit the request for surgery to Utilization Review as required by Section 8.7(i)(3) of the Act. Having established casual connection, the Respondent has no legal basis to deny the necessity of surgery. For the aforementioned reasons, the Arbitrator orders the approval surgery prescribed by Dr. Ronald Michael on 9/4/14.

With respect to penalties and attorney's fees, the Arbitrator finds as follows:

The Arbitrator finds that penalties and attorneys' fees pursuant to Section 16, 19(l) and 19(k) of the Act are not warranted. Given the facts presented in this case, and after considering the parties' motion and response, the Arbitrator finds that Respondent had a reasonable dispute regarding the Petitioner's injuries and treatment and that their reliance on the opinion of their Section 12 examinations throughout Petitioner's treatment. Respondent's conduct was not unreasonable, vexatious and/or in bad faith. Thus, Petitioner's claim for penalties and fees under Sections 19(k), 19(l) or 16 of the Act is denied.

Although the Arbitrator's findings in this matter are favorable to the Petitioner, the Arbitrator finds that Respondent's reliance on the opinion of their IME and their denial of benefits based upon that opinion was not unreasonable or in bad faith.

Ketki Steffen
Signature of Arbitrator Ketki Shroff Steffen

5/6/15
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

ESCOBAR, ARTURO
Employee/Petitioner

Case# **13WC014702**

11WC010278

16IWCC0234

MEYER STEEL & DRUM INC
Employer/Respondent

On 5/7/2015, 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 0.07% 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:

1922 SALK, STEVEN B & ASSOC LTD
DAMON FLORES
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

1109 GAROFALO SHREIBER HART ET AL
DAVID HANSON
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

16IWCC0234

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ 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
19(b)

ARTURO ESCOBAR
Employee/Petitioner

v.

MEYER STEEL & DRUM, INC
Employer/Respondent

Case # 11 WC 10278

Consolidated cases: 13 WC 14702

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 **Ketki Steffans**, Arbitrator of the Commission, in the city of **Chicago**, on **12/11/14 & 2/2/15**. 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☒ TPD ☐ Maintenance ☒ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, 2/16/11, 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 $14,699.81; the average weekly wage was $376.92.

On the date of accident, Petitioner was 33 years of age, *married* with 3 dependent children.

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

Respondent shall be given a credit of $15,504.75 for TTD, $0.00 for TPD, $0.00 for maintenance, and $17,912.85 for other benefits, for a total credit of $33,417.60.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $330.00/week for 164 & 6/7th weeks, commencing 3/2/11 – 3/14/11 & 8/8/11 – 9/21/14, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of in the amount of $2,346.16 for the time period commencing 2/17/11 – 3/1/11 & 3/15/11 – 8/7/11, as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical services of $290,200.43, as provided in Section 8(a) of the Act.

Respondent is not liable for penalties under Section 16, Section 19(k) or Section 19(l) of the Act.

Respondent shall authorize surgery as prescribed by Dr. Ronald Michael on 9/4/14.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

Kelli Stetten — Signature of Arbitrator

5/6/15 — Date

ICArbDec19(b)

MAY 7 - 2015

Procedural Histroy

This matter was tried as consolidated cases before Arb. Ketki Steffen on 12/11/14, 2/2/15 and 3/2/15 as an 19(B)/8(a) hearing. 11WC10278 is an Application for Adjustment of Claim for a low back injury for a date of accident of 2/16/11. 13WC14702 is a claim for the same back injury with the same accident date but under the theory of repetitive trauma. The same opinion and findings are being given by Arbitrator Steffen with separate case captions.

Factual History

It has been stipulated by the parties that on 2/16/11, Petitioner and Respondent were operating under the Act and that the accident in question was reported within the time limits of the Act. It has also been stipulated that on the date of accident, Petitioner was thirty-three (33) years of age, married, and had three (3) dependent children. The parties also stipulated that through the date of arbitration, Respondent paid Petitioner $15,504.75 in TTD benefits and $17,912.85 in PPD advances. The issues in dispute at arbitration were accident, causal connection, reasonableness and necessity of accrued medical, TTD, TPD, prospective medical, and penalties and attorneys' fees.

As of the date of accident, Petitioner had been employed by Respondent, working eight hour shifts as a laborer on the production line for approximately five (5) years (T1 at 11 & 19). Respondent is in the business of reconditioning metal drums/barrels. Petitioner testified these drums are four (4) feet high, two and half (2 ½) to three (3) feet in diameter and varying in weight from forty to sixty (40 – 60) pounds (T1 at 12). It was Petitioner's responsibility to straighten out dented drums with the use of a machine. The drums arrived to Petitioner's station atop a conveyor line which was

one (1) foot above the ground. Petitioner would bring the drum down off the conveyor line by bending over, slightly bending his knees and placing his left hand below and the right hand atop as he brought the drum down (T1 at 18). Once on the ground, Petitioner would roll the bottom edge of the drum two to three (2-3) feet to the straightening machine (T1 at 79). Petitioner would then tilt and pick up the end of the drum to feed it into the straightening machine for approximately twenty (20) seconds. The completed drum was then removed from the machine and placed back on the conveyor line. Petitioner estimated that this process was completed two to three (2 – 3) times per minute; this process was repeated throughout Petitioner's entire eight hour shift (T1 at 19). Aside from his drum straightening duties, Petitioner was also occasionally instructed to place metal seals on the drums. Petitioner used similar lifting body mechanics when completing this task (T1 at 20).

Prior to commencing his employment with Respondent, Petitioner had never sought treatment for low back pain. Up through the date of accident in question, he had never injured his low back, sought treatment for his back, or missed work due to low back pain (T1 at 21). On Wednesday, 2/16/11, Petitioner reported to work at 5:30 a.m. in his same general state of good health (T1 at 22). While performing his lifting duties, Petitioner noticed a strong right sided low back pain which he had never experienced before. Petitioner reported the pain to his supervisor, Francisco, at about noon that day (T1 at 24). Francisco told Petitioner that he complained too much and that he had low back pain because he was fat. Petitioner continued working, noticing increased pain as he completed his shift. He reported to work the following Thursday, Friday, and also again on Monday. As he continued working, Petitioner realized the pain would not go

away on its own (T1 at 25). On Tuesday, 2/22/11, Petitioner reported to work but was unable to complete his shift due to increased pain. He once again discussed the pain with Francisco and also spoke with Ornela Joyner (OJ), Respondent's Human Resource manager. Petitioner decided not to file a written accident report because he hoped the pain would improve (T1 at 96). Upon discussing the pain with OJ, Petitioner was instructed to seek treatment at Concentra Medical Center.

The initial examination at Concentra took place that same morning at 10:20 AM (PX1). The first report by Dr. Bunting documented the following:

> CHIEF COMPLAINT: Patient is a 33 year old male employee of Meyer Steel & Drum who complains about his Back which was injured on 2/16/11
>
> PATIENT STATEMENT: Patients states: "lifting heavy containers, I felt pain in my lower back."
>
> HISTORY OF PRESENT ILLINESS: "The mechanism of injury was lifting of [sic] many 40-50# barrels in a day and he noticed his back begin hurting almost a week ago. He thought the pain would get better but did not (PX 1)."

Dr. Bunting diagnosed Petitioner with a back sprain, prescribed pain medication with physical therapy and further instructed Petitioner to report to work with ten (10) pound lifting restrictions. Petitioner testified that he did not attend physical therapy because OJ told him it was not necessary (T1 at 27). Petitioner's testimony regarding OJ's medical advice is supported by Dr. Bunting's chart in which he documents a troublesome conversation he had with Respondent's HR manager, noting:

> "OJ called and asked if PT was necessary. I indicated I thought it would aid him and speed his recovery; **but, she requested he just take it easy and maybe get a day off.** I told her I would reevaluate him on Friday and placed him on light duty (PX 1)."

Without Respondent's permission to attend physical therapy, Petitioner continued working and did not improve.

Approximately two days after this first date of service, Petitioner once again met with OJ. During the second meeting, OJ informed Petitioner that she reviewed his social security number and that she was going to send a report to the IRS (T1 at 92). Respondent knew he was working with a invalid social security number; nevertheless, following this meeting, Petitioner continued working for Respondent for another six (6) months through August of 2011 (PX 31 and RX 4).

Dr. Bunting's 2/25/11 follow up note documents exacerbated symptoms with bending, squatting, lifting, carrying and twisting; nevertheless, instead of decreasing the restrictions to avoid further aggravation, Petitioner's work restrictions were increased to twenty-five (25) pounds (PX 1). Petitioner never followed up with Concentra Medical after the second date of service. Petitioner testified that he decided to seek a second opinion because he was frightened when he noticed his feet and legs started to feel asleep and numb (T1 at 28).

On 3/2/11, Petitioner sought treatment with Dr. Bermudez at Herron Medical Center (a/k/a Alivio Physical Therapy); he reported complaints of low back pain which traveled down both legs with some tingling and numbness (PX 2). Petitioner informed his new medical provider that the low back pain was due to the repetitive lifting of steel drums weighing forty to fifty (40–50) pounds (PX 2). Dr. Bermudez requested an MRI of the low back and instructed Petitioner to remain off work. The 3/2/11 MRI was read by Dr. Payvar to identify grade I anterior spondylolisthesis of the L5 with respect to S1,

most likely as a result of underlying spondylosis; at L5-S1 there was disc dehydration with moderate bilateral foraminal stenosis (PX 2).

Post MRI, Petitioner was referred to Dr. Suneela Harsoor who on 3/10/11 reviewed the films and identified grade I L5 on S1 lumbar spondylosis and spondylolisthesis with mild arthritis; she also identified mild facet arthritis with stenosis (PX 3). The clinical exam revealed right lateral flexion pain anterior flexion pain and left later flexion pain. Dr. Harsoor prescribed physical therapy and lumbar epidural steroid injections at L5/S1 which took place on 3/22/11. The physical therapy took place at New Life Medical Center (PX 4). Petitioner testified that he returned to work with restrictions while under the care of Dr. Harsoor (T1 at 32). On 4/7/11, Petitioner reported mild relief of pain with the injection (PX 3); he testified the injection calmed his pain, but the returned after a week (T1 at 33). On 4/19/11 Dr. Harsoor administered a lumbar facet joint block to address the facet arthropathy symptomology; Petitioner once again reported mild relief with the procedure. Dr. Harsoor's 5/3/11 dictation documents worsening pain at work on 4/29/11 (PX 3). On 6/14/11, Dr. Harsoor administered epidural steroid injections at L5/S1. Post injection, on 6/2/11, Petitioner reported mild relief, pain at a 7/10 with continued numbness down both legs (PX 3). Petitioner was allowed to continue working with restrictions and was referred to a surgeon for further evaluation.

Petitioner was examined by Dr. Ronald Michael on 7/18/11 at the Illinois Nuerospine Institute (PX 6). The initial dictation documents a consistent accident history with low back pain and bilateral leg pain with numbness' and tingling. Dr. Michael reviewed the MRI scan and noted a broad-based subligamentous disk

herniation at L5/S1 with possible small extruded fragments. Dr. Michael advised Petitioner he could either learn to live with the pain or undergo an lumbar diskography to define the pain generator (PX 6). The 8/4/11 diskography with Dr. Harsoor documented 5/5 concordant pain at the L5/S1 level (PX 6). The post diskogram CT identified a grade IV radial tear at L5/S1; Dr. Payvar also noted grade I anterior spondylolisthesis of L5 with respect to S1 which appeared to be the result of associated underlying spondylosis at L5 (PX 6).

On of 8/8/11 Dr. Michael prescribed Soma, Ultram, Mobic and Zantac; he further instructed Petitioner to remain off work pending receipt and review of the diskography report.

On 8/15/11, Dr. Michael diagnosed Petitioner with a herniated nucleus pulposus at L5/S1 with an annular tear, grade I spondylolisthesis at L5/S1, and bilateral L5 spondylosis. Dr. Michael stated, "There is clearly a causal relationship between his current condition of ill-being and the work related injury described previously. The patient did not have low back problems prior to this. Indeed, he used to carry heavy weight with no problems whatsoever (PX 6)." Dr. Michael instructed Petitioner to remain off work and advised Petitioner he could either live with the pain or consider a lumbar fusion. Petitioner decided to move forward with surgery because he was in a lot of pain and felt he was unable to do anything (T1 at 40).

On 10/3/11, Petitioner sent an email correspondence with medical records to Respondent's counsel supporting the request for payment of TPD through 8/7/11 and TTD through the date of the correspondence (PX 35). At Respondent's request, Petitioner was examined by Dr. Jesse Butler on 11/7/11 (RX 1 at 6). Upon examination

of Petitioner, review of the diagnostic tests, and also the notes from Dr. Harsoor and Dr. Michael, Respondent's expert diagnosed Petitioner with spondylolisthesis spondylosis at L5/S1 (RX 1 at 8). He opined that the initial epidural injection was reasonable and necessary (RX 1 at 37). He further opined that the follow-up epidural injection was not indicated because the first did not provide much relief; Dr. Butler also disputed the necessity of the diskogram and the medial branch block (RX 1 at 10). Dr. Butler found Petitioner to be a candidate for a spinal fusion due to the failure of conservative care (RX 1 at 8). Post operatively, Respondent's expert opined that Petitioner would remain off work for six months (RX 1 at 38). Dr. Butler withheld his causation opinion because Respondent failed to provide the initial clinic notes from Concentra Medical Center (RX 1 at 9).

Dr. Butler authored a second report on 2/23/12 after receipt of the treatment records from Alivio Physical Therapy. Within the addendum report, Dr. Butler was of the opinion that the records from Alivio provided additional support to establish causality (RX 1 at 34). Respondent's expert noted that Petitioner reported progressive intolerance; he surmised that "unless the Concentra records contradict this report of Dr. Bermudez, there appears to be causal connection (RX 1 at 34)."

On 5/16/12, Karen Collier from Alternative Risk Management (ARM) sent a correspondence to Dr. Michael indicating the lumbar fusion would be covered by ARM; in-network services would be covered at 80% while out of network services were to be covered at 60%; Dr Michael was also informed that there would be an out of pocket deductible (PX 37). On 5/18/12, Petitioner sent an email correspondence to Respondent's counsel requesting confirmation that Respondent would cover the

deductible (PX 37). Petitioner sent a facsimile to Respondent's counsel on 8/20/12 asking for status of TTD benefits and reminding Respondent that surgery was set for 9/5/12 (PX 44).

Dr. Michael performed a L5/S1 posterolateral discectomy and fusion on 9/5/12 at Metro South Medical Center (PX 6 & PX 7). Post-surgery Petitioner was prescribed a bone growth stimulator to enhance bony fusion and healing (PX 6). As of 10/16/12 Petitioner reported 50% improvement to Dr. Michael. Physical therapy was prescribed on November 27, 2012.

Dr. Butler examined Petitioner for a second time on 12/17/12; it was during this second examination that he was finally provided the initial treatment records from Concentra Medical Center (RX 1 at 14). Despite the reported accident described within the Concentra Records (PX 1), as of 12/17/12, Dr. Butler opined that there was no causal connection between Petitioner's work activity and a specific incident that caused an injury (RX 1 at 18). Instead, Dr. Butler opined that there was a gradual deterioration that manifested and that his pain complaints seemed to reflect the natural history in a morbidly obese deconditioned young man (RX 1 at 24). Dr. Butler also testified Petitioner could return to work with twenty-five (25) pound lifting restrictions.

Petitioner continued his post-operative treatment with Dr. Michael. Upon completion of eight (8) weeks of physical therapy, as of 1/22/13, Petitioner reported minimal low back pain with occasional right leg pain and 60% overall improvement (PX 6). Dr. Michael instructed Petitioner to remain off work as he completed an additional course of physical therapy.

At Respondent's request, on 2/18/13 Dr. Butler authored a final report in which he opined that the records depicted vague if not conflicting descriptions of an injury. He summarized that Petitioner had pre-existing spondylolisthesis that pre-dated the accident date at hand. Dr. Butler set forth his own legal definition of causation, stating, "In order to establish causality, there needs to be an event or series of events that led to an aggravation of [Petitioner's] condition (RX 1 at 26)."

Petitioner continued physical therapy at New Life Medical Center through 4/26/13 (PX 4A). On 7/12/13 an FCE performed at New Life Medical Center found Petitioner capable of returning to work at a light physical demand level (PX 4A).

On 7/24/13 Dr. Michael noted continued complaints of low back and bilateral leg pain. Petitioner reported 60% overall improvement as compared to his pre-surgical state (PX6). Dr. Michael prescribed Mobic, Protonix, Ultram, Topamax, and Flexeril; he found Petitioner to be at MMI per the FCE with a weight limit of five (5) pounds and avoidance of bending, twisting, and lifting to the extent possible (PX 6).

On August 15, 2013, Petitioner sent Respondent's counsel an email correspondence requesting past due benefits and reminding Respondent that Petitioner had been discharged with permanent restrictions; Respondent was also reminded that the medical providers had yet to receive payment (PX 45). A follow-up correspondence was sent by Petitioner on 8/23/13 requesting authorization of vocational rehab and maintenance benefits (PX 46). On 8/30/13, Petitioner sent copies of all outstanding medical bills to Respondent (PX 47).

Petitioner testified that he attempted to return to work for his employer; however, Respondent did not give him his job back (T1 at 46). Petitioner took it upon himself to

look for work with other employers. With the use of his documented job search diary (PX32), Petitioner testified that he contacted approximately thirty (30) employers from 7/29/13 through 10/17/13 (*Note: PX 32 actually identifies thirty-two potential employers*). Petitioner testified the employers were unable to give him work because of his work restrictions (T1 at 47). Petitioner testified he contacted from eighty to ninety (80-90) employers from October 2013 through September 2014. He stopped documenting the employers contacted because he felt it was no longer helping (T1 at 51).

Petitioner received a check from ARM in the amount of $3,353.25 dated 9/25/13, (PX 51). Karen Collier testified that this check was sent to Petitioner at the request of Ornela Joyner (T2 at 20). Ms. Collier testified she sent a check to Petitioner in the amount of $2,419.60 at Ms. Joyner's instruction; this check is dated 5/13/14 and is also from ARM Insurance Services (PX 51).

Although he was discharged with permanent restrictions, Petitioner continued following up with Dr. Michael to refill his pain medication. Dr. Michael's dictations document increased symptoms of low back pain and lower extremity complaints. As of 7/22/14, Dr. Michael noted complaints of low back pain with bilateral lower extremity numbness and tingling; a CT scan of the lumbar spine was ordered and completed on 7/28/14 (PX 6). The study demonstrated post-operative changes at L5/S1 with grade 1 anterolisthesis at L5/S1 and no evidence of hardware complication (PX 6). As of 8/5/14, Dr. Michael identified three possible causes of Petitioner's ongoing complaints: 1) pseudoarthrosis; 2) hardware irritation; or 3) adolescents level disc disease. Dr. Michael recommended a lumbar diskogram to rule out the cause of the ongoing complaints.

The 8/26/14 diskogram administered by Dr. Michael failed to demonstrate any concordant discs superior to the fused L5/S1 level (PX 6). Dr. Michael determined that the two remaining causes of pain were either pseudoarthrosis or hardware irritation at L5/S1 (PX 6). On 9/4/14 Dr. Michael recommended surgery to assess the fusion. If the fusion healed properly, this means that the hardware irritation is the reason for the ongoing pain and Dr. Michael simply seeks to permanently remove the hardware. If it is determined during the surgery that the fusion failed, Dr. Michael intends repeat the fusion surgery by reinserting new hardware (PX).

Subsequent to Dr. Michael's surgical recommendation, on 9/22/14 Petitioner found employment as a laborer through a temporary agency. From the date of hire through the initial date of arbitration, 12/11/14, Petitioner worked through this temp agency on a conveyor belt line as a packer. Petitioner described the work as light duty; he generally works forty hours per week and finds himself standing all day performing his packing duties (PX 63). Since the return to work, Petitioner has noticed increased pain which prevents him from standing all day. Petitioner testified that he was initially hesitant to move forward with surgery. Since his return to work, Petitioner has decided to proceed with surgery because he cannot stand the pain and the pills are no longer helping (T1 at 63). As of the date of arbitration Petitioner testified he was taking seven (7) different medications; Petitioner testified that the medication makes him feel sleepy and occasionally hurts his stomach (T1 at 52 & 94). Petitioner was unable to recall each medication he was taking on a daily basis. With the use of a hand written list, Petitioner identified Gabapentin, Topiramate, Cyclobenzaprine, Meloxicam, Tramadol, Pantoprazole, and Ketoprogen (EX 33). Petitioner testified that his family has suffered

since his work accident. He wants to undergo the surgery because he wants to work "the right way" and help his children (T1 at 65). On cross examination, Petitioner acknowledged he is not a US Citizen; nevertheless, he listed himself as a citizen when applying for employment for Respondent in order to support his family.

Petitioner's supervisor, Francisco Calderas, testified on Respondent's behalf and stated Petitioner had worked for Respondent for five years (T2 at 55). As a supervisor, Mr. Calderas was familiar with Petitioner's work station. According to the supervisor, Petitioner worked on the platform fixing drums (T2 at 40). The drums arrived at Petitioner's station atop a blaster or roller conveyor belt (T2 at 41). Petitioner would pull the drum off the roller, roll the drum to the (straightening) machine and then slides the drum into a machine that is a foot off the ground by tilting the drum and using force to push up the drum (T2 at 41 & 61-62). Mr. Calderas confirmed Petitioner's testimony that through the initial date of accident Petitioner completed his work duties without complaints of low back pain, that Petitioner reported the accident on 2/16/11 and continued working until 2/22/11 when the Petitioner could no longer stand the pain (T2 at 47, 52 & 54). On cross examination, Mr. Calderas confirmed that Respondent terminated approximately 80% of its workforce due to issues with their immigration status (T2 at 63).

Karen Collier, an employee from Alternative Risk Management (ARM) also testified on Respondent's behalf. Ms. Collier confirmed that Respondent is self-insured and as an employee of ARM, she processes checks and reviews both workers' compensation and group health claims for Respondent. (T2 at 7-8). According to Ms. Collier, OJ is the Respondent's HR manager who decides whether treatment is covered

by the Workers' compensation insurance (T2 at 22). During the time frame of Petitioner's treatment, Ms. Collier acknowledged it was especially common for Respondent to push treatment on injured workers through group heath when there is a pending Worker's compensation claim (T2 at 29-30). After being informed that Petitioners' claim was not work related, OJ instructed Ms. Collier to send the 5/16/12 correspondence to Dr. Michael which is is the subject of PX 37 (T2 at 9).

Findings/Analysis

With respect to accident, the Arbitrator finds as follows:

The Arbitrator took into account Petitioner's demeanor and found him to be a credible witness. The Arbitrator finds that Petitioner did sustain an accident that arose out of and in the course of employment.

An injury is accidental within the meaning of the Workers' Compensation Act when it is traceable to a definite time, place, and cause and occurs in the course of employment unexpectedly and without affirmative act or design of the employee. Matthiessen & Hegeler Zinco Co. v. Industrial Board, 284 Ill. 378 (1918). Even if the claimant has a preexisting condition, the injury is categorized an accident if "a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor." Laclede Steel Co. v. Industrial Commission, 6 Ill.2d 296 (1955).

Leading up through 2/16/11, there is no history of low back pain. Petitioner worked for the Respondent for five (5) years. Petitioner's testified that he had low back complaints. The Petitioner testimony regarding his work duties and the injury are of record. On 2/16/11 Petitioner was at work when he began to experience low back pain

which was non-existent prior to the date in question. Petitioner reported the pain to his supervisor, but continued working while hoping the pain would subside. Respondent's witness corroborated the fact that Petitioner reported the accident and continued working.

Petitioner completed his shift an worked and additional three days. Petitioner testified that his pain increased and he informed his supervisor of the increased complaints. After a brief discussion with OJ in HR, Petitioner reported to the company clinic and provided a consistent account of the mechanism of injury.

During the initial date of service at Concentra, Petitioner informed Dr. Bunting he hurt his back on 2/16/11 while lifting heavy containers (PX 1). The mechanism of injury was specifically identified as the repeated lifting of forty to fifty (40-50) pound barrels (PX 1). This is the same history provided to each medical provider.

Dr. Butler's opines that Petitioner did not sustain a work accident on the date in question, however, Petitioner has identified the time, place, and cause of his low back injury. The incident was reported immediately to a supervisor. The Arbitrator finds that the mechanism of injury remained consistent throughout the record. The Arbitrator therefore finds that Petitioner sustained a work accident on 2/16/11 that arose out of and in the course of employment, i.e. the repetitive lifting of metal drums.

With respect to causal connection, the Arbitrator finds as follows:

The Arbitrator finds Petitioner met his burden of proof and established that he sustained a low back injury on 2/16/11 which was causally related to the lifting of metal drums during the course of his employment.

It is well established law that proof of prior good health and change immediately following and continuing after an injury may establish that an impaired condition was due to the injury. Navistar International Transportation Corporation, 315 Ill. App. 3d 1197, 1206 (2000). The Court specifically stated that causal connection between work duties and a condition may be established by a chain of events including Petitioner's ability to perform duties before the date of the accident and inability to perform the same duties following that date. Id.

In the case at hand, Petitioner's testimony regarding the chain of events surrounding the injury is documented within the medical records and also supported by the testimony of Petitioner's supervisor. Prior to the incident in question, Petitioner never sought low back treatment was completely asymptomatic and he was able to complete his job duties without incident. Petitioner showed up to work on the date in question without low back discomfort. On 2/16/11, Petitioner reported to work in his same general state of good health, commenced his work activities, noticed the increasing low back pain, and reported the pain to his supervisor. Thinking the pain would subside, Petitioner continued working through 2/22/11, at which point he could no longer tolerate the pain. The chain of events demonstrates Petitioner's health deteriorated from a state which allowed him to work without issue through 2/16/16, to a state of disability after that date.

The Arbitrator is further convinced by the credible opinions of Dr. Michael who found Petitioner's condition of ill-being to be causally related to the work activities performed on 2/16/11 (PX 6; See dictation 8/15/11 & 1/22/13). The Arbitrator is unconvinced by the testimony of Respondent's expert. Dr. Butler authored a report on

2/23/12 in which he opined the medical records from Alivio Physical Therapy (a/k/a Herron Medical Center) provided additional support to establish causality (RX1 at 34). The initial dictation from Dr. Bermudez at Alivio Physical Therapy dated 3/2/11 states "[T]he patient noticed pain in the lower back due to repetitive lifting of steel drums. These drums weigh anywhere from 40-50 lbs [sic] and place them on machine lines. He noticed this on 2/16/11 and reported the injury on 2/22/11 (PX 2)." The 2/23/12 report was authored by Dr. Butler prior to his review of the initial treatment notes from Concentra medical records; he concluded that unless the Concentra records contradict the report of Dr. Bermudez, there appeared to be causal connection (RX 1 at 34).

It was not until 12/17/12 that Dr. Butler finally had the opportunity to review the notes from Concentra Medical Center (PX 1) and additional notes form New Life Medical Center (PX 4). Petitioner informed Concentra that he injured himself on 2/16/11; "the mechanism of injury was lifting of many 40-50# barrels in a day and he noticed his back begin hurting almost a week ago (PX 1)." Despite the consistent accident history documented within the initial note at Concentra on 2/22/11, Dr. Butler ignored his prior opinion and determined there was no causal connection between Petitioner's work activities and Petitioner's condition of ill-being (RX 1 at 25). Dr. Butler found the records to be conflicting and vague and therefore determined Petitioner's pre-existing spondylolisthesis was not aggravated by his work duties because there was no clear injury but a gradual deterioration that manifested itself (RX 1 at 24).

Assuming arguendo that Petitioner experienced gradually increasing low back pain prior to 2/16/11 as as Dr. Butler indicated, it is undisputed that Petitioner never sought treatment for low back pain. He was able to complete his work duties without

issue up to through date of accident. It was not until 2/16/11 that Petitioner's pain became sufficiently bothersome that he reported the pain to Respondent and eventually sought treatment. Upon seeking treatment, Petitioner consistently told each provider that the back pain resulted from the repetitive lifting of metal drums/barrels at work. Taking into account the lack of prior history and the immediacy of his complaints, the Arbitrator finds that there exists a causal connection between Petitioner's work duties on 2/16/11 and his condition of ill-being. For the aforementioned reasons, the Arbitrator finds Petitioner satisfied his burden of proof and established causal connection.

With respect to reasonableness and necessity of accrued medical, the Arbitrator finds as follows:

The Arbitrator finds that all the treatment rendered prior to arbitration was reasonable and necessary to treat Petitioner's condition of ill-being. There is no dispute within the records as to the reasonableness and necessity of the majority of the treatment rendered. Dr. Butler agreed with the necessity of the first epidural steroid injection on 3/22/11 and Dr. Michael's recommendation of a lumbar fusion (RX1 at 10). Respondent's hired medical expert only negates the necessity of the lumbar facet block (4/19/11), the second epidural steroid injection (6/14/11) and the discogram (8/4/11) (RX 1 at 10). Aside from the three procedures isolated by Dr. Butler as unnecessary, the record is devoid of any dispute regarding reasonableness and necessity of the remaining treatment rendered through the date of arbitration.

The Arbitrator notes that Respondent failed to rely upon a utilization review to deny the reasonableness and necessity of the treatment rendered. Pursuant to Section 8.7(i)(3) of the Act, "An employer may only deny payment of or refuse to authorize payment of medical services rendered or proposed to be rendered on the grounds that

the extent and scope of medical treatment is excessive and unnecessary in compliance with an accredited utilization review program under this Section." This section of the Act is applicable to all treatment rendered on or after 9/1/11. Once a Petitioner meets its burden of proof and establishes causal connection, if Respondent fails to offer a utilization review opinion into evidence denying treatment, then all treatment is therefore deemed reasonable and necessary.

Through the date of Arbitration, the following balances remained outstanding pursuant to the fee schedule:

1. Alivio Physical Therapy	3/2/11 – 4/18/11	$793.30
2. Delaware Place MRI	3/2/11	$1,617.75
3. New Life Medical	3/19/11 – 7/12/13	$44,811.80
4. Rogers Park One Day Surgery (Fac)	3/22/11 – 8/4/11	$18,949.22
5. Rogers Park One Day Surgery (Phys)	3/22/11 – 8/4/11	$482.28
6. Paulina Anesthesia	3/22/11 – 8/4/11	$3,510.00
7. EQMD	3/30/11 – 7/26/13	$47,994.46
8. Dr. Ronald Michael	7/18/11 – 10/14/14	$36,333.68
9. Lakeshore Open MRI	8/4/11	$1,368.00
10. Pronger Smith Medical Center	5/17/12	$20.00
11. NW IND. Radiology	5/21/12	$27.36
12. OPTECH	5/22/12	$1,730.24
13. Metro South Medical Center	9/5/12 – 9/7/12	$114,939.51
14. BI Anesthesia	9/5/12	$3,597.95
15. BIOMET	9/18/12	$3,133.48
16. Archer Open MRI	1/12/12 – 7/29/14	$1,164.55
17. Walgreens	12/31/12 – 2/14/13	$70.00
18. G&U Orthopedics	3/18/13	$2,133.02
19. 900 North Michigan Surgical Center	8/26/14	$4,558.83
20. Northwestern Memorial Hospital	8/26/14	$2,965.00
	TOTAL BALANCE:	**$290,200.43**

The Arbitrator found accident and causal connection. The Arbitrator notes the absence of UR denying the necessity of treatment rendered and adopts the credible opinions of Petitioner's medical providers as it pertains to the procedures Dr. Butler found to be unnecessary. Accordingly, for the reasons noted, the Arbitrator finds all

medical treatment rendered through the date of arbitration to be reasonable, necessary, and causally related to the low back injury sustained on 2/16/11.

With respect to TTD & TPD, the Arbitrator finds as follows:

Respondent denies the accident and therefore denies Petitioner is entitled to any TTD/TPD benefits. Having established accident and causal connection, the Arbitrator finds Petitioner satisfied his burden of proof and is entitled to TTD benefits from 3/2/11 through 3/14/11 and 8/8/11 through 9/21/14 for a total of 164 & 6/7th weeks. Petitioner has also satisfied his burden of proof in establishing entitlement to TPD benefits from 2/17/11 through 3/1/11; 3/15/11 through 8/7/11, and 9/22/14 through 12/11/14.

During the time in question, Petitioner was either completely off work or capable of returning to work with restrictions. Petitioner testified that although off work for periods of time, he did return to work with restrictions for Respondent while treating at Concentra (2/17/11 - 3/1/11) and while he waited for approval of surgery (3/15/11 - 8/7/11). From 2/20/11 through 3/1/11, Petitioner had a net income of $484.95; he is therefore entitled $35.67 in TPD (PX 31 & RX 4). During the second return to work for Respondent, Petitioner had net income of $2,704.14 through 6/28/11 and gross income of $1,691.59 through 8/7/11 (PX 31 & RX 4). [*Note: The amendments to Section 8(a) of the Act became effective 8/28/11.]* Petitioner is therefore entitled to $2,310.49 for the second period of work with restrictions.

After undergoing surgery, Petitioner sought to return to work with restrictions for Respondent but was never provided light duty work. He then found work through a

temporary agency (9/22/14 - 12/11/14). Respondent failed to offer evidence negating Petitioner's testimony regarding his attempt to return to work or the necessity of Petitioner's work restrictions. Petitioner earned more while working for the new employer and therefore is not entitled to TPD during the final period of work with restrictions.

Aside from the TPD, Petitioner is also entitled to TTD benefits for the periods of time he was either off work completely, or able to work with restrictions but unable to find employment (3/2/11 - 3/14/11 & 8/8/11 - 9/21/14). Taking into account an AWW of $376.92 and a minimum TTD rate of $330.00, Petitioner should have been paid $54,402.86 in TTD benefits during the time period in question.

Through the date of arbitration, Petitioner should have been paid a total of $54,749.02 in TTD/TPD benefits. Respondent is entitled to a total credit of $33,417.60 (TTD paid = $15,504; PPD Advance = $17,912.85). Taking into account the credit, the Petitioner is awarded $21,331.42 in back due TTD/TPD benefits.

With respect to future medical, the Arbitrator finds as follows:

The Arbitrator finds the surgery prescribed by Dr. Ronald Michael to be reasonable, necessary, and causally related to the 2/16/11 work accident. As noted above, the Arbitrator finds Dr. Michael to be credible and therefore is persuaded by his opinions. The Respondent failed to offer into evidence any opinion which negates the necessity of the surgery prescribed by Dr. Michael on 9/4/14. Although hesitant to undergo surgery at first, Petitioner testified he wants to proceed with the surgery because he is still in pain, no longer want to continue taking medication, and wants to be able to properly provide for his children.

The Arbitrator further notes that Respondent failed to submit the request for surgery to Utilization Review as required by Section 8.7(i)(3) of the Act. Having established casual connection, the Respondent has no legal basis to deny the necessity of surgery. For the aforementioned reasons, the Arbitrator orders the approval surgery prescribed by Dr. Ronald Michael on 9/4/14.

With respect to penalties and attorney's fees, the Arbitrator finds as follows:

The Arbitrator finds that penalties and attorneys' fees pursuant to Section 16, 19(l) and 19(k) of the Act are not warranted. Given the facts presented in this case, and after considering the parties' motion and response, the Arbitrator finds that Respondent had a reasonable dispute regarding the Petitioner's injuries and treatment and that their reliance on the opinion of their Section 12 examinations throughout Petitioner's treatment. Respondent's conduct was not unreasonable, vexatious and/or in bad faith. Thus, Petitioner's claim for penalties and fees under Sections 19(k), 19(l) or 16 of the Act is denied.

Although the Arbitrator's findings in this matter are favorable to the Petitioner, the Arbitrator finds that Respondent's reliance on the opinion of their IME and their denial of benefits based upon that opinion was not unreasonable or in bad faith.

Ketki Steffen
Signature of Arbitrator Ketki Shroff Steffen

5/6/15
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael L. McCarty

Petitioner,

vs.

NO. 11WC 26560

16IWCC0235

Community Living Options,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary disability, permanent disability, medical expenses, causal connection, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 16, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

16IWCC0235

No bond is required for removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 3 1 2016
SJM/sj
o-3/10/2016

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McCARTY, MICHAEL L
Employee/Petitioner

Case# **11WC026560**

16IWCC0235

COMMUNITY LIVING OPTIONS
Employer/Respondent

On 9/16/2015, 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 0.26% 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:

0157 ASHER & SMITH
CRAIG SMITH
P O BOX 340
PARIS, IL 61944

1337 KNELL LAW LLC
MATT BREWER
504 FAYETTE ST
PEORIA, IL 61603

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

16IWCC0235

☐ 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

MICHAEL L. McCARTY
Employee/Petitioner

Case # 11 WC 26560

v.

Consolidated cases: N/A

COMMUNITY LIVING OPTIONS
Employer/Respondent

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 Molly Dearing**, Arbitrator of the Commission, in the city of **Urbana, Illinois**, on **July 15, 2015**. 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 **June 14, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$19,859.84**; the average weekly wage was **$381.92**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **0** dependent children.

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$1,745.94** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$1,745.94**.

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

ORDER

Respondent shall pay all reasonable and necessary medical services relative to Petitioner's bladder rupture, as provided in Sections 8(a) and 8.2 of the Act, and subject to the fee schedule. Petitioner was at maximum medical improvement for his condition resultant from his work injury on August 15, 2011. All medical bills after that date are denied. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay temporary total disability benefits of $254.61 for a period of 7 weeks, commencing June 14, 2011 through August 1, 2011, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $253.00 for 37.5 weeks, because the injuries sustained caused the 7.5% loss of use of his person as a whole, as provided in Section 8(d)2 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.

Arbitrator Molly Dearing

September 11, 2015
Date

SEP 16 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MICHAEL L. MCCARTY
Employee/Petitioner

v. Case No. 11 WC 26560

COMMUNITY LIVING OPTIONS
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

STATEMENT OF FACTS

The parties stipulated that on June 14, 2011, Petitioner sustained an accidental injury that arose out of and in the course of his employment on June 14, 2011. Arb. X 1. On his date of accident, Petitioner was fifty-nine years of age (Arb. X 1) and employed by Respondent performing maintenance work. He testified that his job duties included lifting bags of salt, filling water softeners, mowing, unloading groceries, climbing onto the roof of the facility, cleaning the gutters, moving equipment such as a washers or dryers, repairing hot water heaters, and performing general maintenance work. Petitioner described the job as requiring lifting up to one hundred thirty pounds.

Petitioner testified that on June 14, 2011, he was operating a commercial scrubber when he hit a squeegee that was lying on the floor, and the handle of the commercial scrubber twirled around and hit him in the lower abdominal area. The force of the blow knocked him to the floor. He was taken to Paris Community Hospital emergency room, where he was treated and then transferred to Carle Foundation Hospital. PX 1. He was admitted to Carle Foundation Hospital, where he came under the care of Dr. Gregory Maurer. A CT of the pelvis revealed a bladder laceration without apparent fracture in the pelvis. Dr. Maurer assessed him with an extraperiotenal bladder rupture and he was catheterized for four weeks. Petitioner was discharged with a Foley catheter and a follow-up appointment with Dr. Maurer in four weeks. He was removed from work at that time. PX 2, 3. Petitioner denied experiencing any low back pain subsequent to his work accident.

On July 6, 2011, Petitioner underwent a CT of the abdomen and pelvis, which revealed that the fluid collection present on June 14, 2011 had resolved and the perforation had been sealed without extravasation. PX 2, RX 11. A cystogram of July 11, 2011 revealed left-sided vesicoureteral reflux to the level of the renal pelvis without ureteral dilatation and prostate calcifications, and it was negative for evidence of bladder rupture or persistent extravasation. PX 2. Also on July 11, 2011, Petitioner presented to Dr. Maurer, who noted that his cystogram "looks good", and his bladder appeared to be healing nicely post-surgery. Dr. Maurer ordered urodynamic testing and he released Petitioner to return to work on August 1, 2011 with no noted restrictions. PX 2, RX 10. Petitioner testified that at this time, Dr. Maurer ordered work restrictions of no lifting greater than ten pounds with no climbing and to self-catheterize four times daily.

Petitioner presented to his primary care physician, Dr. Leland Phipps, on July 14, 2011 and reported that "things are starting to heal" following his bladder rupture and subsequent cystoscopy. He stated that Dr. Maurer was going to allow him to return to work on August 2, 2011, but stated that he "does need a weight restriction." Dr. Phipps assessed him with a history of a "bladder rupture in a gentleman who has had numerable neurologic problems in the last three months." Dr. Phipps ordered work restrictions of no lifting greater than fifty pounds until he returned to Dr. Maurer on August 15, 2011. PX 22.

On August 15, 2011, Petitioner presented to Dr. Leland Phipps and reported having difficulty with urinary incontinence for the prior week. "He had not had much difficulty with this before." He also reported self-catheterizing, but denied any new complaints. Dr. Phipps assessed Petitioner with a urinary tract infection from self-catheterization caused by his ruptured bladder. He prescribed him Cipro and he allowed him to return to work without restrictions. PX 4, RX 10. Petitioner testified that he believed he was under work restrictions by Drs. Phipps, Maurer, and Schwartz in August 2011.

On August 29, 2011, Petitioner presented to Dr. Maurer and reported that he had not been catheterizing himself for the prior two weeks. He had been experiencing overflow incontinence. "[W]hat we are looking at here is that he has an atonic bladder, that there is not a whole lot I can really do for that." Dr. Maurer prescribed him Bethanechol and advised him to catheterize himself three to four times per day. Dr. Maurer ordered him to discontinue the use of Flomax and return in three months. PX 2, 3.

On September 20, 2011, Petitioner returned to Dr. Phipps and complained of being despondent and experiencing some dysuria. He reported self-catheterizing four times per day. "Dr. Maurer has told him that this is how it is going to be for the rest of his life and that has left him a bit despondent." He denied any new complaints with the exception of being tired. Dr. Phipps assessed him as status-post bladder rupture "now with bladder that just does not work." He was prescribed Fluoxetine and instructed to discontinue Bethanechol, and he was ordered to undergo a urinalysis, and a C and S and general health panel. PX 4.

On September 26, 2011, Petitioner requested Dr. Phipps refer him to Dr. Ron Steele because he was "not very happy" with Dr. Maurer. PX 4.

On September 29, 2011, Petitioner presented to the emergency department at Union Hospital. He reported occasional urine leakage at night, as well as extreme lower abdominal pain that had developed over the prior two weeks. Petitioner noted a history of being in "normal health until the Spring of 2011 when he had a urinary tract infection. He was referred to Carle Clinic and was told he had kidney stones. In roughly May or June 2011 he had a procedure at Carle Clinic. He recalls having some sort of cystoscopy, some stents placed in his ureter and the thinks he had a laser treatment on a kidney stone and he felt fine. Unfortunately a month later he suffered trauma to his lower abdomen...He was taken to the emergency room and was felt to have a ruptured bladder. He went back to Carle Clinic and was there for about a week. He did not have surgery...he has been self-catheterization four times a day since he left the hospital at Carle Hospital following his one week admission, following his traumatic rupture." Petitioner was assessed with acute lower abdominal pain, acute renal failure, hyperkalemia, microcytic anemia, recent rupture of the bladder, and recent kidney stone procedure. Dr. Stephen Schwartz opined that Petitioner's acute renal failure was most likely due to obstructive uropathy and bilateral

hydronephrosis, "[t]he patient most likely is not self catheterizing himself as he claims to be", relative hypotension, persistent use of ibuprofen, and a possible urinary tract infection. A Foley catheter was anchored and urology and nephrology specialists were consulted. PX 5, 6.

On October 12, 2011, Petitioner presented to Dr. Schwartz and reported doing very well with his Foley catheter. Dr. Schwartz noted that he "was on ISC previously, but had trouble, mainly because he was not cathing enough." Dr. Schwartz's impression was areflexic neurogenic bladder, resolved obstructive uropathy, polyuria, and history of kidney stones. Petitioner was instructed to return for a pressure flow study and assessment for a clear intermittent bladder catheterization, and to continue utilizing the Foley catheter. PX 6.

On October 13, 2011, Petitioner presented to Dr. Phipps. He reported having been admitted to Union Hospital for acute renal failure and outlet obstruction. Petitioner indicated "feeling quite a bit better now" with improved anxiety and depression. Dr. Phipps assessed him with outlet obstruction and a neurogenic bladder. PX 4.

On October 19, 2011, Petitioner returned to Dr. Phipps and reported feeling "fairly well." He also reported having renal failure "secondary to outlet obstruction all secondary apparently to his ruptured bladder. He saw his nephrologist yesterday and was given Cipro for an 'infection' but had been told in the hospital that Cipro was not going to be effective for him." Dr. Phipps prescribed him Levaquin and removed him from work until he was cleared by his nephrologist. PX 4.

Petitioner underwent an MRI of the lumbar spine on December 14, 2011, which revealed degenerative facet changes of the lumbar spine, mild to moderate left-sided neural foraminal narrowing at L3-4 and L4-5. PX 7. Petitioner continued to return to Dr. Schwartz for treatment through December 2011. PX 6.

On February 14, 2012, Petitioner presented to Dr. Richard Bihrle. He reported prior treatment for multiple bladder infections in January 2011, developing urosepsis and urinary tract stones in April 2011, incomplete bladder emptying for which he began intermittent catheterization four times daily, and the removal of urinary stones in May 2011. Petitioner also reported sustaining a bladder rupture in June 2011 when he was struck in the abdomen with equipment while polishing floors. Dr. Bihrle assessed Petitioner with a small capacity, high pressure bladder, recurrent urosepsis, history of bladder perforation, history of renal stones, and history of renal failure. Dr. Bihrle ordered repeat imaging, including a noncontrast CT scan of the abdomen and pelvis, as well as a video urodynamic. PX 8.

A CT of the abdomen and pelvis of March 27, 2012 revealed no urinary stones and abnormal appearance of left kidney showing cortical scarring, perinephric stranding and mid prominent of ureter that may suggest low-grade infectious changes. PX 8.

On April 9, 2012, Petitioner underwent an MRI of the lumbar spine, which showed a mild diffuse disc bulge at L3-4, mild bilateral facet and ligamentum flavum hypertrophy at L3-4, mild bilateral neuroforaminal stenosis at L3-4, a mild diffuse disc bulge at L4-5, mild bilateral facet and ligamentum flavum hypertrophy at L4-5, mild bilateral neuroforaminal stenosis at L4-5, and mild bilateral degenerative facet arthropathy at L5-S1. The radiologist's impression was mild

degenerative disc and facet disease of the lumbar spine, without significant spinal canal stenosis or neuroforaminal compromise. PX 8.

On May 17, 2012, Petitioner underwent a spiral ileal Monti creation and ileal bladder augmentation with Dr. Bihrle with a post-operative diagnosis of neurogenic bladder, small bladder capacity, recurrent urinary tract infections with urosepsis, and history of bladder perforation. Petitioner returned to Dr. Bihrle for post-operative care thereafter. PX 8, 9, RX 12. Petitioner testified that subsequent to his surgical procedure on May 17, 2012, his self-catheterization process became more extensive and presently takes thirty five to forty five minutes, whereas he catheterized himself in twenty minutes prior to that procedure.

On September 23, 2012, Petitioner presented to the emergency department at IUH Hospital with complaints of an onset of acute abdominal pain. Dr. Bihrle noted that there was "no preceding trauma and there was no identifiable cause for this." The severity of Petitioner's pain caused him to blackout at that time, and he was transferred to the emergency department, where he was catheterized and approximately three hundred fifty milliliters of urine was removed. A CT scan performed in the emergency department revealed a possible bladder perforation. He was admitted to the hospital and given IV medications, fluids and conservative management with an indwelling catheter. Petitioner improved following his admission to the hospital and a subsequent CT scan of the pelvis of September 26, 2012 revealed a mucosal dissection of the ileal Monti chanel without any evidence of any urinary bladder rupture. He was discharged on September 27, 2012. RX 12.

Petitioner underwent physical therapy at Paris Community Hospital from October 24, 2012 through January 7, 2013. PX 11.

Petitioner returned to Dr. Bihrle on October 16, 2012 and January 8, 2013. PX 8.

On January 15, 2013, Petitioner presented to Dr. Tazudeen Vathiar for a neurological evaluation. Petitioner reported "some back problems since he feel [sic] in June 2011 and he ruptured his bladder." He further reported being "healthy until he hurt his lower abdomen at work in June of 2011 and he had bladder surgery last year." Dr. Vathiar's impression was intention tremors in both upper extremities, back problems possibly related to L5-S1 root irritation, and cerebellar ataxia. Dr. Vathiar ordered an MRI of the brain and cervical spine, as well as an EEG. He prescribed Petitioner Mysoline on a trial basis. PX 12. On July 9, 2013, Petitioner returned to Dr. Vathiar and stated that since his injury on June 14, 2011, "he has lost control of his bladder and he has poor bladder function. He has no erection since the injury. He has stoma from the bladder. He self-catheterizes. He has some nerve damage around the perineum from this injury He has right ulnar neuropathy, which was operated and carpal tunnel syndrome. He has neurogenic bladder since the accident two years ago." Dr. Vathiar opined that he was unable to evaluate Petitioner's "bladder problems properly" and instructed him to follow an urologist to assist him with that condition. Dr. Vathiar released him from care. PX 12.

Dr. Andrew Zelby performed a records examination on October 1, 2014 pursuant to Section 12 of the Act. After reviewing Petitioner's treating medical records subsequent to and prior to his work accident, as well as his imaging studies, Dr. Zelby opined that Petitioner did not develop a neurogenic bladder as a consequence of his work accident of June 14, 2011. He stated that, "[i]t was clear that he did have incontinence and had to self-catheterize for his bladder

rupture." He explained that a symptom of overflow incontinence is an extended bladder, and that a common cause for overflow incontinence can be a neurogenic bladder. "Whatever the cause, this condition was present prior to his June 2011 work injury. Dr. Zelby further opined that Petitioner's work injury did not cause, aggravate, exacerbate any pre-existing condition in his lumbar spine. RX 7.

Dr. Zelby testified by way of evidence deposition on March 19, 2015. He is board-certified in neurosurgery. Dr. Zelby testified that he treats patients with neurogenic bladder. He further testified that he did not review any of Petitioner's treating urologists records, though he stated he was aware that Petitioner had undergone multiple bladder surgeries. RX 7.

Dr. Richard Bihrle testified by way of evidence deposition on March 15, 2013. Dr. Bihrle is board-certified in urology. He testified that he initially treated Petitioner on February 14, 2012. Dr. Bihrle testified that his impression at that time was that Petitioner "clearly had a neurogenic bladder." He described a neurogenic bladder as a paralyzed one. Dr. Bihrle stated that "the exact cause of that [the neurogenic bladder] was not clear to me. I think I had probably opined to him that the bladder perforation itself would be unlikely to lead to a neurogenic bladder." He stated that perforation of the bladder requires a significant impact, and is generally seen alongside pelvic fractures and in motor vehicle accidents. Petitioner's perforation of the bladder suggested that Petitioner suffered a significant trauma as a result of his work accident, such as a ruptured disc, degenerative disc disease, spinal stenosis, or facet arthritic changes, because "the rupture itself doesn't injure the nerves." Dr. Bihrle opined that the impact of Petitioner's work accident may have caused a neurological injury that led to a neurogenic bladder condition, rather than the perforation causing the neurogenic bladder, as it "was just something occurring at the same time." He testified that "I know he had an MRI that we had a report of that showed some disc space disease, some spinal stenosis, some facet arthritic changes. And so perhaps, if they were at the level of the exit of S1, S2 and S3 nerves, this could lead to a neurogenic bladder from a neurologic injury, not from the perforation." PX 8.

Dr. Bihrle noted that his opinion assumed Petitioner had "a normal bladder, you don't have some, you know, unusual bladder, some preexisting problem with your bladder..." prior to the work accident. He stated that "if I had to put this together, that there was no preexisting urinary problem and then there is after this perforation, I think that it's more likely than not a neurological problem from disc." Dr. Bihrle testified that if Petitioner had urinary difficulties prior to his work accident, then that would be significant to his causation opinion because preexisting urination difficulties could correlate to his current condition, as a history of urinary retention with urinary tract infection with Foley catheter in place prior to his work accident would be consistent with a neurologic bladder and consistent with the symptoms for which he presented to Dr. Bihrle. Dr. Bihrle opined that Petitioner may have had neurogenic bladder prior to his work accident, though it may not have been documented at that time. He testified that he did not opine as to the causation between Petitioner's bladder trauma resultant from his work injury of June 14, 2011 and the surgery that he performed. Dr. Bihrle testified that a ruptured bladder will generally heal with a small scar and the bladder will function normally, and a patient would be at maximum medical improvement approximately two months following a bladder perforation. PX 8.

Petitioner testified that prior to his work accident, he experienced difficulty with urine leakage for which he sought treatment with Dr. Maurer, who instructed to self-catheterize to assist with the urinary leakage. He stated that he then discovered he had kidney stones that were

surgically removed and Dr. Maurer released him to return to work on May 16, 2011. Petitioner was unable to recall whether he suffered any urinary incontinence issues prior to the work accident.

Petitioner testified that subsequent to his June 14, 2011 work injury, his catheterization schedule changed. He explained that he was instructed to self-catheterize every four hours daily following the work accident, whereas prior to, he was under no specific guideline for routine catheterizations, though he acknowledged that he catheterized himself four times daily before his work accident. Petitioner testified that he presently catheterizes himself six times daily. He stated that he attempted to return to work for the Respondent in August 2011, and was refused return to work with restrictions by Tara Wright. He testified that, "she said, you know, that she wanted to know about the weight restriction, who would carry the bags of salt, who would help with this and that. I don't know, but I'm going to do what the doctor tells me. It's not going to be me, you know. And who is going to get on the roof and clean the gutters. I said I'm doing what the doctor says, and it's not going to be me. She didn't agree with the cathing... she just told me she would not allow me to return to work until I had no restrictions." Petitioner testified that he did not return to employment with Respondent, and he denied that he returned to work on August 2, 2011. Thereafter, Petitioner obtained employment with a mass transit authority as a driver, though he did not return to that position following his surgery on May 17, 2012.

Petitioner identified photographs of his surgical site, as well as the catheter he used and continues to use, and the procedure for catheterizing his bladder stoma. PX 10.

Petitioner testified that following his work injury, he presently has a restriction of no lifting greater than ten pounds and he continues to catheterize himself, a process that generally consumes thirty five to forty five minutes, every four hours daily. He stated that he does not "have the strength I used to have. I can't do the things that I used to be able to do. I mean I've learned to adjust to this, but like I say, this is something I'm going to do the rest of my life, you know, and it's all related to that injury that I received. I've tried to get some different kind of help, but just nothing has really worked out." He stated that he is not able to drive long distances in a car or mow his yard due to the vibrations and bouncing of the mower. Petitioner testified that Dr. Bihrle has prescribed him pain medication to manage pain resultant from bladder spasms that often last five minutes and occur approximately four times per month. He continues to return to Dr. Bihrle every two months for care and treatment.

Petitioner testified that following Respondent's refusal to accommodate his work restrictions in August 2011, he spoke to Jo Donaldson, the supervisor of Respondent's Tanner Place facility, who assisted him in completing the letter admitted as Respondent's Exhibit 4. He stated that he partially dictated the letter to Ms. Donaldson. The letter indicates that, "this letter is to inform you that due to medical issues I must resign my position...My recent medical condition is not related to my bladder issues or my kidney stone issues. My recent medical issues make it impossible for me to carry out the expected maintenance objectives at Tanner Place and Highview Terrace." RX 4. Petitioner testified that he submitted the letter on September 3, 2011, and he testified that he reviewed the letter prior to submitting it to Respondent. He identified the signature on the letter as his own. Petitioner testified that as of his resignation on September 3, 2011, that he was not under any work restrictions.

Tara Wright testified at Arbitration on behalf of Respondent. She is employed as an administrator for Respondent's facilities in Danville and Paris, Illinois. Ms. Wright testified that

Petitioner returned to work following his work injury on June 14, 2011 approximately on August 2, 2011, and then again went off of work on September 2, 2011, though he acknowledged that Respondent does not have any records reflecting that Petitioner received any pay during that time period. Ms. Wright testified that she was aware of his catheter, as they had discussed it. She did not recall having any conversation with the Petitioner about him returning on light duty, but she stated that Respondent would not have refused light duty had it been aware of the circumstances. Ms. Wrist testified that had Respondent not received Petitioner's resignation of September 3, 2011, his job would still have been available to him.

Petitioner's treating medical records prior to his work accident of June 14, 2011 were admitted into evidence. On January 4, 2011, Petitioner presented to Dr. Phipps with complaints of nocturia for the past few weeks and an odor with urination. He also reported that "it is hard to get his stream to start." He was assessed with prostatitis and he was prescribed Cipro. RX 10. On January 31, 2011, Petitioner returned to Dr. Phipps and reported continued difficulty with nocturia and urinary incontinence. He stated that his stream is getting smaller, though he denied dysuria. Dr. Phipps assessed him with benign prostatis hypertrophy and urinary incontinence. RX 10.

On April 18, 2011, Petitioner presented to Dr. Phipps with complaints of fevers, chills and aches over the prior twenty four hours. He reported self-catheterizing himself for the past ten years, but he "may not have done quite as a sterile job as he could this weekend when he was camping." A urinalysis was positive and he exhibited a white count of 12,900 with a shift. Dr. Phipps assessed Petitioner with a urinary tract infection to which he was prescribed Rocephin. He later represented being unable to care for himself at home and he was referred to hospitalists for admission at Paris Hospital. On April 18, 2011, Petitioner presented to Dr. Otyonye Onywewuchi at Paris Community Hospital with complaints of fever bouts, feeling sickly, difficulty walking, falling spells, and flank pain. Dr. Onywewuchi assessed Petitioner with urinary retention of unknown etiology and his antibiotics were continued. RX 10.

On April 20, 2011, Petitioner was treated at Carle Foundational Hospital for a neurological consultation. He had presented to Paris Hospital two days prior for rigors, fevers, and "black-outs", and he was diagnosed with a urinary tract infection and bacteremia. Petitioner thereafter had profound weakness, which prompted a request for a neurological workup. Petitioner reported he began experiencing urinary incontinence and bed wetting in January 2011, and he had been treated for prostatism, but his symptoms persisted. He presented to the urology department at Carle Clinic on April 11, 2011 and he was instructed to self-catheterize four times daily. "He did so until sat 4/16 but then went on an over night camping trip and did not cath himself again until Sunday after returning home." That night, he experienced episodes off rigors, and the following day, he developed vertigo and repeated "black-outs". He was take to Paris Hospital and was admitted. He complained at that time of extreme weakness and an inability to stand without assistance. Petitioner was assessed with urinary tract infection with sepsis, strep bacteremia, ARF, general weakness likely due to sepsis, "black-out" spells, obesity, a history of urinary retention with overflow incontinence, self-catheterizing at home. Petitioner was admitted to Carle Hospital. Dr. R. Alzaraz ordered blood work, a urine analysis and culture, a renal ultrasound, an EKG, an infectious disease and neurology consultation, physical therapy, and he prescribed Petitioner Levofloxacain. RX 8. Petitioner denied experiencing dizziness, vertigo, or black-out spells prior to his work accident of June 14, 2011 and he did not recall why he was hospitalized in April 2011. He could not recall whether he experienced dizziness, vertigo, fevers or black-out spells in April 2011, and he could not recall being diagnosed with bacteremia at that time.

On April 27, 2011, Petitioner returned to Dr. Phipps and reported feeling well. He was assessed with pyelonephritis, resolving sepsis, and urinary retention. RX 10.

On May 12, 2011, Petitioner underwent a surgical procedure with Dr. Maurer in which three small stones were extracted. There was a fourth larger stone that Dr. Maurer was not able to get to, which was on the right ureteral orifice. He next turned his attention to the left stent, was able to use a holmium laser to break up the stone on the left into smaller fragments. The Petitioner was to follow-up with Dr. Maurer following the surgery the next week for stent removal. Petitioner had a follow-up with Dr. Maurer on May 16, 2011, when he was released to go back to work. RX 13.

On June 6, 2011, Petitioner presented to Dr. Phipps with complaints of dysuria that began the weekend prior. He reported a burning sensation with urination. A urinalysis was positive. Petitioner was assessed with a urinary tract infection and prescribed Cipro. RX 10.

OPINION AND ORDER

In regard to disputed issue (F), Respondent disputes the casual relatedness of Petitioner's condition of ill-being to his work accident subsequent to August 15, 2011. Arb. X 1.

The Arbitrator concludes that Petitioner has failed to prove by a preponderance of the credible evidence that his current condition of ill-being is causally related to his work accident. In so concluding, the Arbitrator notes that Petitioner's treating urologist, Dr. Birhle, did not causally relate Petitioner's current neurogenic bladder condition or the surgical procedure he underwent on May 17, 2012 to Petitioner's work accident. Dr. Bihrle specifically testified that he did not form an opinion as to the causal relatedness of Petitioner's surgical procedure of May 17, 2912 to his bladder trauma resultant from his work injury of June 14, 2011, and he opined that Petitioner may have had neurogenic bladder prior to his work accident, though it may not have been documented at that time. PX 8. Moreover, Dr. Bihrle testified that a bladder perforation itself would be unlikely to lead to a neurogenic bladder because he explained that "the rupture itself doesn't injure the nerves." Dr. Bihrle instead related Petitioner's neurogenic bladder condition to a neurological injury, such as a ruptured disc, degenerative disc disease, spinal stenosis, or facet arthritic changes, that may have been caused by the trauma of the work accident. PX 8. He testified that "I know he had an MRI that we had a report of that showed some disc space disease, some spinal stenosis, some facet arthritic changes. And so perhaps, if they were at the level of the exit of S1, S2 and S3 nerves, this could lead to a neurogenic bladder from a neurologic injury, not from the perforation." Petitioner's MRI of his lumbar spine of December 14, 2011 showed degenerative facet changes of the lumbar spine and mild to moderate left-sided neural foraminal narrowing at L3-4 and L4-5 (PX 7), and an MRI of August 9, 2012 revealed only mild degenerative disc and facet disease without significant spinal canal stenosis or neuroforaminal compromise. PX 8. Petitioner's imaging studies lack significant findings at S1 and the record is devoid of any findings at S2 or S3, and in conjunction with Petitioner's testimony in which he denied experiencing any low back complaints following his work accident, do not support the presence of a sufficient neurological injury at the pertinent levels resultant from his work accident so as to be causative of a neurogenic bladder condition.

The Arbitrator further notes that Dr. Bihrle's opinions were based upon the lack of Petitioner's pre-exiting bladder complaints or difficulties prior to his work accident. He testified that his opinion assumed "a normal bladder, you don't have some, you know, unusual bladder, some preexisting problem." PX 8. However, Petitioner's treating medical records demonstrate that Petitioner had significant overflow incontinence issues temporally proximate to the work accident, as well as difficulties with bacteremia and urinary tract infections. Dr. Bihrle specifically testified that if Petitioner did indeed have urinary difficulties prior to his work accident, then such information would affect the causal relatedness in the present case. PX 8. Because Dr. Bihrle's causation opinion is based upon an inaccurate understanding of Petitioner's urological history, and given that his causation opinion may likely have changed had he been aware of Petitioner's prior urinary difficulties, the Arbitrator is disinclined to place evidentiary weight on such opinions. In light of the totality of the record, the Arbitrator instead is persuaded by Dr. Bihrle's testimony that the presence of preexisting urinary difficulties prior to his work accident, as Petitioner indeed exhibited, would correlate his current condition to his preexisting one rather than to his work accident, as Dr. Bihrle explained that a history of urinary retention with urinary tract infections with a Foley catheter in place prior to Petitioner's work accident would be consistent with a neurogenic bladder and consistent with the symptoms for which he presented to Dr. Bihrle. PX 8.

Further, in finding Petitioner's current condition of ill-being unrelated to his work accident, the Arbitrator finds significant the similarity in Petitioner's current complaints with those he experienced prior to his work accident. The Arbitrator notes that less than two months prior to his work accident, Petitioner presented for treatment for rigors, fevers, "black-outs" spells, weakness, and an inability to walk for which he was diagnosed with a urinary tract infection and bacteremia, and urinary retention with overflow incontinence. RX 8. Although Petitioner testified he improved thereafter, his treating records indicate that less than ten days prior to his work accident, Petitioner again presented to Dr. Phipps with complaints of dysuria and a burning sensation with urination. A urinalysis was positive. He was assessed with a urinary tract infection and prescribed Cipro. RX 10. The symptomatology Petitioner experienced prior to the work accident – overflow incontinence, frequent urinary tract infections, and bacteremia (RX 8, 10, 13) – redeveloped less than three months following his work accident and continued thereafter. PX 1, 5, 6, 8. Although Petitioner testified that his catheterization schedule changed as a result of his accident, the Arbitrator notes that Petitioner acknowledged catheterizing himself four times daily prior to the work accident, which is corroborated by his treating records (RX 8), and he continued to self-catheterize with the same frequency following his work injury. PX 1. The lack of any change in Petitioner's urinary condition from prior to the accident to the present undermines the suggestion of a relationship between his current condition of ill-being and his work injury.

Moreover, the Arbitrator notes that one month following his work accident, Petitioner reported an improvement in his condition upon presentation to Dr. Phipps on July 14, 2011. Petitioner's CT scan of July 6, 2011 revealed that his bladder perforation was sealed, and his cystogram of July 11, 2011 reflected no evidence of a recurring bladder rupture, which demonstrate that Petitioner's urinary leakage and incontinence subsequent to August 15, 2011 are unrelated to his bladder rupture resultant from his work accident. On August 29, 2011, Petitioner reported to Dr. Maurer experiencing overflow incontinence and Dr. Maurer diagnosed him at that time with a atone bladder. PX 1. The Arbitrator notes that Petitioner's overflow incontinence and subsequent complaints of dysuria on September 20, 2011, urinary leakage on September 29, 2011 (PX 5, 6), and neurogenic bladder (PX 6, 8) for which he underwent surgical intervention (PX 8) did not develop contemporaneously with the work accident and instead arose months subsequent

thereto, which further negates the finding of a causal relationship between his work accident and his current condition of ill-being. The aforementioned evidence demonstrates that Petitioner's ongoing urological difficulties subsequent to August 15, 2011 are unrelated to his work accident, and instead, a recurrence of his pre-existing condition.

The Arbitrator concludes that as a result of Petitioner's work accident of June 14, 2011, he sustained a bladder rupture for which he was released to return to work without restrictions by his urologist, Dr. Maurer, on August 1, 2011 and by his primary care physician, Dr. Phipps, on August 15, 2011. The Arbitrator finds he was at maximum medical improvement on August 15, 2011. The Arbitrator notes that Dr. Bihrle testified that following a bladder rupture, patients generally heal with a small scar and the bladder functions normally thereafter. He opined that patients with a bladder rupture are generally at maximum medical improvement approximately two months following a bladder perforation (PX 8), which supports a finding of maximum medical improvement on August 15, 2011.

In regard to disputed issue (J), and in accordance with the Arbitrator's foregoing conclusions, the Arbitrator finds that Petitioner's medical treatment to address his bladder rupture was reasonable and necessary, and Respondent shall pay all reasonable and necessary medical services relative to that condition, as provided in Sections 8(a) and 8.2 of the Act, and subject to the fee schedule. The Arbitrator finds that Petitioner was at maximum medical improvement for his work injury on August 15, 2011. All medical bills after that date are denied as unrelated to Petitioner's work accident. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In regard to disputed issue (K), Petitioner seeks temporary total disability benefits from June 15, 2011 through September 30, 2012. Arb. X 1. The Arbitrator notes that Petitioner was removed from work on June 15, 2011 by Dr. Maurer and then released to return to work without restrictions on August 1, 2011. PX 1, RX 10. Although Dr. Phipps placed work restrictions on Petitioner of no lifting greater than fifty pounds on July 14, 2011, he did so upon Petitioner's representations to him that he required "a weight restriction" (PX 22), which has no basis in the record. While Petitioner testified that he believed he remained under work restrictions in August 2011, his testimony is undermined by Dr. Phipps' release to return to work without restrictions on August 15, 2011 (PX 1) and Petitioner's acknowledgement that he was under no active work restrictions at the time of his resignation on September 3, 2011. Based upon the foregoing, Respondent shall pay Petitioner temporary total disability benefits for a period of 7 weeks, commencing June 14, 2011 through August 1, 2011. Respondent shall be given a credit in the amount of $1,745.94 for temporary total disability benefits paid.

In regard to disputed issue (L), as a result of his work accident, Petitioner suffered a bladder rupture, which subsequent diagnostic studies revealed healed thereafter (PX 2, RX 11), and required he self-catheterize four times daily. Dr. Maurer released him to return to work without restrictions on August 1, 2015, as did Dr. Phipps on August 15, 2015, though he resigned from his employment with Respondent on September 3, 2011. Based upon the foregoing and the record in its entirety, the Arbitrator finds that Petitioner is permanently and partially disabled to the extent of 7.5% of his person as a whole as a result of his work accident, pursuant to Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Krenc,

Petitioner,

vs. NO. 12WC 18873

Swallow Sewer & Water Construction,

16IWCC0239

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary disability, permanent disability, medical expenses, causal connection, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 3, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

16IWCC0239

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 3 1 2016
SJM/sj
o-3/24/2016
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KRENC, JAMES
Employee/Petitioner

Case# **12WC018873**

SWALLOW SEWER & WATER CONSTRUCTION
Employer/Respondent

16IWCC0239

On 8/3/2015, 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 0.14% 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:

5278 MARKS & ASSOCIATES LTD
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16IWCC0239

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

James Krenc
Employee/Petitioner

v.

Swallow Sewer & Water Construction
Employer/Respondent

Case # 12 WC 18873

Consolidated cases: ___

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 **Brian Cronin**, Arbitrator of the Commission, in the city of **Wheaton**, on **December 8, 2014**. 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. [x] 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. [x] 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. [x] 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. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] 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 **May 3, 2012**, 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 $**68,640.00**; the average weekly wage was $**1,320.00**.

On the date of accident, Petitioner was **48** years of age, ***single*** with **0** 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 $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**0.00**.

Respondent is entitled to a credit of $**0.00** under Section 8(j) of the Act.

ORDER

Medical benefits

The Arbitrator finds the medical care to be reasonable and necessary and orders Respondent to pay Petitioner an amount equal to the unpaid medical bills, **$78,712.17** (PX 5), pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of **$880.00**/week for **12-5/7** weeks, commencing **May 10, 2012** through **August 6, 2012**, as provided in Section 8(b) of the Act.

Permanent Partial Disability

Based on the five factors as required in §8.1b(b) of the Act, the Arbitrator finds that as a result of the accident of May 3, 2012, Petitioner has sustained a permanent loss of use, person as a whole, to the extent of **2.5%** thereof, pursuant to §8(d)(2) of the Act. Therefore, Respondent shall pay Petitioner **$695.78**/week for **12.5** weeks. Please see analysis on pages 16-17 of attachment.

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.

Signature of Arbitrator

July 31, 2015
Date

AUG 3 - 2015

16IWCC0239

ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES KRENC Employee/Petitioner	)	
v.	)	Case #: 12 WC 18873
SWALLOW SEWER & WATER CONSTRUCTION Employer/Respondent	)	Setting: WHEATON

FINDINGS OF FACT

Testimony of James Krenc

James Krenc ("Petitioner') is currently 51 years old and resides in West Chicago, Illinois. He is single and lives with his 26-year-old son. He also has a 24-year-old daughter. His highest level of education is high school. He is currently employed by Pro Drivers as a truck driver and has worked there since April 1, 2014. From August 2012 through March 2014, he was employed by Custom Companies. Prior to that, Petitioner had been employed by Swallow Sewer & Water Construction ("Respondent") for nearly 11 years.

While employed by Respondent, Petitioner worked as a truck driver and laborer. He operated a "low boy." Petitioner carried loads of dirt and stone in the back of his truck. On occasion, he would get out of the truck and lift a load. He lifted chains, picked up sewer frames and sewer pipe and gathered up anything that was left over at the job site.

On May 3, 2012, Petitioner was working for Respondent at the York Township job site. He started at 7:00 that morning. He moved a machine to the job site in Lombard, Illinois. The project entailed putting in a water main for the water tower. One of his job duties included getting the "dump box." Petitioner was loading scrap pipe into a truck. Petitioner testified that he bent over to pick up a piece of pipe to put it in the bucket when he felt a sharp pain in his lower abdomen on the right side. The piece he picked up was at least a couple hundred pounds and was made of cast iron. This incident occurred at 3:30-4:00 that afternoon, which was a Thursday. Petitioner eventually finished loading the truck with pipe and drove the truck back to the yard, which is located off Lacey Road in Downers Grove, IL.

When he returned to the yard, there was an employee in the yard named Pete Katralis. Mr. Katralis asked Petitioner why he was limping and Petitioner told him that he hurt himself on the job.

Petitioner went home that evening and experienced soreness and a burning-type pain.

Petitioner did not work on Friday. He was uncomfortable on Friday.

Petitioner attended his son's softball game. His son asked him to be first base coach.

On Sunday, May 6, 2012, Petitioner was sore. He went out for a walk and felt excruciating, burning pain on his right side. He called his girlfriend and asked her to pick him up. Due to the pain, Petitioner was unable to walk anymore. They drove to Delnor-Community Hospital ("Delnor"). At Delnor, Petitioner told the staff that that he was walking. He did not tell them that he had been hurt at work because he was afraid he would lose his job.

Petitioner sustained a previous, work-related injury to his hand while working for Respondent. At the time of the hand injury, he reported such injury to Anthony Rendina. Mr. Rendina got mad, yelled at him, and told him to get off the job. Petitioner did not work for 4-5 days and then went into Mr. Rendina's office and talked to him.

Anthony Rendina is in the courtroom today. He is the son of the owner of Respondent. He is either president or vice-president of Respondent.

Petitioner underwent a CT scan of his abdomen at Delnor on May 6, 2012. It showed that he had a hernia and that his bladder was being strangled. Dr. Batty scheduled surgery. Such surgery was not carried out because Petitioner did not have insurance.

On May 8, 2012, Petitioner went to Provena Mercy Medical Center ("Provena"). Petitioner told the Provena staff that he got hurt at work lifting pipe on a job site. They referred him to Dr. Borncamp. Petitioner saw Dr. Borncamp on May 9, 2012 and underwent hernia surgery a few days later. Petitioner paid $1,000.00 up front and out-of-pocket to Dr. Borncamp and $2,000.00 up front and out-of-pocket to Provena. Petitioner saw Dr. Borncamp on two occasions after the surgery. He last saw Dr. Borncamp in August 2012.

In August 2012, Petitioner was able to return to work. He did not return to work for Respondent, but for Custom Companies.

Petitioner sustained an umbilical hernia 10-15 years before the trial date (12/8/2014). He had follow-up visits at that time, but has not experienced any problems with the umbilical hernia since that time.

Petitioner reviewed Petitioner's Exhibit #5, which is a summary of the medical bills. Petitioner testified that these are all the medical bills that he incurred as a result of the hernia/accident that is at issue in this case.

On cross-examination, Petitioner testified that he did not work on May 4, 2012. He further testified that on May 4, 2012, he phoned and spoke with Anthony Rendina and reported that he sustained an accident the previous day.

Petitioner testified that he did not recall telling the Delnor staff that he got hurt at work. Petitioner did not recall saying "No" to the question "Is this a work-related injury/illness?" He told them that he went for a walk and had a sudden onset of pain. Petitioner did not recall denying any injury. Petitioner spoke with Dr. Holtsford and said he was coaching at first base and said the pain developed when he was jogging to first base. When Petitioner saw Dr. Batty he did not tell him how it happened. Petitioner agreed that he did not give a history of a work-related injury because he was afraid of losing his job. Petitioner did give a history of a work-related injury to the staff at Provena on May 8, 2012.

Petitioner denied that he asked his brother to contact Anthony Rendina and to ask Rendina if he could put this claim under workers' compensation because Petitioner did not have insurance.

Petitioner denied that he asked Mr. Rendina to increase his pay so that he could buy medical insurance.

After Respondent's attorney showed Petitioner Respondent's Exhibit #4, a document that indicates Petitioner agreed to buy health insurance with money from a raise, Petitioner testified that he did not buy health insurance.

Respondent's attorney showed Petitioner Respondent's Exhibit #3, which is a Substance Abuse & Standard of Conduct memo from Anthony Rendina to All Swallow Construction Employees. Such memo states, *inter alia*, that the failure to immediately report an accident or

work-related injury is a violation of company policy. Petitioner acknowledged the receipt of such memo and testified: "we went over this every year."

On May 3, 2012, when he returned to the yard, Petitioner noticed that no one was present outside, and he did not think to go inside, the office. He went home.

Petitioner began working for Custom Companies on August 17, 2012 or August 18, 2012. Petitioner does not recall sustaining an accident at Custom Companies. Petitioner did not see Dr. Borncamp and report re-injuring himself at Custom Companies. Since August 2012, Petitioner has not treated for his hernia.

On redirect examination, Petitioner agreed with his attorney that he told the staff at Delnor Hospital that he was jogging to first base when he thought he felt some leg pain. He was coaching at first base. A ball went into the gap. He was jogging and his pain increased at that time. The pain had been present since the accident - - it just increased when he was jogging and increased when he went for a walk.

Petitioner further testified that he did not get insurance because he has pre-existing conditions of hypertension and sleep apnea.

With regard to Respondent's Exhibit #3, Petitioner testified that he was supposed to report a work injury, but the last time he did that he was sent home for 5 days without pay.

On recross-examination, Petitioner testified that when he was rejected for a health insurance policy, he did not give back the $4.00/hour amount to Anthony Rendina.

Petitioner did not recall every word the Delnor staff mentioned to him. They gave him something for the pain, perhaps Norco.

Petitioner began working as a truck driver in 1989. Petitioner agreed that every employer for whom he has worked has instructed him to report an accident immediately. Petitioner realizes that if one does not report an accident immediately, there could be a problem.

Testimony of Pete Katralis

Peter Katralis testified on behalf of Petitioner. Mr. Katralis is currently employed at Keenan Transit as a mechanic.

On May 3, 2012, Peter Katralis was performing services for Respondent on the same York Township job site as Petitioner. Mr. Katralis recalled being on the job site that day. Mr. Katralis recalled seeing Petitioner. When Mr. Katralis finished up that day, he returned to the shop. Petitioner returned to the shop later on that day. Mr. Katralis observed Petitioner after he returned to the shop and noticed that Petitioner walked with a limp and held his hand to his side. Petitioner told Mr. Katralis that he was not sure if he pulled a muscle and that it hurts. Mr. Katralis testified that he had an opportunity to observe Petitioner at the job site earlier that day and did not notice him limping.

On cross-examination, Mr. Katralis testified that on May 3, 2012, he did not technically work for Respondent. On that date, he was employed by Luby's, but was paid by Swallow Sewer & Water Construction. Mr. Katralis did not recall who supervised him that day, but did recall that he worked on the Swallow trailer and worked in the same area as Petitioner.

Mr. Katralis denied that his employment with Luby's ended after he destroyed a $6,000.00 motor. Mr. Katralis did not recall walking off the job that day.

Mr. Katralis did recall that in May 2012, Anthony Rendina asked him if he knew anything about Petitioner sustaining an accident. He told Mr. Rendina at that time that all he saw was Petitioner limping. Mr. Katralis testified that some time after May 3, 2012 - - perhaps in the summer of 2012 - - Mr. Rendina and others met with him and "went over" Katralis' interaction with Petitioner on May 3, 2012. Mr. Katralis further testified that he felt like he was being "coached" as to what happened that day. Mr. Katralis told them that he fixed the trailer that day and saw Petitioner walking with a limp with his hand to his side.

Mr. Katralis testified that prior to May 2012, to his recollection, Petitioner did not have a limp and he *knows* Petitioner did not walk with his hand to his side.

Mr. Katralis stated that he does not recall receiving letters and voice mails from Respondent's attorney.

On redirect examination, Mr. Katralis testified that in the meeting with Mr. Rendina and two others - - the meeting in which he felt he was being coached - - he found out that Petitioner's brother had called and said that Petitioner got hurt and that "he didn't have insurance."

On recross-examination, Mr. Katralis testified that he met with his Petitioner's attorney on the morning of the trial (12/8/2014). At that time, Mr. Katralis provided Petitioner's attorney with an affidavit that Katralis had signed.

Testimony of Anthony Rendina

Anthony Rendina is the secretary and superintendant of Respondent. He was one of Petitioner's supervisor's during his employment at Swallow Sewer & Water Construction. He has known Petitioner for 10-12 years. Petitioner worked for Respondent for a while, then he didn't, and then he came back. In the time that he has known Petitioner, he noticed that Petitioner "always had kind of a limp."

Mr. Rendina testified that he heard Petitioner's testimony about his previous work injury to his hand. Mr. Rendina did not recall such injury.

On May 3, 2012, Petitioner was to pick up pipe on the York Township job with an end loader that has a big bucket on the front of it. The type of pipe he was to collect was huge and would be lifted by machine - - Petitioner would have known that. There would have been a foreman on the job site who would have been Petitioner's supervisor.

Mr. Rendina did not recall Petitioner coming by his office on May 3, 2012, although Rendina's truck may not have been outside. However, there were 2 people in the office that day.

Petitioner did not phone him on May 4, 2012 to report an accident.

When Respondent's attorney showed him Respondent's Exhibit #3, Section 13, Mr. Rendina testified that they go over this material each year and talk about how to get the job done safely.

When Respondent's attorney showed him Respondent's Exhibit #4, Mr. Rendina testified that they had a group insurance policy but that one person drove the rates up. So, we told our employees to go get insurance and if you show us proof, we will increase your pay.

In August 2010, Petitioner came to Mr. Rendina and showed him that it would take a $4.00/hour increase in pay in order to buy a health insurance policy. We never checked to see if Petitioner ever bought such policy.

On May 7, 2012, Petitioner was not scheduled to work. On that day, however, Petitioner's brother, Steve, called Mr. Rendina. Steve has a trucking company.

Subsequently, Mr. Rendina conducted an investigation. No one told Mr. Rendina that Petitioner had an accident.

Mr. Rendina testified that Mr. Katralis did not say what he said today. Mr. Katralis worked for Luby's on that day. He may have been paid directly by Respondent for the bigger jobs. Mr. Rendina owns Luby's as well. For the bigger jobs, Mr. Rendina would put it through Swallow Sewer & Water Construction.

Prior to December 8, 2014, the last time Mr. Rendina saw Petitioner was on May 3, 2012. If Rendina saw him after that, he does not recall.

On cross-examination, Anthony Rendina agreed that on direct examination he testified that the first time he had knowledge that Petitioner hurt himself was on May 7, 2012 when Petitioner's brother phoned him. In this phone call, Petitioner's brother told him that Petitioner was not hurt at work, but asked Mr. Rendina if Rendina could put it through workers' comp. since Petitioner does not have insurance. Mr. Rendina testified that even though he was informed that Petitioner sustained a non-work-related accident, he still conducted an investigation and spoke to Peter Katralis.

Anthony Rendina testified that Steve Krenc, Petitioner's brother, called back a couple of days later - - 5/6 or 5/8 - - after "Jim" (Petitioner) said it happened at work. Steve left a voice mail message for Mr. Rendina in which he stated that Petitioner's injury *was* work-related, and that's when Rentina began the investigation.

Mr. Rendina then contacted the insurance company. He did not know when the insurance company called them. They would have called Mike Stringfellow, who works for

Respondent. If a document indicates that Respondent first called the insurance company in June 2012, Mr. Rendina would not disagree. He would not disagree that it would have been 6 weeks after Steve Krenc left a voice mail in which he said Petitioner's injury was work-related.

Mr. Rendina did not retain the voicemail message he claims was left by Petitioner's brother advising that the injury was work related.

With regard to health insurance, Mr. Rendina testified that each employee is to get his own health insurance policy and is to show Respondent the amount of the premium and Respondent will make up this amount in the employee's pay.

On redirect examination, Anthony Rendina testified Mike Stringfellow filled out the first report of injury. Mr. Rendina agreed that the Form 45, the first report of injury, is dated 6/13/12 and was completed 5-6 weeks after Rendina received a voice mail message from Steve Krenc that indicated Petitioner's injury was work-related. When asked the reason Stringfellow wrote in the report "unknown" and "employee refused to cooperate" in response to the question "What was the employee doing at time of injury?", Mr. Rendina explained that he wrote "unknown" because we did not know if Petitioner treated in the emergency room and we tried to contact Petitioner and he would not call back.

Petitioner's attorney then showed Anthony Rendina another report (Respondent's Exhibit #9 for identification). When asked why the second Form 45 - - typewritten with lots of information, including an indication that the injury occurred when lifting and that he treated for an hernia at Delnor - - is so different from the first Form 45, Mr. Rendina testified that Stringfellow was in charge of filling out both Form 45s, that Rendina is Stringfellow's supervisor, that Rendina did not meet with Stringfellow about the Form 45s and that Stringfellow was there with Mr. Katralis.

On redirect examination, Mr. Rendina testified that he does not know why there are differences between these two reports. It is possible that he received information from the insurance company and filled it in. Mr. Rendina further testified that he does not know how Stringfellow developed this report.

Testimony of Dr. Erik Borncamp

Dr. Erik Borncamp is a general surgeon who has been licensed to practice medicine in the state of Illinois since 2001. (PX 6, p. 5) He received his undergraduate degree from the University of California at Davis in 1990 and was graduated from Chicago Medical School in 1996. (Id. at pp. 5-6) Thereafter, he performed a residency in general surgery at Mount Sinai Hospital in Chicago. (Id. at p. 6)

His practice is known as West Suburban Surgical and he has worked there since 2010. (PX 6, p. 7) As a general surgeon, he treats conditions of the gall bladder, hernias, breast cancer and performs intestinal surgery. (Id.) In 2012, he performed 250 to 270 surgeries. (Id. at pp. 7-8) Of those surgeries, approximately 80-100 were hernia surgeries. (Id. at p. 8) A good percentage of his practice is spent operating on patients who have hernias. (Id.)

Dr. Borncamp first saw Petitioner on May 9, 2012. (PX 6, p. 9) By way of history, Petitioner indicated that he was lifting some heavy equipment at a work site, which caused a pulling and tearing sensation in his groin. (Id.) Two to three days later he noted a right inguinal hernia. (Id.) Dr. Borncamp examined Petitioner and found that he had bilateral inguinal hernias, right greater than left. (Id. at pp. 9-10) He reviewed a CT scan that was done which documented a large right inguinal hernia and recommended surgical repair of the hernia. (Id. at p. 10)

Surgery was performed on May 15, 2012, at Provena. (PX 6, p. 11) At the time of surgery he found a large indirect hernia and a large lipoma of the cord. (Id.) Dr. Borncamp did not appreciate a left inguinal hernia at the time of surgery. (Id.) The hernia was very large and so it required a larger mesh than usual. (Id. at p. 12)

Dr. Borncamp saw Petitioner in follow-up after surgery and last saw him on August 6, 2012. (PX 6, p. 13) At that time, he was having only minor symptoms and he was released to return to work without restrictions. (Id. at 14) He ordered Petitioner off work from May 10, 2012 through August 6, 2012, as a result of the hernia for which he treated Petitioner. (Id. at 23-24)

Dr. Borncamp reviewed Petitioner's records from Delnor and, specifically, the history provided by Petitioner to Delnor on May 6, 2012, in which he reported a sudden onset of right

groin pain after going for a walk and jogging to first base while coaching his son's baseball game. (PX 6, pp. 17-18) Generally speaking, a hernia of the size that Dr. Borncamp saw in Petitioner is typically caused by force. (Id. at pp. 12-13) In his opinion, walking and jogging are not activities that have enough force to cause a large hernia as seen in Petitioner. (Id. at 21) It is not unusual for those activities (walking and jogging) to irritate a hernia and cause increased symptoms. (Id. at 29)

Based upon a reasonable degree of medical and surgical certainty, Dr. Borncamp opined that Petitioner's hernia was caused by lifting heavy pipes at work. (PX 6, p. 20) His opinion is based on the history provided to him by Petitioner and the affidavit of Peter Katralis that seemed to substantiate the fact that Petitioner was hurt at work while lifting pipes. (Id. at p. 20) Finally, his opinion is based upon his experience, his review of the records, and the fact that the other events, walking and jogging, did not require sufficient force to produce a hernia as large as the one he saw in Petitioner. (Id. at pp. 20-21)

On cross-examination, Dr. Borncamp testified that obesity can be a factor in the cause of hernias. Dr. Borncamp further testified that Petitioner had an indirect, inguinal hernia. Dr. Borncamp testified that a cough, a sneeze, or a heavy bowel movement in an obese person could cause an indirect hernia. However, an umbilical hernia is more commonly associated with obesity.

Petitioner had an indirect hernia with a large dilation of the internal ring and that is most commonly caused by trauma. (Id. at p. 40)

MEDICAL RECORDS

Delnor-Community Hospital

Petitioner presented to Delnor-Community Hospital on May 6, 2012, with complaints of pain and swelling in his right groin and pelvic region with radiating pain down his right leg. (PX 1, pp. 32, 35) Petitioner indicated that prior to presenting to the emergency room, he went for a 2-1/2 mile walk and felt a sudden onset of right groin pain. (Id. at pp. 35, 55) He also indicated that he had previously coached his son's baseball game and had felt some right leg pain while jogging to first base. (Id. at p. 55) Upon examining Petitioner, the physician found

him to be in mild distress secondary to pain with swelling and fullness in the right inguinal area of the abdomen. (Id. at p. 56) A CT scan was performed with findings consistent with a right inguinal hernia. (Id. at pp. 53-54) Petitioner was diagnosed with an inguinal hernia, referred to Dr. Paul Batty, and discharged home. (Id. at pp. 36, 47, 57)

The records from Delnor also reveal that Petitioner was seen on May 27, 2010, with complaints of pain to his left hand after the back gate of a semi-trailer fell on his hand. (PX 1, p. 16) The records reflect: "It is a work-related injury but says his boss fired him today because of the injury." (Id.)

Surgery Group, S.C.

On May 7, 2012, Petitioner presented to the office of Dr. Paul Batty with a chief complaint of abdominal pain. (PX 2, p. 5) Specifically, he was noted to have right groin pain in the inguinal area, which was described as acute, burning, intermittent and throbbing. (Id.) Upon examining his abdomen, Dr. Batty noted that a right inguinal hernia was present and reducible. (Id. at p. 6) Dr. Batty diagnosed Petitioner with a right inguinal hernia and recommended surgery. (Id.)

Provena Mercy Medical Center

Petitioner was seen at Provena Mercy Medical Center on May 8, 2012, due to increased pain in his abdominal area. (PX 3, pp. 75-76) He indicated that he was previously scheduled for surgery with Dr. Batty, but that Dr. Batty would not proceed with the surgery due to a lack of insurance. (Id. at p. 75) He was noted to have 3-4 days of right inguinal pain that increased after taking a walk a few days ago. (PX 3, p. 80) A CT scan of the abdomen and pelvis was performed with an impression of bilateral inguinal hernias. (Id. at p. 83) The hernia on the right side was noted to contain "fat as well as a portion of the bladder." Id. Petitioner was given Norco for pain and instructed to follow-up with Dr. Borncamp. (Id. at p. 84)

On May 15, 2012, Petitioner underwent surgery at Provena Mercy Medical Center to repair a right inguinal hernia. (PX 3, pp. 38-40) The history and physical conducted by Dr. Borncamp prior to surgery indicates that Petitioner was lifting heavy equipment at work when

he developed right-sided groin pain. (Id. at 28) Dr. Borncamp noted a "large indirect hernia" at the time of surgery. (Id. at 38) Dr. Borncamp stated that a larger mesh was required due to the size of the hernia. (Id. at 40)

West Suburban Surgical, S.C.

Petitioner was seen at West Suburban Surgical by Dr. Erik Borncamp on May 9, 2012. (PX 4, p. 6) He was noted to have right inguinal pain after lifting heavy equipment at work. (Id.) Dr. Borncamp diagnosed him with a right inguinal hernia and recommended surgery. (Id.)

Petitioner was seen in follow-up after surgery on July 2, 2012. (PX 4, p. 5) His pain was noted to be improved and he was instructed to follow-up in one month. Id. Petitioner was last seen by Dr. Borncamp on August 6, 2012, at which time he was released to return to work without restrictions. (Id. at p. 4)

CONCLUSIONS OF LAW

In support of his conclusion with regard to issue (C) "Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?", the Arbitrator finds as follows:

On May 3, 2012, Petitioner was employed with Respondent as a truck driver and laborer. He was working at the York Township job site lifting pieces of pipe onto a truck on that date. Some pieces of pipe weighed in excess of 100 pounds. When Petitioner bent over to pick up a piece of pipe, he felt a sharp pain in his lower abdomen on the right side.

While Petitioner did not report the injury to his supervisor on May 3, 2012, he did advise his co-worker, Peter Katralis, that he hurt himself at work. Katralis testified that Petitioner told him that that day that he was not sure if he pulled a muscle and that it hurts. Katralis observed Petitioner after he returned to the shop (yard) and noticed that Petitioner walked with a limp and held his hand to his side. Katralis testified that he had an opportunity to observe Petitioner at the job site earlier that day and did not notice him limping.

The testimony of Peter Katralis largely corroborates Petitioner's testimony.

The Arbitrator finds the testimony of Anthony Rendina to be less credible than the testimony of Petitioner. It simply does not follow that Mr. Rendina would initiate an investigation into a work-related injury after having been advised by Petitioner's brother that the Petitioner's condition was not due to a work-related event, as he claimed. Mr. Rendina explained his actions by testifying that after Petitioner's brother first phoned him, Petitioner's brother later left a voice mail message for him in which he stated that Petitioner's injury *was* the result of a work accident. However, Mr. Rendina did not save such voice mail message. Furthermore, Anthony Rendina testified that he had knowledge of Petitioner's hernia condition and the recommended surgery prior to filling out of the Illinois Form 45 five to six weeks later. Yet, Respondent wrote in this first Form 45 "unknown" in response to inquiries with regard to Petitioner's claimed injury and treatment.

The Arbitrator asks: Why did it take 5-6 weeks for Respondent to report the accident to the insurance company?

Moreover, Mr. Rendina never offered an explanation for Petitioner's absence at work on May 4, 2012.

With regard to the histories Petitioner provided to the Delnor-Community Hospital staff, the Arbitrator finds Petitioner's actions to be disingenuous. Moreover, at the time Petitioner was unable to purchase a health insurance policy, he did not reveal this fact to Anthony Rendina and did not reimburse Rendina the monies that were to be allocated to health insurance premiums.

Nevertheless, the Arbitrator concludes that due to a fear of retaliation by Anthony Rendina, Petitioner failed to immediately report the accident and gave inaccurate histories to Delnor. Such conclusion is based on the evidence, especially Petitioner's testimony, Peter Katralis' testimony and the Delnor-Community Hospital medical records of May 27, 2010.

The Arbitrator gives substantial weight to the Delnor record of May 27, 2010.

The Arbitrator notes that it was only after Petitioner's phone call to Anthony Rendina on May 4, 2012 that Petitioner gave a history of a non-work-related injury. Anthony Rendina

denies that he and Petitioner ever had a phone conversation on May 4, 2012. Petitioner first testified to such phone conversation during cross-examination.

Additionally, the Arbitrator carefully considers the opinions of Dr. Borncamp with regard to the etiology of Petitioner's inguinal hernia.

Therefore, based on a mere preponderance of the weight of the totality of evidence, the Arbitrator finds that on May 3, 2012, Petitioner sustained an accident that arose out of and in the course of his employment.

In support of his conclusion with regard to issue (F) "Is Petitioner's current condition of ill-being causally related to the injury?", the Arbitrator finds as follows:

There is no dispute as to Petitioner's diagnosis of a hernia that was initially made in the emergency room at Delnor-Community Hospital on May 6, 2012. When asked to provide a history by the hospital staff, Petitioner noted an onset of right groin pain 3 hours before presenting to the emergency room while taking a 2-1/2 mile walk. He also indicated that he experienced some groin pain earlier that weekend while coaching his son's baseball game when he was jogging to first base. Petitioner testified that he did not provide a history of a work injury because he feared losing his job after what happened when he reported an accident to Respondent in 2010.

Dr. Borncamp, Petitioner's treating physician, testified that he first saw Petitioner on May 9, 2012, and was advised by Petitioner that his injury occurred while lifting heavy equipment at work. At the time of surgery, Dr. Borncamp found a large, indirect right inguinal hernia. A hernia of that size, Dr. Borncamp testified, is typically caused by force.

Dr. Borncamp had the opportunity to review Delnor's records of Petitioner's treatment and was made aware of the histories noted in the records regarding an onset of groin pain after going for a walk and jogging while coaching his son's baseball team. While it is not unusual for those activities to aggravate a hernia and to cause increased symptoms, Dr. Borncamp opined, they are simply not activities that had enough force to cause a hernia of the size he saw in

Petitioner. In his opinion, Petitioner's hernia was caused by lifting heavy pipes at work. That opinion is based on the history provided to him by Petitioner, his review of the Peter Katralis' affidavit, his experience in treating patients who have sustained hernias and his knowledge regarding the amount of force required to cause a large hernia as the one he saw in Petitioner.

Dr. Borncamp's handwritten notes of August 6, 2012 indicate that Petitioner sustained an injury 1 week ago when he was lifting tires and one bumped him in the groin. (PX 4) However, there is no evidence that such tire-bumping incident broke the causal chain. In fact, Dr. Borncamp discharged Petitioner on August 6, 2012 and released him to return to work with no restrictions, effective August 7, 2012.

Respondent offered no medical opinion at the time of trial. The only medical opinion with regard to causation contained in the record is that offered by Dr. Borncamp.

Based on the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being, specifically, his right-sided inguinal hernia, is causally related to the work accident of May 3, 2012.

In support of his conclusions with regard to issue (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?", and (K) "What temporary benefits are in dispute? TTD", the Arbitrator finds as follows:

Following his work accident, Petitioner was initially seen in the emergency room at Delnor-Community Hospital on May 6, 2012. He had a follow-up visit with Dr. Batty of The Surgery Group, S.C., on May 7, 2102, and visited to the emergency room at Provena Mercy Medical Center on May 8, 2012. Petitioner saw Dr. Borncamp on May 9, 2012, and underwent surgery to repair his hernia at Provena on May 15, 2012. Petitioner had follow-up visits with Dr. Borncamp subsequent to surgery and was last seen by Dr. Borncamp on August 6, 2012.

The medical bills incurred by Petitioner to treat his hernia were admitted into evidence as Petitioner's Exhibit 5.

The Arbitrator finds such medical care to be reasonable and necessary and orders Respondent to pay Petitioner an amount equal to the unpaid medical bills, $78,712.17, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Dr. Borncamp testified that Petitioner was ordered off work from May 10, 2012, through August 6, 2012, as a result of the hernia for which he treated Petitioner. Petitioner was released to return to work effective August 7, 2012.

The Arbitrator further finds that Respondent is liable for payment of temporary total disability benefits from May 10, 2012, through August 6, 2012, or a period of 12-5/7 weeks.

In support of his conclusion with regard to issue (L) "What is the nature and extent of the injury?", the Arbitrator finds as follows:

Section §8.1b(b) of the Act requires that in determining the level of permanent partial disability, the Commission shall base its determination on the following five factors: (i) the reported level of impairment pursuant to subsection (a); (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. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the reported level of impairment pursuant to subsection (a) of §8.1b was not offered into evidence. Dr. Borncamp offered an opinion as to Petitioner's impairment (PX 6, pp. 37-38), but such opinion was not pursuant to subsection (a) of §8.1b. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a truck driver/laborer at the time of the accident and that he was able to return to work in his prior capacity after treating for his hernia. Petitioner

currently works as a truck driver for Pro Drivers. Because Petitioner was able to return to his prior employment, the Arbitrator gives some weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 48 years old at the time of the accident. The Arbitrator therefore gives some weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes the Petitioner was able to return to his customary work without a reported loss in wages. Because Petitioner's earning capacity has not been affected by the accidental injury, the Arbitrator gives some weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes on May 15, 2012, Petitioner underwent surgery to repair a very large, indirect inguinal hernia on the right side. Dr. Borncamp inserted larger mesh rather than the usual medium mesh. Dr. Borncamp also found a very large lipoma of the cord that he reduced and excised and took out through the port. (PX 4) In his August 6, 2012 handwritten notes, Dr. Borncamp concluded: "Does not have same symptoms as last visit. Mass is fixed c̄ cord. Does not move with valsalva, fixed." (PX 4) On that day, Dr. Borncamp released Petitioner to return to work with no restrictions, effective August 7, 2012. (PX 6, Dep. Ex.) The Arbitrator gives great weight to this factor.

Based on the five factors, the Arbitrator finds that Petitioner sustained a permanent loss of use, person as a whole, to the extent of 2-1/2% thereof, pursuant to Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kerry Epps,

Petitioner,

vs. NO. 14WC 10737

16IWCC0238

UPS,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 6, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

16IWCC0238

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $13,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 3 1 2016

Stephen J. Mathis

David L. Gore

Mario Basurto

SJM/sj
o-3/24/16
44

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

EPPS, KERRY D
Employee/Petitioner

Case# 14WC010737

16IWCC0238

UPS
Employer/Respondent

On 8/6/2015, 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 0.16% 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:

2194 STROM & ASSOCIATES
LINDSEY STROM
180 N LASALLE ST SUITE 2510
CHICAGO, IL 60601

2461 NYHAN BAMBRICK KINZIE & LOWRY
VIRGINIA A GRAVES
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

Kerry D. Epps
Employee/Petitioner

v.

UPS
Employer/Respondent

Case # 14 WC 10737

16IWCC0238

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 **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **3/18/2015**. 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. [x] 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 **3/5/2014**, 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 $**73,517.12**; the average weekly wage was $**1,633.71**.

On the date of accident, Petitioner was **48** years of age, *married* with **0** dependent children.

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

Respondent *has* paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**636.88** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

Respondent is entitled to a credit of $**636.88** under Section 8(j) of the Act.

ORDER

Respondent shall be given a credit of $636.88 under Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $721.66/week for 20 weeks, because the injuries sustained by Petitioner caused a 4% loss of use of person as a whole as provided in § 8(d)2 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.

Signature of Arbitrator

August 5, 2015
Date

AUG 6 - 2015

KERRY EPPS v. UPS CORRECTED 16IWCC0238
14 WC 10737

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth on March 18, 2015. The disputed issue was: ***L:*** What is the nature and extent of the injury?: ***N:*** Is the Respondent due any credit?

Petitioner testified at the hearing. Both parties submitted documents in evidence. The Arbitrator took all evidence under consideration.

FINDINGS OF FACT

Petitioner testified that he is employed as a "feeder driver" for Respondent and has been working in this capacity for 3 years. Petitioner works Monday through Friday, from 2:00 pm to 2:00 am. Petitioner is required to pick up loads from the rail yard, which are trailers full of packages. He picks up between 50 and 60 trailers per night. Petitioner explained that he handles equipment that varies in weight. The heaviest piece of equipment that he has to lift is a steel dolly which connects two trailers. Petitioner testified that the dolly itself weighs approximately 1,000 to 1,500 pounds but that this weight is counterbalanced. He explained that the back of the dolly sits on a wheel but the front part is heavy. Petitioner testified that he usually handles this dolly twice per day.

On March 5, 2014, Petitioner testified that he was working without any problems. He was separating the dolly from the back of a trailer. Because the trailer was on an incline, he had to push the dolly uphill. While pushing the dolly, he felt a sharp pain in his left-side groin.

Petitioner was seen at MacNeal Occupational Clearing Clinic (MacNeal) on March 4, 2014. (PX #1) He was diagnosed with a left inguinal hernia as well as a right hip flexor strain, caused by work. He was restricted from lifting more than 10 pounds. Respondent accommodated his work restrictions.

Petitioner came under the care of Dr. Peter Mihalakakos at of Presence St. Joseph Medical Center, Joliet. (PX #2) On May 5, 2014 Dr. Mihalakakos performed a physical exam. He confirmed a left inguinal hernia. Dr. Mihalakakos performed a surgical repair of the hernia on May 15, 2014. The operative report states that "a direct hernia was readily apparent." The hernia was ultimately reduced with an extra-large PerFix plug. Postoperatively, Petitioner saw Dr. Mihalakakos on June 24, 2014. Petitioner was doing well with minimal discomfort with stretching. Petitioner was released for return to work without restriction on June 30. Petitioner testified that the plug has not been removed and that his doctor never indicated that he planned to remove it.

Petitioner testified that he had never been to a doctor for left-sided groin pain prior to the work injury or that he took any medications for this type of pain prior to the injury. Petitioner currently takes Aleve for his left-sided groin pain once or twice per week. Petitioner

previously suffered a prior work related hernia on the right. Petitioner testified that following his visit to MacNeal, he worked a light duty position, and sustained no significant lost time.

Petitioner testified that he currently works full duty without restrictions for Respondent, but that he still continues to experience some soreness and discomfort, particularly with stretching.

Petitioner testified that he makes the same amount of money as he did prior to his work injury.

Petitioner saw Dr. Koehler for an examination pursuant to § 12 of the Act July 30, 2014. Petitioner testified that Dr. Koehler performed a physical exam on him that lasted about 7 to 10 minutes. He testified that Dr. Koehler did not take any measurements of his stomach or groin. Petitioner testified that Dr. Koehler did not ask him to perform any kind of simulated lifting.

Petitioner testified that he makes the same amount of money now as he did prior to his work injury.

Deposition of Dr. Koehler (October 15, 2014)

Dr. Koehler testified that he is certified to assess impairment according to the American Medical Associations *Guide to Evaluation of Permanent Impairment, 6th Edition.* Dr. Koehler testified that in order to become certified to assess AMA impairment ratings, one needs to pass a test after completing a 2 day course.

Dr. Koehler testified that he practices occupational medicine and that he does not perform hernia surgeries. (RX #1, pp 21-23) He reviewed Petitioner's medical records and conducted a clinical examination. After the records review and the examination Dr. Koehler assessed Petitioner at 0% impairment.

On cross-examination Dr. Koehler admitted that he was not qualified to answer why a surgeon would use a "plug" versus mesh for a hernia repair. When asked whether he had any experience with the plug that was described in the operative report, Dr. Koehler testified that he did not. When questioned as to whether this type of plug can aggravated or become undone, Dr. Koehler's response was, "I don't have any experience with that. I am not a surgeon". (RX #1, p 23)

Dr. Koehler testified that he did not order any diagnostic studies on the date of the exam and that he did not review any prior diagnostic studies. He testified that Petitioner had no physical findings other than mild induration beneath the surface (RX #1, p 12). He assessed Petitioner with a 0% impairment rating (RX #1, p 18); however, he testified that an impairment rating does not in any way help to formulate an opinion as to how Petitioner may feel now or in the future.

Dr. Koehler testified that Petitioner has a heavy job and that Petitioner may suffer an aggravation based on his review of the job description that Respondent provided (RX #1, pp 25-26).

Dr. Koehler testified that although he believed Petitioner to be at MMI, that it did not necessarily mean that Petitioner is back to his pre-injury status. (RX #1, p 27) He also testified when someone reenters the work force and is performing their full duty job that there is a possibility of re-injury (RX #1, p 27). Dr. Koehler admitted on cross-examination that a hernia

repair can rupture when intra-abdominal pressure is put upon it and that a number of things can cause this kind of pressure. (RX #1, p 30)

CONCLUSIONS OF LAW

N: Is the Respondent due any credit?

The Parties stipulated that Petitioner was entitled to TTD from April 3, 2014 through June 29, 2014, representing 12-4/7 weeks. Arbitrator's Exhibit #1. (AX #1) Based on the stipulated average weekly wage of $1,633.71, Petitioner is entitled to TTD benefits at the rate of $1,089.14. Petitioner was entitled to TTD benefits for a period of 12-4/7 weeks, or $13,692.05. The Parties also stipulated that Respondent paid $14,328.93 in TTD benefits. (AX #1) Therefore, Respondent shall be due a credit of $636.88, representing overpayment of TTD benefits.

L: What is the nature and extent of the injury?

It is undisputed that Petitioner was performing the regular duties of his employment with Respondent when he injured his left-side groin. He was ultimately diagnosed with a left inguinal hernia and a right hip flexor strain. After surgical repair of his hernia Petitioner was released to unrestricted work. He continues to work for Respondent.

The date for this injury, March 5, 2014, is subject to § 8.1b of the Act. Accordingly the Arbitrator notes the following:

Evidence of impairment – A 0% AMA impairment rating regarding the left-side hernia was submitted and testified to by Dr. Koehler. Dr. Koehler did not testify regarding Petitioner's right hip flexor strain. Dr. Koehler is not a surgeon and expressed little knowledge about surgical repair of inguinal hernias. The Arbitrator places no weight on this factor.

Occupation – Petitioner is a feeder driver and has to lift heavy equipment frequently throughout his shift. This is the job Petitioner returned to without restriction. Petitioner's statistical worklife expectancy is 14 years. The Arbitrator places great weight on this factor.

Age – Petitioner was 49 at the time of the work-related injury. He has a statistical life expectancy of 30 years. The Arbitrator places moderate weight on this factor.

Future earning capacity – Petitioner has returned to the job he worked at the time of his injury. There was testimony that a hernia repair may fail in the future but the Arbitrator finds this to be speculative. Without other evidence that the injury will affect future earnings the Arbitrator places no weight on this factor.

Evidence of disability corroborated by the medical records – Petitioner was released to return to work without restriction effective June 30, 2014. Petitioner testified that it was a heavy job. Dr. Mihalakakos did document minimal discomfort on stretching in the discharge note. The Arbitrator takes note that Petitioner testified to occasional soreness related to his injury. The Arbitrator also notes that Petitioner had a prior inguinal hernia repair on the right and that Petitioner did not specify if his soreness is general or left-sided or right-sided.

Based upon the above, the Arbitrator finds that Petitioner sustained 4 % loss of use of person as a whole pursuant Section 8(d)(1).

Aug 5, 2015

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Pamela Davis,

Petitioner,

vs.

NO. 14WC 11005

SOI/IYC Harrisburg,

16IWCC0236

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, causal connection, permanent disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 2, 2015 is hereby affirmed and adopted.

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: MAR 3 1 2016
SJM/sj
o-3/10/2016
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DAVIS, PAMELA
Employee/Petitioner

Case# **14WC011005**

SOI/IYC HARRISBURG
Employer/Respondent

16IWCC0236

On 7/2/2015, 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 0.11% 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:

4463 GALANTI LAW OFFICES
PATTI GIAMBATTISTA
PO BOX 99
EAST ALTON, IL 62024

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0558 ASSISTANT ATTORNEY GENERAL
AARON L WRIGHT
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

1350 CENTRAL MANAGEMENT SYSTEMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

JUL 2 - 2015

RONALD A.RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

16IWCC0236

☐ 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

Pam Davis
Employee/Petitioner

v.

SOI/IYC Harrisburg
Employer/Respondent

Case # **14 WC 011005**

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 **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **May 12th, 2015**. 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 **3/5/14**, 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 not*** 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $40,999.92; the average weekly wage was **$788.46**.

On the date of accident, Petitioner was **51** years of age, ***married*** with **0** dependent children.

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $- for TTD, $- for TPD, $- for maintenance, and $- for other benefits, for a total credit of $-.

Respondent is entitled to a credit of **any medical benefits paid through its group carrier** under Section 8(j) of the Act.

ORDER

Petitioner has failed to meet her burden of proof and thus shall be barred from recovery. Petitioner suffered an Idiopathic fall for which the employer is not responsible. Claim denied.

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.

Signature of Arbitrator

6/22/15
Date

JUL 2 - 2015

FINDINGS OF FACT

A full hearing was held in this matter. The issues at trial were accident, and causal connection, liability for medical costs and the nature and extent of the injury.

Petitioner testified that she works as at the Illinois Youth Center-Harrisburg as an executive secretary. She works the Day shift.

During trial during direct examination, Mr. Shaffer testified, "I went out to check my phone, came right back in, and came around the corner into the hallway, and my feet slipped out from under me, and I fell."

At trial Respondent proffered exhibit #3; video coverage of Ms. Davis's fall. It is evident from the video that Petitioner actually tripped over her own feet after traveling down the hallway for several steps. There is no evidence of any defect in the floor. Nor for that matter did the Petitioner testify to any defect in the floor. Her testimony was that her feet were wet from traveling outside; that she walked across a thin carpet, "I rounded the corner through the doorway to the administration hall and took two or three steps, I would say, and my feet slipped out from under me." She further testified she walked approximately 15-18 feet from the front door to where she fell.

A complete viewing of the video evidence demonstrates the Petitioner tripped on her own feet while walking perfectly normally. The video starts at 12:53, at 12:53:15 the video shows that Ms. Davis tripped over her own feet. There is no evidence of anything out of the ordinary. While unfortunate, the law is clear in the state of Illinois this is an Idiopathic fall and the Employer is not responsible.

CONCLUSIONS OF LAW

Petitioner has failed to meet her burden of proof and thus shall be barred from recovery. Petitioner suffered an Idiopathic fall for which the employer is not responsible. Claim denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF McLEAN)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daniel Snyder,

Petitioner,

vs.

NO. 14WC 21282

16IWCC0237

Eaton Corporation a/k/a Cutler Hammer,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 14, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

16IWCC0237

No bond is required for removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 3 1 2016
SJM/sj
o-3/10/16
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SNYDER, DANIEL
Employee/Petitioner

Case# **14WC021282**

EATON CORPORATION A/K/A CUTLER HAMMER
Employer/Respondent

16IWCC0237

On 8/14/2015, 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 0.24% 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:

2028 RIDGE & DOWNES LLC
JOHN MITCHELL
415 N E JEFFERSON AVE
PEORIA, IL 61603

0771 FEATHERSHUN GAUMER ET AL
DAN GAUMER
225 N WATER SUITE 200
DECATUR, IL 62526

STATE OF ILLINOIS)
)SS.
COUNTY OF MCLEAN)

☐ 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
NATURE AND EXTENT ONLY

Daniel Snyder
Employee/Petitioner

v.

Eaton Corporation
A/K/A Cutler Hammer
Employer/Respondent

Case # 14 WC 21282

16IWCC0237

The only disputed issue is the nature and extent of the injury. 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 **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Bloomington**, on **July 30, 2015**. By stipulation, the parties agree:

On the date of accident, **March 12, 2012**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

On this date, Petitioner sustained 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 $**39,520.00**, and the average weekly wage was $**760.00**.

At the time of injury, Petitioner was **53** years of age, ***single*** with **0** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

Respondent shall be given a credit of $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**0.00**.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner the sum of $**456.00**/week for a further period of **4.05** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **15% permanent disability to the Petitioner's left ring finger.**

Respondent shall pay Petitioner compensation that has accrued from **March 12, 2012** through **July 30, 2015**, and shall pay the remainder of the award, if any, in weekly payments.

RULES REGARDING APPEALS Unless a Petition for Review is filed within 30 days after receipt of this decision, and a review is perfected 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.

Arbitrator Anthony C. Erbacci

August 10, 2015
Date

AUG 14 2015

16IWCC0237

In Support of the Arbitrator's Decision relating to the nature and extent of the injury, the Arbitrator finds and concludes as follows:

The Petitioner suffered an undisputed accidental injury which arose out of and in the course of his employment with the Respondent on March 12, 2012. The Petitioner testified that on March 12, 2012, he was working for the Respondent as a tool and die worker and that he had been so employed for 38 years. The Petitioner testified that he was changing a weld tip when he accidentally struck his left ring finger with a hammer that weighed about three pounds. The Petitioner was taken to Abraham Lincoln Hospital where he was treated by a Dr. Harmon. Dr. Harmon cleaned and stitched the fingertip. An x-ray was performed that showed a comminuted fracture of the left ring finger. The Petitioner testified that his fingernail fell off and that he followed up treating with Dr. Harmon about a week later at which time she removed the sutures on his finger. The Petitioner missed no time from work as a result of his injury and he continues to perform his regular job in an unrestricted manner at the present time.

The Petitioner testified that he currently continues to experience some loss of sensation in the tip of the left ring finger as well as stiffness in the finger. The Petitioner indicated that the tip of the finger is harder than the tips of his other fingers and that when he taps the finger on the table it makes an audibly different noise than his other fingers. On cross-examination, the Petitioner indicated that he has not received any medical care on his finger during the last year and he has no future appointments to treat for his finger.

Based upon the Petitioner's testimony and the medical records admitted into the record, the Arbitrator finds that the Petitioner did sustain some degree of permanent disability as a result of the accident of December 12, 2012. Because the Petitioner's accident occurred after September 1, 2011, Section 8.1(b) of the Act requires consideration of the following criteria in determining the level of permanent partial disability:

* The reported level of impairment based upon the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment;
* the occupation of the injured employee;
* the age of the employee at the time of the injury;
* the employee's future earning capacity; and
* evidence of disability corroborated by the treating medical records.

No single enumerated factor shall be the sole determinant of disability but the relevance and the weight of any additional factors used must be explained.

In the instant case, the Petitioner suffered a comminuted fracture of the left ring finger which was cleaned and sutured. The Petitioner testified that he currently continues to experience some loss of sensation in the tip of the left ring finger as well as stiffness in the finger.

With regard to the reported level of impairment pursuant to Section 8.1(b), the Arbitrator notes that neither party submitted a report regarding the Petitioner's level of impairment determined pursuant to the American Medical Association's Guides to Evaluation of Permanent Impairment With regard to the occupation of the injured employee, the Petitioner's occupation is that of a tool and die worker, which the Arbitrator notes requires significant use of the hands. The Arbitrator concludes that the Petitioner's ability to perform the duties of his employment will be somewhat more adversely affected by his permanent partial disability than would the ability of an individual who performs lighter work. The Arbitrator finds the Petitioner's occupation to be a significant factor in the determination of the Petitioner's disability.

With regard to the age of the employee at the time of injury, the Petitioner's age at the time of injury was 53 years old and the Arbitrator considered this factor to be of no significance in the determination of the Petitioner's disability. Similarly, with regards to the Petitioner's future earning capacity, the Arbitrator notes that there is no evidence that the Petitioner's future earning capacity has in any way been affected by his injury. Thus, the Arbitrator concludes that the Petitioner future earning capacity is not of any significance in the determination of the Petitioner's disability.

With regard to the evidence of disability corroborated by the treating medical records, the Petitioner credibly testified that he currently experiences some loss of sensation in the tip of the left ring finger as well as stiffness in the finger. The Petitioner indicated that the tip of the finger is harder than the tips of his other fingers. These complaints are corroborated in the medical records of the Petitioner's treatment. The Petitioner's complaints as supported by the medical records, evidences a disability as indicated by Commission decisions regarded as precedent pursuant to Section 19(e).

The determination of permanent partial disability is not simply a calculation but an evaluation of all 5 factors as stated in the Act. In making this evaluation of permanent partial disability, consideration is not given to any single enumerated factor as the sole determinant. Therefore, having considered the factors enumerated in Section 8.1(b) of the Act, 820 ILCS 305/8.1(b), and the totality of the credible evidence adduced at hearing, the Arbitrator finds that as a result of his accidental injuries the Petitioner has sustained 15% disability to his left ring finger.

STATE OF ILLINOIS)	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF)	☒ Remand	☐ Second Injury Fund (§8(e)18)
WILLIAMSON		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Amy Schilling,

Petitioner,

vs. NO: 14 WC 37004

Dollar General,

16IWCC0232

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of jurisdicition, accident, benefit rates, employment, medical expenses incurred and prospective, notice, occupational disease, causation and temporary total disablity and being advised of the facts and law, vacates the Arbitrator's decision and remands this matter back to the Arbitrator for a new hearing.

The Commission finds that the Petitioner did not give the Respondent proper notice pursuant to the Commission rules. Therefore, it was improper for the Arbitrator to proceed to hearing ex parte against the Respondent.

This was a request for a 19(b) hearing. The Commission rules indicate that a petition for a 19(b) hearing must include a description of attempts by parties or counsel to resolve the dispute. This would include the date of the conference, the parties involved and the result of said conference. (Section 7020.80 (a))

The Commission rules also require that a date certain for trial be given on the date that the motion is presented. "If any party fails without good cause to appear, the Arbitrator will hear the motion for trial date ex parte, and if the Arbitrator determines the matter is ready for trial will set a trial date convenient to the Arbitrator and the party that appeared. The party that appeared shall notify the opposing party of the trial date." (Section 7030.20 (C) (3))

16IWCC0232

In the case at hand, the Petitioner motioned this matter up under Section 19(b) on January 12, 2015 in Williamson County. There was nothing on the motion or the petition regarding any prior attempts to settle the 19(b) allegations. There was no appearance by the Respondent on the motion date and the Arbitrator set it for trial on January 16, 2015.

Since this was a 19(b) motion and there was no effort by the Petitioner of his attempts to contact the Respondent, the Arbitrator should not have given this matter a date certain for trial. Most importantly, the Petitioner failed to notify or attempt to notify the Respondent of the date certain for trial. The Arbitrator was in error for trying this matter ex parte.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is vacated and this matter is remanded back to him for a new trial.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 3 1 2016

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

HSF
O: 2/10/16
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION
CORRECTED

SCHILLING, AMY
Employee/Petitioner

Case# **14WC037004**

DOLLAR GENERAL
Employer/Respondent

16IWCC0232

On 5/26/2015, 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 0.08% 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:

0969 THOMAS C RICH PC
6 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

1505 SLAVIN & SLAVIN LLC
BRIAN H DRISCOLL
20 S CLARK ST SUITE 510
CHICAGO, IL 60603

16IWCC0232

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION
19(b)

Amy Schilling
Employee/Petitioner

v.

Dollar General
Employer/Respondent

Case # 14 WC 37004

Consolidated cases: _____

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 **Michael Nowak**, Arbitrator of the Commission, in the city of **Herrin**, on **January 16, 2015**. 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. [x] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [x] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [x] What were Petitioner's earnings?
H. [x] What was Petitioner's age at the time of the accident?
I. [x] What was Petitioner's marital status at the time of the accident?
J. [x] 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. [x] Is Petitioner entitled to any prospective medical care?
L. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

16IWCC0232

FINDINGS

On the date of accident, **March 13, 2014**, 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 **$38,000.00**; the average weekly wage was **$730.77**.

On the date of accident, Petitioner was **52** years of age, ***married*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $376.00 to Steeleville Family Practice, $9,468.50 to Chester Memorial Hospital, and $1,664.00 to Cape Foot Clinic, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay for any further reasonable and necessary medical care required by Petitioner.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

Signature of Arbitrator

5/19/15
Date

ICArbDec19(b)

MAY 26 2015

16IWCC0232

FINDINGS OF FACT

This was an ex parte hearing. This cause was initially set for hearing on Petitioner's § 19(b) Petition on December 12, 2014. Petitioner presented original Certified Return Receipts as proof that notice was served on Respondent. No one appeared on Respondent's behalf and no attorney had entered an appearance on behalf of Respondent. The Arbitrator continued the matter to give Respondent full and fair opportunity to appear in its defense. The Arbitrator set the matter for Trial Date Certain during this docket cycle. Petitioner again appeared before the Arbitrator on this date of hearing, January 16, 2015, with proof that notice of the hearing was served on Respondent via certified mail. Petitioner also served Respondent by certified mail with a copy of the Transcript of Proceedings indicating that the matter would be set for a hearing during this docket cycle. No attorney entered his or her appearance and no one appeared on behalf of Respondent. The Arbitrator therefore proceeded to hear the evidence on Petitioner's §19(b) Petition ex parte.

Petitioner testified that she is employed with Respondent, Dollar General, as a Store Manager. (T.8) Petitioner earns a salary of $38,000.00 per year. (T.8, 9) Petitioner is 53 years of age and married with no dependents under the age of 18. (T.9) Petitioner testified that her annual earnings/average weekly wage and are based on a full 52 week work year. (T.13).

Petitioner sustained accidental injury on March 13, 2014, at Respondent's retail store located in Steeleville, Illinois. (T.9, 10) In the course of removing boxes off of the "rolltainer," a device used to stock merchandise, a case of antifreeze weighing approximately 60 pounds fell and stuck Petitioner on her left foot. (T.10; PX5) Petitioner had no accidents or treatment to her left foot prior to the accident. (T.10) Petitioner notified Respondent of the injury when she completed an accident report and submitted it to risk management at Respondent's Corporate Office on the day of the accident. (T.11, 12).

Petitioner sought treatment with her family physician at Steeleville Family Practice. (PX3) X-rays were negative for fracture, and Petitioner's MRI was impressive for calcaneal spurring and a small cystic focus. (PX4) Petitioner's pain and swelling persisted despite rest, ice, compression, elevation, anti-inflammatory medication and change of footwear. (PX4). On June 10, 2014, Petitioner continued to suffer marked discomfort and pain with any weight bearing. (PX4, 6/10/14) Petitioner was assessed with left metatarsalgia and referred to a podiatrist for evaluation. *Id.*

Petitioner saw a podiatrist, Dr. Zenon Duda, on July 15, 2014. (PX5, 7/15/14) Dr. Duda noted Petitioner's painful gate and left foot physical examination findings of tenderness over the left lateral midfoot. discomfort and pain with inversion stress and tenderness to palpation of the third metatarsal base. *Id.* Dr. Duda ordered a bone scan to evaluate potential subtle bone injury and/or change in blood flow related to nerve injury. *Id.* Petitioner's bone scan showed some increase in uptake, but Petitioner's problem appeared to be more related to a contusion induced nerve injury and/or impingement due to the location of the problem. (PX5, 8/12/14) Petitioner was placed in a cam walker. *Id.*

After three weeks of using the boot, Petitioner continued to suffer discomfort in the dorsal aspect of her left foot related to contusion of the dorsal cutaneous sensory nerves. (PX5, 9/2/14) Petitioner also reported numbness in addition to persistent left foot pain. *Id.* Dr. Duda recommended physical therapy. *Id.* When

Petitioner returned on October 2, 2014, and reported improvement with the current treatment plan, Respondent began pressuring Petitioner's physician to modify Petitioner's restrictions. (PX5, 10/2/14) Dr. Duda noted the following:

> Workmans Comp rep has been calling and made some threat about loss of benefits and has made an attempt at FB friending which seems highly unusual. Will increase from 6-8 hours with boot with discussion held regarding transitioning out of boot. *Id.*

Petitioner's condition regressed following this interference and premature modification of duty. Petitioner returned on October 16, 2014, with reports of extreme left foot pain despite use of the boot. (PX5, 10/16/14) Petitioner's left foot remained markedly tender over the dorsal midfoot in the region of the contusion and pressure provoked pain noted to be neuritic in nature. *Id.* Petitioner was given a trigger point injection and assessed with mononeuritis of unspecified site in the left foot. *Id.*

Petitioner also developed right foot pain as a result of favoring her right foot since her left foot crush injury. (PX4, 10/20/14; PX5, 10/27/14) Petitioner's family physician noted a large knot on Petitioner's right foot with associated pain. (PX4, 10/20/14) A cyst developed and was aspirated by Dr. Duda on October 27, 2014. (PX5, 10/27/14). Petitioner's left foot pain continued to worsen despite use of Lidoderm patches and lidocaine topical cream. (PX5, 12/1/14) Petitioner reported that she changed her Lidoderm patch more often, but reported that did nothing to relieve her pain while she was at work because "she is on her feet all the time." *Id.* Petitioner is slated to receive pain management; however, Petitioner began experiencing difficulty getting the recommended treatment because Respondent ceased responding to calls requesting authorization for treatment. (T.11).

Petitioner testified at Arbitration that she currently has pain in the top part of her left foot that increases with activity. (T.13) Petitioner also has stabbing, shooting pains in her foot while sitting as a result of nerve-related pain. (T.13) Petitioner has not missed more than 3 consecutive days following her injury and at this time only seeks additional medical care for her injury. (T.12, 13).

CONCLUSIONS OF LAW

Issue (A): Was Respondent operating under and subject to the Illinois Workers' Compensation Occupational Diseases Act? and-
Issue (B): Was there an employee-employer relationship?

The Arbitrator finds that on March 13, 2014, 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. Petitioner testified that she is a store manager for Respondent, Dollar General.

Issue (C): Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

To obtain benefits under the Act, Petitioner must prove by a preponderance of the evidence that she sustained accidental injuries that arose out of and in the course of her employment with Respondent. 820 ILCS 305/1(d). The Arbitrator finds that Petitioner met her burden.

The term "accident" encompasses anything that happens without design or any event that is unforeseen by the victim. *E. Baggot Co. v. Indus. Comm'n*, 290 Ill. 530, 533, 125 N.E. 254, 255 (1919). If the injury coincides with this definition and is traceable to a definite time, place, and cause, then the injury is accidental within the meaning of the Act. *Laclede Steel. Co. v. Indus. Comm'n*, 6 Ill.2d 296, 300, 128 N.E.2d 718, 720 (1955). An injury arises out of employment if the risk is incidental to his employment or occurs in the performance of the claimant's job duties. *Orisini v. Indus. Comm'n*, 117 Ill.2d 38, 45, 509 N.E.2d 1005, 1008 (1987). "In the course of" simply refers to the time, place, and circumstances under which the accident occurs. *Orisini*, Ill.2d at 44, N.E.2d at 1008.

The uncontroverted evidence in the record shows that Petitioner's foot was unsuspectingly crushed by a box of antifreeze while performing her job duties. This clearly constitutes an "accidental" injury arising out of and in the course of her employment with Respondent. (T.10).

Issue (D): What was the date of the accident?

All medical and related evidence in the record establishes that Petitioner's injuries occurred on March 13, 2014. Petitioner testified to same and there is no evidence to the contrary. (T.9, 10).

Issue (E): Was timely notice of the accident given to Respondent?

Petitioner testified without rebuttal that she notified Respondent of the accident on the same day it occurred by way of completing an incident report and submitting it to risk management at Respondent's Corporate Office on the day of the accident. (T.11, 12). Accordingly, the Arbitrator finds that Petitioner gave timely notice of her accidental injury.

Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?

The uncontroverted circumstantial and medical evidence prove that Petitioner's current condition of ill-being is causally related to her accident of March 13, 2014. Petitioner testified to no accidents or treatment to her left foot prior to the accident. (T.10) The records are silent as to any other cause for Petitioner's complaints. Petitioner consistently reported the cause of her symptoms to all of her medical providers. Petitioner consistently treated for her condition from the date of the accident, and there is no evidence in the record of an intervening accident. A claimant's testimony standing alone may be sufficient to support an award of benefits under the Act. Medical testimony is not essential to support the conclusion that an accident caused a claimant's condition of ill-being. Circumstantial evidence can be sufficient to prove a causal nexus between an accident and the claimant's injury. [Citations]; *Univ. of Illinois v. Indus. Comm'n of Illinois*, 365 Ill. App. 3d 906, 912, 851 N.E.2d 72, 78 (1st Dist. 2006). The Arbitrator notes that Petitioner's injury is not of the sort where the question of causal connection rests only in the realm of expert knowledge. The Arbitrator therefore finds that

Petitioner met her burden of proving that her current condition of ill-being is causally related to her work-related accident.

Issue (G): What were Petitioner's earnings?

Petitioner testified that she earns a salary of $38,000.00 per year. (T.8, 9) Petitioner testified that her annual earnings/average weekly wage and are based on a full 52 week work year. (T.13) The Arbitrator therefore finds that Petitioner's average weekly wage was $730.77. However, no temporary total disability benefits have been claimed.

Issue (H): What was Petitioner's age at the time of the accident?
Issue (I): What was Petitioner's marital status at the time of the accident?

Petitioner testified that she was 52 years old at the time of the accident. Petitioner testified that she is married with no dependents under the age of 18. (T.9). The Arbitrator so finds.

Issue (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?

Upon a claimant's establishment of a causal nexus between injury and illness, employers are responsible for the employees' medical care reasonably required in order to diagnose, relieve, or cure the effects of the claimant's injury. *Plantation Mfg. Co. v. Indus. Comm'n*, 294 Ill.App.3d 705, 691 N.E.2d 13 (2000); *F & B Mfg. Co. v. Indus. Comm'n*, 325 Ill.App.3d 527, 758 N.E.2d 18 (1st Dist. 2001).

Based upon the above finding regarding causal connection, the Arbitrator finds that Petitioner is entitled to medical benefits under the Act. $376.00 to Steeleville Family Practice, $9,468.50 to Chester Memorial Hospital, and $1,664.00 to Cape Foot Clinic, as provided in Sections 8(a) and 8.2 of the Act.

Issue (K): Is Petitioner entitled to any prospective medical care?

Petitioner testified without rebuttal that she is in need of further medical care. (T.12, 13) Her testimony is borne out by the medical records, which demonstrate that Petitioner is still under the active care of her podiatrist. (PX5) Respondent shall therefore continue to provide for Petitioner's care and treatment necessary to relieve her of the effects of her injury as required by the Act. 820 ILCS 305/8(a); *F & B Mfg. Co. v. Indus. Comm'n*, 758 N.E.2d 18 (1st Dist. 2001).

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Awilda Rivera,
Petitioner,

vs. NO: 09 WC 45322

Southwest Airlines,
Respondent.

16IWCC0229

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of nature and extent of Petitioner's permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 8, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

16IWCC0229

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $11,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 8 2016

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-03/23/16
jdl/wj
68

[illegible]

[illegible]

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RIVERA, AWILDA
Employee/Petitioner

Case# **09WC045322**

SOUTHWEST AIRLINES
Employer/Respondent

16IWCC0229

On 10/8/2015, 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 0.06% 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:

0154 KROL BONGIORNO & GIVEN LTD
RANDALL W SLADEK
120 N LASALLE ST SUITE 1150
CHICAGO, IL 60603

0766 HENNESSY & ROACH PC
QUINN M BRENNAN
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

☐ 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
NATURE AND EXTENT ONLY

Awilda Rivera
Employee/Petitioner

v.

Southwest Airlines
Employer/Respondent

Case # 09 WC 45322

16IWCC0229

The only disputed issue is the nature and extent of the injury. 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 **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **September 21, 2015**. By stipulation, the parties agree:

On the date of accident, **7/30/2009**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

On this date, Petitioner sustained 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 $**37,651.12**, and the average weekly wage was $**724.06**.

At the time of injury, Petitioner was **43** years of age, ***single*** with **1** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

Respondent shall be given a credit of $**73,096.29** for TTD, $**-0-** for TPD, $**-0-** for maintenance, and $**-0-** for other benefits, for a total credit of $**73,096.29**.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $434.44/week for 25.05 weeks, because the injuries sustained caused the 15% loss of the left foot, as provided in Section 8(e) of the Act.

RULES REGARDING APPEALS Unless a Petition for Review is filed within 30 days after receipt of this decision, and a review is perfected 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.

David A. Kane
Signature of Arbitrator

October 7, 2015
Date

OCT · 8 2015

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Awilda Rivera	)	
	)	
Petitioner,	)	
	)	
vs.	)	No. 09 WC 45322
	)	
Southwest Airlines	)	
	)	
Respondent.	)	16IWCC0229

MEMORANDUM OF DECISION OF ARBITRATOR

STATEMENT OF FACTS

The Petitioner is a 49-year-old female who is presently employed with Southwest Airlines as a Center Operations Associate. She has been employed by Respondent for approximately 15 years. She describes her job as an administrative liaison. Her job responsibilities include taking care of Reservations Agents, such as scheduling and programming. She testified that her job responsibilities are clerical in nature.

At the time of all three of the Petitioner's accident dates, she was employed as a Customer Service Agent. Those job responsibilities included checking passengers into flights, and transferring customer luggage from check-in to the conveyor belt. The Petitioner received permanent work restrictions as a result of the 7/18/2015 work accident, which prevented her from returning to work for Respondent in the same capacity. She was subsequently placed into the new position as a Center Operations Associate at a lesser rate of pay. The new position is within said restrictions and the Petitioner continues to work in that capacity as of the trial date.

July 30, 2009 Accident

The Petitioner testified that on July 30, 2009, that she twisted her left ankle while running bags from the service area to the ticket counter. The Petitioner underwent an MRI of her left foot/ankle on 8/29.2009 which her treating physician, Dr. Johnny Lin, diagnosed as a posterior tibial tendon tear. He attempted to treat the condition with physical therapy, but when the Petitioner's pain persisted he recommended an updated MRI which Petitioner underwent on March 12, 2010.

The updated MRI revealed a calcaneal heel spur within the Archilles' insertion. Since Petitioner failed conservative treatment, he performed an arthroscopic Achilles tendon debridement, tendon transfer and excision of the bone spur on April 13, 2010. The operation provided relief for Petitioner's left foot.

The Petitioner underwent post-operative physical therapy and reported resolution of her pain but with discomfort. The Petitioner was undergoing physical therapy for her left wrist at the same time.

The Petitioner's left foot/ankle pain persisted, prompting Dr. Lin to perform a second surgery on Petitioner on April 27, 2012. The procedure was a gastrocsoleus recession to eliminate the pain over her Achilles tendon. The Petitioner underwent post-operative physical therapy. By July 11, 2012, she reported improve in her pain and function. Dr. Lin opined the Petitioner had reached maximum medical improvement and release the Petitioner from care.

The Petitioner has not pursued any medical treatment for her left foot/ankle since being released from Dr. Lynn's care. She testified that she continues to experience pain in her left foot/ankle, that her leg cramps, and that she no longer wears high heeled shoes.

CONCLUSIONS OF LAW

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING THE NATURE AND EXTENT OF THE PETITIONER'S INJURIES SUSTAINED AS A RESULT OF THE WORK ACCIDENT, THE ARBITRATOR FINDS THE FOLLOWING:

In regard to the left foot injury sustained as a result of the July 30, 2009 work accident (09 WC 45322), the Petitioner was diagnosed with a tear in the posterior tendon and a calcaneal bone spur in the heel, which required arthroscopic debridement and spur removal. The Petitioner had ongoing complaint in the left foot, and in 2012 underwent a second surgical procedure consisting of a gastrocsoleus recession to eliminate the pain over her Achilles tendon. The Petitioner reported improvement in her pain and received a full duty release for the left foot on July 22, 2012. The Petitioner has pursued no additional medical treatment since her release. The Arbitrator finds that the medical evidence considered in conjunction with Commission precedent, that the Petitioner incurred a permanent and partial disability to the extent of 15% loss of use of the left foot (25.05 weeks).

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Patricia K. Russell,
Petitioner,
vs.

NO: 10WC 24374

16IWCC0227

Wal-Mart,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 29, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 8 2016

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RUSSEL, PATRICIA K
Employee/Petitioner

Case# **10WC024374**

WAL-MART
Employer/Respondent

16IWCC0227

On 1/29/2015, 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 0.07% 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:

0062 BELL & TEPLITZ
JOEL BELL
221 N LASALLE ST SUITE 1900
CHICAGO, IL 60601

0210 GANAN & SHAPIRO PC
RON MARCH
210 W ILLINOIS ST
CHICAGO, IL 60654

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

☐ 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

Patricia K. Russell
Employee/Petitioner

v.

Wal-Mart
Employer/Respondent

Case # **10 WC 24374**

Consolidated cases: **N/A**

16IWCC0227

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 **Gerald Granada**, Arbitrator of the Commission, in the city of **Geneva**, on **December 12, 2014**. 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 _____

16IWCC0227

FINDINGS

On 2/5/2010, 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 not*** 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**35,180.08**; the average weekly wage was $**676.54**.

On the date of accident, Petitioner was **54** years of age, ***single*** with **0** dependent children.

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

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

Respondent is entitled to a credit of $**550.00 for Indemnity payments and $2,762.00 in medical benefits** under Section 8(j) of the Act.

ORDER

The Arbitrator finds the Petitioner did not sustain an injury arising out of and in the course of Petitioner's employment. Accordingly, benefits are denied.

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.

Signature of Arbitrator

1/28/15
Date

JAN 29 2015

16IWCC0227

FINDINGS OF FACT

On and prior to February 5, 2010, the Petitioner, Patricia K. Russell, (hereinafter referred to as Petitioner) was employed by Wal-Mart (hereinafter referred to a Respondent). Petitioner testified on February 5, 2010, she was employed by Respondent as a cashier. Petitioner testified on February 5, 2010, while performing her normal duties as a cashier, she went to move something and alleges to have hurt her neck while performing this activity. Petitioner did continue working the entire day after the alleged injury. Petitioner testified she continued to work in a full duty, unrestricted capacity from the date of the alleged incident, February 5, 2010 through February 21, 2010. Petitioner testified from February 5, 2010 through February 21, 2010, she did not seek any medical care.

On said date Petitioner was working on register #9, a cashier station which uses a conveyor belt. Petitioner testified her duties included ringing up various items purchased by customers. Register #9 has a handheld wireless scanner which the Petitioner can use. The scanner allows the Petitioner to walk out of the cashier area and scan items left on customer's shopping carts. The scanner is also to be used on large or heavy items on the conveyor belt so the Petitioner does not have to lift or move the larger items. Petitioner testified she underwent training with Respondent prior to working as a cashier. Petitioner testified part of her training included instruction on the proper methods of scanning large and heavy items by using the scanner.

Petitioner testified that on February 6, 2010, she reported the incident to her supervisor (Respondent's exhibit #12). Petitioner testified when reporting the incident she filled out a required form, The Associate Incident Log Form (Respondent's Exhibit #12) which was signed by Petitioner on the same day. She testified there are two forms available for an employee to fill out and sign if an incident occurs on the job. The first is the Incident Log which is used when an employee has an incident at work but does not sustain a physical injury. The second form, used when an actual physical injury occurs, is called an Associate Statement (Respondent's exhibit #2).

When filling out the Incident Log form Petitioner hand wrote "spinner too far to reach to put things on". (Respondent's exhibit #12). The Incident Log indicates the Petitioner was in fact working on Register #9 and while working on said register pulled a muscle. Petitioner complained of a sore neck on the right side. She refused medical care. Petitioner returned to work in her normal capacity full duty. No lost time occurred.

On February 21, 2010, the Petitioner was asked to work once again on a register. After the request was made, Petitioner stated she was unable to perform the activities and requested to fill out an Associate Statement since she stated for the first time to have an actual physical injury, and for the first time requested medical care.

Petitioner testified when she asked to fill out an Associate Statement she was sent to see her supervisor, assistant manager, Maria Quiles-Rosas, (hereinafter referred to as Ms. Rosas) Petitioner testified Ms. Rosas is the individual she was instructed to see regarding any work-related injuries. On February 21, 2010, the Petitioner met with Ms. Rosas. Petitioner testified she filled out the form by hand. (Respondent's exhibit #2) On said form under question number 3, she was asked "if you were lifting or handling an object at the time, give its approximate size and weight." The Petitioner handwrote, "large liquid container" with reference to the weight, the claimant stated, "I'm not sure." The Associate Statement was signed by Petitioner on February 21, 2010 as well as Ms. Rosas.

Petitioner testified after advising Ms. Rosas of the alleged injury to her neck, she was once again offered medical attention. For the first time Petitioner agreed to seek medical attention. The Petitioner sought medical treatment on February 21, 2010 at Dreyer Medical Clinic. (Petitioner's exhibit #2) The medical records from

Dreyer Medical Clinic on February 21, 2010, indicate a history as follows: "she (Petitioner) said she pulled her neck working at the large register where it required a lot of lifting and twisting." Petitioner also hand wrote in the Patient Statement of Injury: "out of zone area to move merchandise." (Petitioner exhibit #2). The medical records indicate subjective complaints with reference to the Petitioner's neck. Petitioner was diagnosed with an acute cervical neck spasm. Petitioner was released to return to work on a light duty basis. (Petitioner's exhibit #2)

Petitioner testified after she began treatment at Dreyer Medical Clinic, she continued to work for Respondent in a restricted capacity. Petitioner testified she worked as a people greeter.

Petitioner continued to treat at Dreyer Medical Clinic. On Petitioner's next visit to Dreyer, February 23, 2010, a complete exam and history was obtained from the Petitioner. The records reflect "she (Petitioner) denies any pain radiation down the upper extremities. Denies any numbness, tingling or apparent weakness at the upper extremities." (Petitioner's exhibit #2). Petitioner was diagnosed with "neck and trapezius strain." (Petitioner's exhibit #2). Petitioner was again released to modified work. Petitioner testified she did continue to work for Respondent.

Petitioner testified she continued to treat at Dreyer until May 10, 2010. The medical records from Dreyer on May 10, 2010, revealed an examination of the cervical spine which showed no obvious deformity, ecchymosis, erythema or swelling. The doctor noted the subjective complaints of mild tenderness. Petitioner did have full range of motion in the cervical spine. The Petitioner was once again restricted to modified work based on her subjective complaints. The Petitioner was instructed to follow up with a neurologist. (Petitioner's exhibit #2)

Petitioner testified she then came under the care of Dr. Andrew Ta, Midwest Neurology. (Petitioner's exhibit #1) Petitioner was first examined on July 14, 2010. The Petitioner provided the following history to Dr. Ta. "she is a cashier at Wal-Mart and she was lifting heavy items when she hurt her neck..." (Petitioner's exhibit #1) The doctor performed a physical examination of the neck which revealed no abnormalities. The doctor also examined the Petitioner's musculoskeletal system which revealed "no abnormality." The doctor's sensory exam, motor exam, movements exam also showed no abnormalities. (Petitioner's exhibit #1). The physical examination showed normal strength throughout with normal sensation and no muscle spasticity. Dr. Ta's impression was, "headache and neck pain dizziness." Dr. Ta prescribed an MRI.

On July 19, 2010, the Petitioner underwent an MRI at Dekalb MRI Imaging Institute. (Petitioner's exhibit # 1) On July 21, 2010 Dr. Ta reviewed the MRI findings with Petitioner and advised the MRI showed "multiple levels of degenerative disc disease." (Petitioner's exhibit #1). Dr. Ta's records reflect "I told her (Petitioner) that I see no significant abnormality" in the MRI findings. (Petitioner's exhibit #1). The doctor performed a neurologic and musculoskeletal exam which again showed no abnormalities. (Petitioner's exhibit #1). The exam by Dr. Ta also showed normal strength and sensation and no muscle spasticity. (Petitioner's exhibit #1). The doctor prescribed and EMG.

Petitioner underwent an electromyogram and nerve conduction test of the right upper extremity on July 28, 2010 performed by Dr. Ta. The impression: "these electromyogram and nerve conduction studies of the right upper limb were within normal limits without signs supporting a diagnosis of radiculopathy, plexopathy or peripheral neuropathy." (Petitioner's exhibit #1)

Petitioner followed up with Dr. Ta on August 11, 2010. On said date, the records reveal Dr. Ta discussed the EMG results with the Petitioner. The record reflects, "her EMG examination did not show any nerve impingement." (Petitioner's exhibit #1) The doctor performed a musculoskeletal and neurologic exam which

all revealed no abnormalities. (Petitioner's exhibit #1) The Petitioner continued to treat with Midwest Neurology and Dr. Ta until September 29, 2010. The records reflect the doctor once again performed a physical examination regarding the musculoskeletal and neurological systems which again showed no abnormalities. (Petitioner's exhibit #1) The doctor also performed a complete physical examination which indicated strength is normal throughout, normal sensation, no muscle spasticity, nor is any pathological reflex is noted. The Petitioner testified on said date, she was discharged from Dr. Ta's care.

Petitioner testified after her discharge from Dr. Ta, she began treating solely with a chiropractor, David Rousseau. Petitioner began treating with the chiropractor on August 23, 2010. (Petitioner's exhibit #3) The records from Rousseau Chiropractic Clinic indicate the Petitioner treated there from August 23, 2010 through July 10, 2014.

Petitioner testified at the hearing she still continues to experience discomfort in her neck, headaches and dizziness. Petitioner testified she continues to experience tingling down her arms. Arbitrator notes the Petitioner was wearing a cervical collar on the date of hearing.

Respondent offered the testimony of Ms. Rosas. Ms. Rosas testified she began employment with Respondent on July 1, 1999 as a sales associate. On February 5, 2010, she was employed as an assistant manager. Her duties included sales, merchandising, scheduling as well as handling potential work-related injuries for associates. Ms. Rosas explained Respondent has two (2) different forms available for associates to complete if a work-related event occurs during an employees work activities. The first form is referred to as an Associate Incident Log Form. An Incident Log Form is filled out when an employee wants to advise Respondent of an event occurring at work. The Incident Log Form is only used when the employee does not require medical attention and there is no alleged physical injury. The second form, An Associate Statement-Workers' Compensation Form, is used when an employee alleges to have sustained a physical injury and may require medical attention. Ms. Rosas stated the two (2) forms are necessary for three (3) reasons. First, for safety issues. If there are is a safety issue which mandates correction, the Respondent can rectify the situation. The second reason is to verify if the injured employee necessitates medical attention which would be offered immediately. Finally, Ms. Rosas testified the third reason is to conduct an investigation in order to determine the validity of the alleged accidental injury.

Ms. Rosas testified she is familiar with Petitioner. Ms. Rosas explained that the Petitioner along with all other cashiers go through a training program referred to as CBL or Computer Based Learning which is to teach the associates how to work as a cashier and to do so safely. Ms. Rosas explained the CBL advises the associates how to handle merchandise which may be too difficult to lift. Ms. Rosas testified each cashier is given a scanner which is handheld. The scanner is to be used by the cashier to scan heavy items which are either placed by the customer on the cashier's conveyer belt, or to be used on heavy items which remain in the customer's cart. Ms. Rosas explained if a heavy item is placed on the cashier's conveyer belt, the associate is to use the scanner and the customer then places the heavy object back into their cart. If the item is in the shopping cart, the associate exits the cashier area and scans the item in the cart. Ms. Rosas also explained there are a number of helpers for each cashier if assistance is needed with heavy items.

Ms. Rosas stated the Petitioner originally filled out an Associate Incident Log Form which alleged an incident had occurred on February 5, 2010. The Incident Log Form (Respondent's exhibit #12) was used for the Petitioner since Petitioner did not claim to have sustained a physical injury, nor did the Petitioner require medical treatment which she was offered. Ms. Rosas testified the Petitioner continued to work in a full duty capacity without restrictions from February 5, 2010 through February 21, 2010. Ms. Rosas explained at no time did the Petitioner request modified duty, help performing her activities, as a cashier, or any other position, nor

did she request any further accommodations while performing her normal activities as a cashier.

Ms. Rosas testified on February 21, 2010, the Petitioner was asked to work a belted-register. Petitioner stated she could not because she prefers using an express register. Ms. Rosas explained due to the lunch schedule, she was needed on a long register. When this request was made of the Petitioner she stated, for the first time, she would like to fill out an Associate Statement-Workers' Compensation Form as a result of the February 5, 2010 incident. The aforesaid information was memorialized on Respondent's exhibit #3. This document was prepared contemporaneously by Maria Quiles-Rosas on February 21, 2010.

Ms. Rosas also reviewed the Form 45 Accident Report (Respondent's Exhibit #1) as well as the Associate Statement-Workers' Compensation Form (Respondent's exhibit #2). With reference to the Form 45 Accident Report, Ms. Rosas explained this was prepared in the presence of the Petitioner based on the information provided directly from Petitioner. Petitioner advised the alleged date of accident was February 5, 2010 at 11:00AM. When asked to describe the nature of injury, the Petitioner provided the following information, "felt injury to neck when lifting heavy liquid." (Respondent's exhibit #1)

Ms. Rosas then reviewed the Associate Statement-Workers' Compensation Form. (Respondent's exhibit #2) This form was handwritten and filled out by the Petitioner. The form reflects Petitioner's signature and is dated February 21, 2010. The document also lists Ms. Rosas as the signature on the same date. The form indicates on February 5, 2010, the claimant was working on Register #9 and pulled something in her neck. When asked to describe the event, the Petitioner wrote, "large liquid container, not sure of the weight." (Respondent's exhibit #2)

Ms. Rosas explained once the Form 45 Accident Report and Associate Statement-Workers' Compensation Forms were filled out an investigation occurred. Ms. Rosas testified Respondent has numerous video cameras located throughout the store. Ms. Rosas stated there is a video camera over register #9, the one Petitioner was working at on February 5, 2010. (Respondent's exhibit #11) Ms. Rosas testified the video is a true and accurate copy of Petitioner's work activities on February 5, 2010. Ms. Rosas testified she personally viewed the video. Ms. Rosas testified further that during her review of the video she documented handwritten notes of all activities the Petitioner performed while on register #9. (Respondent's exhibit #13) Ms. Rosas testified her review of the video, along with her notes made contemporaneously; do not indicate the Petitioner lifting any heavy liquid items. In fact, Ms. Rosas went on to testify the video does not depict the Petitioner lifting or moving any heavy items. Ms. Rosas explained while watching the video, the Petitioner followed her CBL training. Any item that appeared large on the counter was not lifted by the Petitioner. The Petitioner used the handheld scanner and the customer then placed the item back into the shopping cart. For large items that were in a customer's cart, the Petitioner followed the proper protocol and took the handheld scanner, exited the cashier area and then scanned the items while on the customer's cart. Ms. Rosas went on to testify, after viewing the video, it was clear the Petitioner's explanation of the alleged lifting accident was not documented on the video. Ms. Rosas testified based on the video documentation of the Petitioner's work activities and the claimant's verbal description of the alleged incident, as well as the forms filled out including the Form 45 Accident Report and Associate Statement-Workers' Compensation Form, the matter was ultimately denied.

Ms. Rosas went on to testify that from February 5, 2010 through February 21, 2010, the Petitioner continued to work as a cashier performing her normal activities. At no time during this time period did the Petitioner ever request to seek medical attention or ask for a job change to a lighter duty position, and the Petitioner continued to work full time. Ms. Rosas stated if the claimant voiced any complaints or required medical attention, the Petitioner would have advised her of the same. Ms. Rosas testified the

Respondent can accommodate almost any light duty restriction. Wal-Mart has various positions available including working as a store greeter or merchandiser which would require no lifting. Ms. Rosas went on to testify the Petitioner continues to work at Wal-Mart and receives the same salary.

On May 18,2011, Petitioner underwent an examination with Dr. John Cherf at the request of Respondent. (Respondent's exhibit #4) The report from Dr. Cherf indicates a history described by the Petitioner as sustaining an injury on February 5, 2010. The Petitioner advised Dr. Cherf she was working as a cashier on the "long belt." Petitioner described she was moving items off the belt onto a carousel. The objects were grocery items as large as a gallon of milk. According to the doctor's notes, the Petitioner physically described the mechanism of her injury which Dr. Cherf noted as "non contact twisting injury." The doctor performed a complete physical examination which showed no swelling, erythema or ecchymosis about the cervical spine. The doctor noted no tenderness or spasm in the cervical region. The doctor noted good range of motion with flexion, extension, rotation and bending. The Petitioner had 5-5 motor function in all major motor groups in the upper extremity. Sensation was intact to light touch. The Petitioner's biceps, brachioradialis, and triceps' reflexes were all present and symmetrical. However, the doctor would not provide a final diagnosis since he requested to receive a copy of the MRI of the cervical spine and an EMG of the upper extremities. Dr. Cherf never authored an addendum report. (Respondent's exhibit #4)

The Respondent requested the Petitioner undergo a follow up independent medical examination with Dr. Steven Mather. Petitioner underwent said examination on September 11, 2014. The Petitioner described the alleged incident of February 5, 2010 as follows, "she was lifting some items off of the long belt. She is not sure exactly what it was, but she felt a pop in her neck." Dr. Mather performed a complete physical examination and also reviewed the medical records from Dr. Andrew Ta, Rousseau Chiropractic Clinic, the report of Dr. John Cherf, as well as the MRI and EMG. Dr. Mather stated, "it is my opinion that she (Petitioner) has had appropriate conservative treatment and it able to return to work as a cashier for Wal-Mart without restrictions. She is at maximum medical improvement. She does not currently have any focal findings on physical examination and she has diffused complaints that cannot be corroborated by physical examination and/or MRI testing, or EMG testing." (Respondent's exhibit #8).

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has failed to meet her burden of proof. This finding is based on both the testimony of the witnesses and the evidence presented at the hearing, both of which cast doubt on the credibility of Petitioner's claims. Petitioner's claims regarding the details of her alleged accident are first brought into question when she claimed that she was lifting a product, but could not identify the product in question. She then filled out an incident report which indicates she did not sustain a physical injury nor require any medical attention. The Arbitrator notes the Petitioner continued to work in a full duty capacity without restrictions from February 5, 2010 through February 21, 2010 as a cashier. It was not until February 21, 2010, that Petitioner reported a physical injury from February 5, 2010. It was at that time that the Petitioner was asked to work on a long register which she did not wish to do, and the Petitioner states she did not feel she was able to continue to work as a cashier. As a result, the Petitioner was required to meet with her supervisor, Ms. Rosas, and a Form 45 Accident Report (Respondent's exhibit #1) as well as an Associate Statement-Workers' Compensation Form (Respondent's exhibit #2) were filled out. The Arbitrator also relies on the unrebutted testimony of Ms. Rosas, who personally met with the Petitioner while preparing the accident forms that clearly indicate Petitioner's description that she was injured while lifting a large liquid container.

The undisputed testimony of Respondent's witness, Ms. Rosas, indicates video surveillance was obtained in the normal course of business on February 5, 2010. The video was introduced into evidence as Respondent's exhibit #11. In addition, Ms. Rosas testified she personally viewed the video and contemporaneously documented all activities the Petitioner performed while working at register #9 on February 5, 2010. Ms. Rosas testified at no time on the video is the Petitioner depicted as lifting or moving any heavy or large objects. Ms. Rosas testified the video shows the Petitioner to have followed her CBL training when any large or heavy item appeared at her cash register. Ms. Rosas testified that on each occasion where a large or heavy item was placed on the cashier counter, the Petitioner used a handheld scanner to price the object and the customer replaced the item into the shopping cart. If an object was in a customer's cart, the Petitioner exited the cashier area and once again used the scanner to price the item. The Petitioner did not lift, pull or push large or heavy items. The Arbitrator notes that Ms. Rosas' testimony was not challenged or rebutted. .

Based on the above, the Arbitrator concludes that the credibility of Petitioner's testimony outweighed by the evidence. Therefore, the Arbitrator finds the Petitioner did not sustain an accidental injury arising out of and in the course of her employment on February 5, 2010.

2. Based on the findings above, all other issues are rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF Mc HENRY)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mark F. Mago,
Petitioner,

vs. NO: 11 WC 33325

Front Range Environmental,
Respondent.

16IWCC0228

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, permanent partial disability, medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 26, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 8 2016

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-03/23/16
jdl/wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MAGO, MARK F
Employee/Petitioner

Case# **11WC033325**

FRONT RANGE ENVIRONMENTAL
Employer/Respondent

16IWCC0228

On 3/26/2015, 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 0.10% 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:

4595 WHITESIDE & GOLDBERG LTD
JASON M WHITESIDE
155 N MICHIGAN AVE SUITE 540
CHICAGO, IL 60601

0507 RUSIN & MACIOROSKI LTD
DANIEL R EGAN
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF McHENRY)

☐ 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

Mark F. Mago
Employee/Petitioner

v.

Front Range Environmental
Employer/Respondent

Case # **11** WC **33325**

Consolidated cases: _____

16IWCC0228

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 **Andros**, Arbitrator of the Commission, in the city of **Woodstock**, on **January 9, 2015 & Waukegan February 23, 2015**. 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 **Credit under § 8(j)**

FINDINGS

On **July 20, 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 not*** 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**76,500.52**; the average weekly wage was $**1,471.16**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **2** dependent children.

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**0.00**.

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

ORDER

Because Petitioner failed to prove he sustained an accident which arose out of and in the course of his employment, and because Petitioner failed to prove a causal connection between his claimed condition of ill-being and a claimed work accident, benefits are denied under the Workers Compensation Act. This denial includes denial for TTD, benefits under section 8(a) & denial of benefits for any permanency under section 8.

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.

#01 _____
Signature of Arbitrator

March 25th, 2015
Date

MAR 26 2015

16IWCC0228

FINDINGS OF FACT & CONCLUSIONS OF LAW 11 WC 33325

The Petitioner testified that he became employed by Respondent on April 19, 2010. (Transcript, hereinafter, "T." p. 7) His job was that of a project manager to oversee four states. Respondent was a storm water management company and their job was to inspect storm water systems to see whether they were operating correctly and to see whether there was any damage to them. (T. p. 8)

Petitioner testified that his work comprised travel about 60% of his time. Occasionally he would remove manhole covers and visually inspect the inside of the manhole and piping system. (T. p 11) Petitioner would use a hook with a handle to pull the manhole cover up and set it off to the side. (T. p. 12)

In May 2011, Petitioner testified that he was asked to help out on inspections of Lowes' properties. (T. pp. 12, 13) This would require him to pull between 30 to 100 manhole covers depending on the size of the site. (T. p. 13) Petitioner testified that a manhole cover would weigh between 100 and 200 pounds, depending on the size and shape. (T. 14)

Petitioner testified that on July 20, 2011 he was at a Lowes' site in Kirksville, Missouri. (T. p. 19) He was working by himself. (T. p. 48) He had available a cell phone for him to communicate with his employer. (T. p. 48) He was performing an inspection of storm drains. (T. p. 19) On this date, he was having difficulty pulling off a square manhole cover. In doing so, Petitioner testified that he pulled on it hard, and he felt something, like a pulled muscle in his back (T. p. 20). Petitioner testified the pain was just below his shoulder blades. (T. p. 21) Petitioner testified he did not notice any pain in his neck at that time (T. p. 54) Petitioner testified he did not have any low back pain at the time either; it was in the midthoracic area (T. p. 54)

Petitioner understood OSHA policy was that he was to report an accident on the day it happens. (T. p. 48) Petitioner did not report this accident on the day it occurred. (T. p. 49) He continued to work for Respondent after July 20, 2011 until he took a vacation in August, 2011. (T. pp. 20 - 22)

Petitioner testified that on August 19, 2011, he had a conversation with Mr. Heffernan. (T. pp. 23, 73) On that date Petitioner testified that Mr. Heffernan advised him he was being let go. (T. pp. 23, 72) Petitioner agreed that he immediately filed for unemployment benefits. (T. p. 77) After this meeting with Mr. Heffernan, Petitioner testified that he sent an email on August 25, 2011 to Mr. Heffernan wherein Petitioner, for the first time told Respondent of his work injury to have occurred July 20, 2011. (T. p. 73) The email Petitioner sent is the same date he signed his name to an (IWCC) Application for Adjustment of Claim. (T. pp. 73-74; Rx 12) The email Petitioner sent was sent at 5:48 p.m. with copy to Mr. Whiteside, his attorney at bar. (T. p. 75) This is also the first date Petitioner told any physician of being injured on July 20, 2011, while working. (Rx 2)

Petitioner was asked questions as to any ongoing problems with his thoracic spine, which he denied having. (T. 43) Petitioner was asked questions as to ongoing problems with his cervical spine. (T. pp. 41, 42).

PRE-ACCIDENT MEDICAL HISTORY

Prior to the alleged accident date of July 20, 2011, Petitioner was seen by his primary care physician at Centegra Primary care on November 25, 2010. (Rx 6) On this date Petitioner complained of neck and right shoulder blade pain, severe in nature. Petitioner indicated he had been painting. He indicated a history of compression fractures in his cervical and "lower back" from previous injury in "1988 due to mva." On this date he received an injection of Toradol. He was diagnosed as having a thoracic sprain. (Rx 6)

On December 11, 2010, Petitioner was seen in the emergency room at Northern Illinois Medical Center complaining of posterior neck pain extending down both arms. History provided was motor vehicle accident a couple months prior. (Rx 8) A CT scan of the cervical spine revealed neural foraminal narrowing and a recommendation for an MRI.

The cervical MRI was performed at Northern Illinois Medical Center on December 16, 2010. (Rx 8) Results showed severe right foraminal narrowing C6-7, bilateral foraminal narrowing C5-6.

Next Petitioner presented himself to Dr. Qeli at Northen Illinois Orthpaedics for treatment in December 2010, (Rx 7) for complaints regarding his neck. (T. p. 64) Dr. Qeli referred Petitioner to Dr. Graf at Illinois Spine Institute. (Rx 4).

Petitioner testified that he next searched for and sought the services of Dr. Dallas-Prunskis at Illinois Pain Institute. (Rx 3) She administered trigger point injections to his cervical spine in December 2010. She also ordered an MRI due to complaints of shoulder blade and low back pain. The MRI was performed on February 21, 2011, and showed, *inter alia*, a right paracentral broad based small focal disk herniation at T11-12 that indented the right aspect of the thecal sac. (Rx 3)

Thereafter, Petitioner remained under the care of Drs. Qeli, Graf and Dr. Dallas-Prunskis. (Rx 3, 4, 7) Because of the nature of his cervical condition, Petitioner saw Dr. Song at the suggestion of a friend of Mr. Heffernan; he was not required to go there. (T. p. 72) Petitioner saw Dr. Song on June 7, 2011. (Rx 2) On this visit, Dr. Song offered fusion surgery to Petitioner at C5 to C7. (Rx 2) (Emphasis added by underline throughout this document.)

Instead, Petitioner underwent surgery to his right elbow on June 1, 2011 by Dr. Qeli. (Rx 7) Surgery consisted of an anterior transposition of the right ulnar nerve, arthroscopy and removal of osteophytes from the right elbow, and removal of loose bodies. (Rx 7)

Petitioner returned to Dr. Song on June 27, 2011. (Rx 2) He reported having had surgery to his right elbow consisting of ulnar nerve decompression, which helped the numbness in his fourth and fifth fingers, but he still had shoulder, thumb and first finger pain and numbness on the right. He also complained of recent exacerbation of mid thoracic pain. (Rx 2) Dr. Song told Petitioner that he would recommend simple physical therapy for his cervical and thoracic spine as he could not have surgery due to work for a couple months. Dr. Song noted that if Petitioner called back, he would schedule a C5-6 and C6-7 discectomy and fusion. He would also arrange for Petitioner to have thoracic epidural versus trigger point injections. Dr. Song also provided a short course of NORCO for Petitioner's newer thoracic pain. (Rx 2)

A review of Dr. Graf's records (Rx 4) reflect Petitioner was receiving refills of NORCO on May 16, 2011, May 23, 2011, June 13, 2011, June 27, 2011, and he requested a refill for HYDROCODONE on July 14, 2011. (Rx 4) The Arbitrator finds the request for multiple refills of Norco and Hydrocodone very probative of his condition & need for surgery before July 20, 2011.

POST ACCIDENT MEDICAL HISTORY

After the claimed accident date of July 20, 2011, Petitioner did not seek medical care until he saw Dr. Graf on August 3, 3011. (T. p. 69, Rx 4) Petitioner testified he went there of his own choosing (T. p. 71) Dr. Graf's record on August 3, 2011, notes Petitioner to be doing much better after ulnar nerve transposition surgery by Dr. Qeli. He complained of some neck pain as well as periscapular shoulder pain. He noted back pain and stated when he sits and works for prolonged period, he has pain and numbness into his left leg. (Rx 4) The Arbitrator notes there is no mention of any type of work injury on this visit, contrary to Petitioner's testimony that he told Dr. Graf on this date of being hurt at work (T. pp. 69, 70)

Petitioner saw Dr. Graf next on August 10, 2011. (Rx 4) Petitioner complained of severe mid thoracic spine pain. Petitioner stated his pain was so severe he took a week off from work. However, again there is no mention of having been injured at work. Dr. Graf ordered x-rays of the dorsal spine. (Rx 4)

X-rays of the dorsal spine took place on August 12, 2011 at Northern Illinois Medical Center. (Rx 4) The history noted was "Mid back pain for years. Patient does heavy lifting."

An MRI of the thoracic spine was also performed on August 12, 2011 at Northern Illinois Medical Center. (Rx 4) The history for performing same was "Back pain. Thoracic pain." The radiologist described significant degenerative changes from T9 through T12 but did not describe any acute or recent findings. (Rx 4)

On August 15, 2011, Petitioner again saw Dr. Dallas-Prunskis. (Rx 3) Petitioner testified that he was not referred to her by anyone at this time; he chose to see her on his own. (T. p. 71) Petitioner last saw Dr. Dallas-Prunksis on March 9, 2011 for cervical epidural steroid injection. Petitioner complained to Dr. Dallas-Prunskis of having done well until recently, when he began having a lot of mid, low back and thoracic pain as well as head and neck pain. He described the mid thoracic pain as relatively new. (Rx 3) The Arbitrator notes that there is no history of describing a work related injury in these records.

On August 17, 2011, Petitioner returned to Dr. Graf. (Rx 4) Petitioner indicated that in the past week he had been lifting multiple manhole covers in order to inspect drainage systems, and that with this activity his back pain was severe. (Rx 4) However, again, the Arbitrator does not note any history of injury at work, only a complaint of pain with activity at work. Petitioner was to follow up in one month's time. The Arbitrator notes the phone messages to Dr. Graf's office by Petitioner on September 22, 27, and 29, 2011 rescheduling or cancelling appointments due to job interviews or possibly starting a new job, inconsistent with his claim of being totally disabled during this time. (Rx 4) It appears that Petitioner never returned to Dr. Graf thereafter. This is extremely probative.

Instead, Petitioner bounces back so to speak to Dr. Song, whom he saw on August 25, 2011. (Rx 2). This is the exact same date that Petitioner signed his (IWCC) Application for Adjustment of Claim (Rx 12) and sent an email to Respondent. (Px 9) This also represents the very first time Petitioner's medical records reflect a history of a work injury on July 20, 2011. Petitioner complained of newer midscapular pain since July 20 after lifting a manhole cover at work. After examining Petitioner, Dr. Song again recommended discectomy and fusion from C5 to C7. Dr. Song noted Petitioner's main complaint to be mid thoracic pain between the shoulder blades, but that there did not seem to be any surgical lesion in this area. There was an area of mild to moderate central stenosis lower down in the thoracic spine but this area did not require any treatment. Dr. Song also suggested Petitioner be kept off work at this time. (Rx 2)

Petitioner underwent surgery to the cervical spine by Dr. Song on November 9, 2011. (T. p. 78 and Rx 2) Prior to surgery, Petitioner underwent a pre op physical on November 2, 2011 with Dr. Patel. (Rx 6) Dr. Patel noted the onset of Petitioner's cervical condition to be more than one year previous. There is no history of injury or accident to the cervical spine in July 2011. (Rx 6)

According to Dr. Song's records, he last saw Petitioner on January 3, 3012. (Rx 2) At that time, he recommended Petitioner begin physical therapy for his neck. Petitioner was to return in one month's time. (Rx 2)

Noteworthy -Instead of returning to Dr. Song, Petitioner had resumed treatment with Dr. Dallas-Prunskis. (Rx 3) She provided a course of care to the thoracic spine consisting of radiofrequency on December 1, 2011, lumbar facet injections on January 25, 2012, trigger point injections to the thoracic spine on February 15, 2012, lumbar facet injections on March 7, 2012, and radiofrequency of the lumbar spine on March 22, 2012. (Rx 3) She ordered a Functional Capacity Evaluation (FCE) which was performed on April 4, 2012. On April 18, 2012. Dr. Dallas-Prunskis noted the FCE indicated Petitioner capable of heavy duty work. (Rx 3)

Petitioner boldly denied that he returned to work in April, May, June or July 2012. (T. p. 80) However, this testimony is contradicted by video surveillance (Rx Group 9) which depicts Petitioner engaged in a variety of physical activities and by reasonable inference was employed during this time.

Petitioner testified to coming under the care of Dr. Neckrysh due to bladder control issues. (T. pp. 35, 36) Petitioner testified he found Dr. Neckrysh on his own. (T. pp. 80, 81) Yet, in contravention Dr. Neckrysh's medical records reflect that he saw Petitioner at the request of his attorney, Jason Whiteside. (Px 8). Further, Dr. Neckrysh testified that he and Petitioner's attorney met at a hockey game and as a result of their discussion at the game, it was agreed Petitioner would see Dr. Neckrysh (Px 11, p. 34) Eventually, Dr. Neckrysh performed surgery on Petitioner on July 18, 2012 consisting of laminectomies and fusion from T9 through T12. (Px 8).

Prior to surgery, Petitioner underwent a pre-op physical with Dr. Patel on July 3, 2012. (Rx 6) The doctor noted the onset of Petitioner's middle back pain to have been years ago. There is nothing within the record to indicate the need for the upcoming thoracic surgery was work related. (Rx 6) He has not seen Dr. Neckrysh since October 30, 2012 (T. p. 39, Px 8); Petitioner returned to work running a back hoe on sewer crew.

Dr. Jay Levin examined him per section 12 on August 22, 2012 (Rx 1, Ex 2.

CONCLUSIONS OF LAW

C. Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

Based upon the totality of the evidence, the Arbitrator concludes as a matter of law and fact this Petitioner failed to prove he sustained accidental injuries that arose out of and in the course of his employment by Respondent on July 20, 2011. The Arbitrator has studied the medical evidence and studied the Petitioner's testimony. The Petitioner did not tell any one at Respondent of injuring himself on July 20, 2011 until August 25, 2011, when he sent an email to Respondent claiming an accident occurred on that date, this email correspondence not being sent until after Petitioner had been terminated from Respondent. The Petitioner lost no initial time from work, was able to communicate with his employer without impediment up to the date of his termination on August 19, 2011, and never took the opportunity to advise his employer of having injured himself on July 20, 2011.

Most compelling, Petitioner took the time to advise prior to July 20, 2011 that his neck bothered him, as Mr. Heffernan suggested Petitioner discuss seeing Dr. Song via a his friend.

Moreover, Petitioner did not tell his treating medical providers, Dr. Carl Graf , a spine surgeon plus Dr. Dallas-Prunskis, of having been involved in an accident on July 20, 2011 as he claims. The ample medical records reflect that Petitioner had no difficulty explaining to any of his numerous medical providers prior to July 20, 2011, of any health conditions; there is no reason to believe that this changed after July 20, 2011.

In addition, the Arbitrator does not find the testimony of Petitioner to be persuasive on several points. The Arbitrator notes in particular, the testimony surrounding Petitioner's presentation to Dr. Neckrysh. Petitioner testified that he located Dr. Neckrysh himself, when the records and deposition testimony of Dr. Neckrysh make it clear that Petitioner came to be seen at the request of his attorney. The Arbitrator finds it impossible to believe that Petitioner can claim under oath plus by attorney's request before this Commission that he was temporarily totally disabled beginning August 25, 2011, yet claim to the Illinois Department of Labor that he is able to work and seeking work. This latter representation is also consistent with Petitioner's phone messages to Dr. Graf's office.

The Arbitrator finds in support of the denial of this claim to believe that Petitioner can have an accident as he has claimed, continue to work for Respondent and somehow not find the opportunity to advise Respondent of having been injured at work until after being let go. This is especially unpersuasive given his previous awareness of his own condition and or advice of surgery by Dr. Song.

Petitioner acknowledged that he was supposed to report all injuries immediately after they occur. The Arbitrator finds gross negative inferences regarding credibility that the exact day Petitioner signs the (IWCC) Application for Adjustment of Claim is also the day he provides notice of the claimed accident to Respondent, and for the first time provides a new, and concise, precise history of accident on July 20, 2011.

The Arbitrator concludes that Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment by Respondent on July 20, 2011. Petitioner's claim for compensation is denied.

F. Is Petitioner's current condition of ill-being causally related to the injury?

Even assuming, *arguendo,* that an accident in fact occurred, the Arbitrator concludes that Petitioner failed as matter of fact and law to prove his condition of ill-being is causally related to said accident. The record is clear that for at least 8 months prior to the claimed accident, Petitioner had cervical spine issues which required surgery. He had undergone medical care from Dr. Patel, Dr. Qeli, Dr. Graf, Dr. Dallas-Prunskis, and Dr. Song with respect to his cervical spine. In fact, on June 27, 2011, Dr. Song recommended that Petitioner undergo cervical spine fusion from C5 through C7 and Petitioner deferred, citing being too busy at work to have surgery. (Px 2) Petitioner had no further diagnostic studies with respect to his cervical spine after July 20, 2011. He simply found time in his schedule to have the fusion surgery from C5 through C7. In fact, Petitioner testified that at the time of his alleged accident, he did not notice any pain in his neck. (T. p. 54) There is absolutely nothing of record to show that Petitioner somehow aggravated the condition of his cervical spine on July 20, 2011. The Arbitrator is not at all persuaded by the testimony of Dr. Song in this regard.

Similarly, the Arbitrator concludes that the condition of Petitioner's thoracic spine is not causally related to an alleged accident of July 20, 2011. The medical records reflect a history of thoracic strain on November 25, 2010, or about 8 months prior to July 20, 2011. (Rx 6)

Additionally, the medical record reflect that on June 27, 2011, Petitioner complained to Dr. Song of thoracic pain, for which Petitioner was offered physical therapy, but which Petitioner apparently did not perform. (Rx 2) Even after the alleged date of accident , and review of MRI of the thoracic spine, Dr. Song did not feel Petitioner's complaints in the thoracic region were surgical or even required treatment. (Rx 2). The Arbitrator is not at all persuaded by the testimony of Dr. Neckrysh, who was at least Petitioner's fourth separate and independent choice of treating physician, and a referral from Petitioner's attorney.

Petitioner submitted into evidence medical bills for treatment to his low back, primarily by Dr. Dallas-Prunskis. There was no testimony regarding an injury to the low back. There is no opinion providing a causal relationship between the low back and the alleged work accident.

Any claim for compensation due to the low back is denied as not causally related as a matter of fact and conclusion of law.

The Arbitrator adopts the underscores the testimony of Dr. Jay Levin. (Rx 1) Dr. Levin had numerous medical records to study and comment upon; the same records that are in evidence before this Arbitrator. Dr. Levin also studied the same surveillance footage that this Arbitrator has seen. The opinions of Dr. Levin are consistent with the entirety of the medical evidence.

Therefore, even assuming, *arguendo*, that an accident indeed occurred on July 20, 2011, the Arbitrator concludes as a matter of law and fact that Petitioner failed to prove a causal relationship between his condition of ill-being and said accident. Petitioner's claim for compensation is denied.

O. Other Issues- Credits & Section 8 j; E. Notice

Although moot, based upon the Arbitrator's conclusions concerning accident and causal relationship, the Arbitrator notes the parties entered into a stipulation with respect to the medical bills in this matter. Said stipulation is as follows: The parties agree that the medical expenses have been satisfied by various health insurance carriers. The parties agree that if Petitioner's injuries are found compensable, Respondent will hold Petitioner harmless and Respondent will negotiate and reimburse the group insurance, reimburse Petitioner any out of pocket medical expenses and process any unpaid medical bills pursuant to fee schedule. The parties also agree Respondent is given a credit under §8(j) of the Act.

Notice of the alleged accident was given per section 6 of the Act.

J. , K. L. – Medical , TTD plus Nature and Extent of the Injury

Given the findings on Accident and Causal Connection, above, the Petitioner at bar is not entitled to benefits for medical services et cetera under section 8(a), TTD benefits nor benefits for the nature and extent of the injury under section 8.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Richard Wester,
Petitioner,
vs.

NO: 11WC 43258

16IWCC0225

Pactiv,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, temporary total disability, medical, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 20, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 8 2016
o032316
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

[illegible]

[illegible]

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WESTER, RICHARD
Employee/Petitioner

Case# **11WC043258**

PACTIV
Employer/Respondent

16IWCC0225

On 2/20/2015, 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 0.06% 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:

0226 GOLDSTEIN BENDER & ROMANOFF
DAVID Z FEUER
ONE N LASALLE ST SUITE 2600
CHICAGO, IL 60602

1872 SPIEGEL & CAHILL PC
MARTIN T SPIEGEL
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

☐ 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

Richard Wester
Employee/Petitioner

v.

Pactiv
Employer/Respondent

Case # 11 WC 43258

Consolidated cases: N/A

16IWCC0225

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 **Barbara N. Flores**, Arbitrator of the Commission, in the city of **New Lenox**, on **December 15, 2014**. After reviewing all of the evidence presented, the undersigned 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 9, 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 not*** sustain an accident that arose out of and in the course of employment as explained *infra*.

Timely notice of this accident ***was not*** given to Respondent as explained *infra*.

Petitioner's current condition of ill-being ***is not*** causally related to the accident as explained *infra*.

In the year preceding the injury, Petitioner earned $**31,200.00**; the average weekly wage was $**600.00**.

On the date of accident, Petitioner was **56** years of age, ***married*** with **1** dependent child.

Petitioner ***has*** received all reasonable and necessary medical services as explained *infra*.

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services as explained *infra*.

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**6,818.20** for other benefits (i.e., non-occupational indemnity disability benefits), for a total credit of $**6,818.20**.

Respondent is entitled to a credit **for any medical bills paid through its group coverage** under Section 8(j) of the Act. *See* AX1.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner failed to establish that he sustained a compensable accident at work. By extension, all remaining issues are rendered moot and all requested benefits and compensation are denied.

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.

Signature of Arbitrator

February 13, 2015
Date

FEB 20 2015

16IWCC0225

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Richard Wester
Employee/Petitioner

v.

Pactiv
Employer/Respondent

Case # **11** WC **43258**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute at this hearing include accident, notice, causal connection, Respondent's liability for certain unpaid medical bills totaling $69,464.99, Petitioner's entitlement to a period of temporary total disability benefits from September 12, 2011 through December 26, 2011, and the nature and extent of Petitioner's injury. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background

Petitioner testified that he was employed by Respondent in September of 2011 and had been so employed since February 2, 2007. He described his machine operator duties to include lifting boxes and pallets, moving 400-700 pound Styrofoam rolls measuring 42-52 inches wide, and twisting and moving those into position in the "unwind" machine. Petitioner explained that the unwind machine has a roll bar on it, so he would position the Styrofoam so that the machine would lift up the roll and he would cut the sheet back so it could be threaded through the "Irving" machine, a huge oven that heats the Styrofoam to expand it such that the mold presses out Styrofoam plates.

Petitioner also testified that he would lift roughly 1000 boxes weighing 10-15 pounds on any given day depending on the line and the production requirements of the day. He further testified about a "Burford" machine that weighed approximately 35 pounds. He explained that he would have to it pick up and move it to a stand, which he did 1-2 times every two weeks. Petitioner testified that he did not do any "light work" during his work day.

Regarding any prior injuries, Petitioner testified that he injured his back in a car accident previously when he was about 35 years old, but he did not undergo any medical treatment thereafter for 21 years. On July 14, 2011, Petitioner testified that he was feeling sharp pains in his lower back area and this was the first time that he felt any pain in his back.

On cross examination, he testified that he went on vacation in July of 2011, but that his back pain did not start during that time. He further testified that he first started feeling pain in his low back sometime in July, but he is unsure on what date. He explained that he was in the back of a line maneuvering a roll into position when he felt low back pain. At that time, Petitioner testified that he did not know what the cause was. He testified that the pain was not enough to cause him to leave work, but he felt the pain as he was performing his work activity.

Petitioner testified that he felt fine on the morning on September 9, 2011.

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party.

Medical Treatment

The medical records reflect that Petitioner went to the St. James Hospital emergency room on August 8, 2011. PX1. He reported lower back pain radiating to the right thigh with an onset two days earlier. *Id.* On cross examination, Petitioner testified that this notation of an onset two days earlier was incorrect.

Petitioner underwent lumbar x-rays which showed mild degenerative changes. *Id.* He was diagnosed with a lumbar strain, given medications, instructed to follow up with his primary care physician and discharged. *Id.* Petitioner testified that he did not report this as a workers' compensation incident because he did not believe it was related to his job at the time.

Petitioner testified that he then returned to work through September 9, 2011 performing his regular job duties, but his pain worsened every day. He explained that his pain became unbearable and he went to have that evaluated.

Petitioner's original Application for Adjustment of Claim alleged that he sustained a compensable accident on September 10, 2011, which was amended at trial to reflect a claimed date of accident of September 9, 2011.

The medical records reflect that Petitioner returned to St. James Hospital emergency room on September 12, 2011. PX1; RX1. He reported on-and-off low back pain radiating down his right leg with tingling over the past three weeks with no known trauma. *Id.* Petitioner was diagnosed with low back pain and suspected sciatica. *Id.* He was given Motrin and Valium, and discharged. *Id.* Petitioner testified that at this time he still did not believe that his condition was work-related.

On September 13, 2011, lumbar, right hip and pelvis MRIs were ordered, which Petitioner underwent on September 20, 2011 and September 22, 2011. PX1; RX1. With regard to the lumbar MRI, the interpreting radiologist noted the following: (1) a large extruded right paracentral disc at L5-S1 which caused moderate spinal stenosis and impression on the exiting right S1 and S2 nerve roots; (2) moderate spinal canal stenosis at the L4-L5 level, mild stenosis at the L3-L4 level secondary to facet arthropathy and diffuse disc bulges; and (3) an annular tear at L4-L5. *Id.* Petitioner's right hip MRI was normal. *Id.*

On cross examination, Petitioner testified that he saw Dr. Sharma after his second visit to St. James. He testified that he reported right hip pain and difficulty walking, and that he did report low back pain to her. However, Petitioner acknowledged that he was not in an accident and that he did not fall.

Petitioner then went to physical therapy at Therapy Providers of Tinley Park as ordered by Dr. Sharma on September 14, 2011. PX3. At his initial evaluation on September 19, 2011, Petitioner reported "a Hx of Rt hip pain after he was at work, according to him then he went on vacation and then came back and got worse and then when he went back to work he has difficulty walking." *Id.* Petitioner was discharged from physical therapy on November 30, 2011. PX3.

Petitioner testified that at some point he believed that his problem was related to his employment. He testified that this was after a conversation with his physical therapist. No testimony was offered by this physical therapist.

He also testified that he then went to Respondent for the purpose of reporting the accident. He testified that he spoke to the onsite nurse, Pat. He did not recall the date on which he spoke to her, but testified that they spoke in her office around 10:00-11:00 a.m. on a date sometime around September 24, 2011. No testimony was offered by the onsite nurse.

Petitioner testified that he filed his original Application for Adjustment of Claim on November 4, 2011 and that his daughter told him about the Fullerton Drake Medical Center ("Fullerton Drake").

Petitioner then saw Dr. Mark Gerber at Fullerton Drake on November 10, 2011 reporting severe pain and limited low back motion with intermittent pain and numbness down the right leg into the heel. PX2. Regarding the mechanism of injury, it appears that someone from Dr. Gerber's office noted in a handwritten form that "patient was lifting heavy boxes repetitive twisted repetitive 1st-8-11 2nd-9-11, low back, right leg, numbness, right hip, right heel" PX13. Dr. Gerber also noted the following:

> He was doing well until approximately July 2011, lifting heavy boxes and bags during the course of his employment. He kept working with the pain until August, 2011 when due to severe pain, he presented himself to the local ER, where Xrays were performed and he was given medicine. He continued to work through the pain until September 2011, when it became intolerable again so he returned to the ER, where he was referred to Dr. Sharma, who ordered an MRI and therapy. He was told that he had a herniated disc and asked if he wanted surgery.

PX2. On cross examination, Petitioner testified that he reported a history of repetitively lifting heavy boxes until his pain became intolerable in 2011. He explained that in the course of his duties, he would lift boxes, move rolls and lift pallets about 75 feet away.

On physical examination, Dr. Gerber noted left paracentral and central lower lumbar tenderness, positive bilateral straight leg raise tests with a positive braggards at 35 degrees on the right, positive bilateral Patrick's maneuvers, lower lumbar paraspinal muscle spasm, and diminished iliopsoas and lumbar extensor strength. *Id.* He ordered four weeks of physiotherapy three times per week, and a repeat lumbar MRI. PX2; PX14. Petitioner testified that he told Dr. Gerber about the first lumbar MRI and he did not know why Dr. Gerber wanted the second lumbar MRI.

The same day, Petitioner began physiotherapy at Fullerton Drake. PX2; PX13. A TENS unit, moist heating pad, and lumbosacral support belt for pain control and stability were ordered. *Id.* Petitioner underwent the second MRI at Matteson MRI the following day on November 11, 2011. *Id.* Petitioner continued in physiotherapy through January 7, 2012. *Id.*

Dr. Gerber then referred Petitioner to Dr. Richard Kiang at Spine MD Limited for electrodiagnostic medicine consultation and treatment on December 1, 2011. PX2; PX6-PX7. Regarding the mechanism of injury, Dr. Gerber noted the following:

> Petitioner reported that he was doing well until July 15, 2011. During the course of his employment for Pactiv Corporation, he was lifting heavy boxes and bags and then he suddenly developed severe pain and limitation of motion in the low back with pain radiating into the right leg a few hours later.

Id. On cross examination, Petitioner testified that he told Dr. Kiang that he would perform duties including lifting boxes, twisting rolls to get them in position, and lifting pallets. He testified that his duties differed every

night. He also testified that he reported pain that started on or about July 15, 2011 and acknowledged that he did not report his feeling that it was work related until about September.

Dr. Kiang ordered further diagnostic testing to rule out a peripheral polyneuropathy, tarsal tunnel, and lumbosacral radiculopathy. *Id.* Dr. Kiang ordered and administered an EMG/NCV for "back and leg pain[.]" *Id.* He found that the results were consistent with moderately severe acute right L5 and S1 radiculopathy, and that peripheral polyneuropathy and tarsal tunnel syndrome were much less likely. *Id.*

Dr. Kiang diagnosed Petitioner with moderately severe acute right L5 and S1 radiculopathy likely secondary to disc degeneration at L5-S1 with diffuse impingment on the spinal canal to the right of midline with caudal subligamentous involvement deeply into the right lateral recess. *Id.* He ordered two months of physical therapy three times per week and three caudal epidural steroid injections along with right L5 and right S1 nerve root blocks. *Id.* Petitioner underwent the recommended injections on December 7, 2011, December 14, 2011 and December 21, 2011. *Id.* Petitioner testified that he felt relief from the injections. On December 27, 2011, Petitioner was released to work full duty. *Id.*; RX2 at 23; RX3.

Petitioner testified that he returned to work around Christmas-time. He continues to work for Respondent in a different capacity and he was promoted to a quality control team lead position on December 14, 2014. Petitioner's job duties are physically different and he performs less physical work than he did previously.

Section 12 Examination & Evidence Deposition Testimony – Dr. Weber

On March 21, 2014, Petitioner submitted to an independent medical evaluation at Respondent's request with Dr. Kathleen Weber at Midwest Orthopedics at Rush. RX3. Dr. Weber reviewed various treating medical records, including those of an "unclear author." *Id.* Given Petitioner's testimony at trial regarding treatment after his visits to St. James Hospital and before seeing Dr. Gerber, it appears that these notes are from treatment with Dr. Sharma. *See* RX4.

Dr. Weber reviewed a September 13, 2011 note of "Right hip pain secondary no injury or fall; sudden hip pain." *Id.*; RX4. Dr. Weber further highlighted Petitioner's report that "'[a] month ago right after his vacation he had a problem with his back.' He reports he was seen in the emergency room and diagnosed with a sciatic nerve problem. Was treated with medications. He states that he returned from vacation and worked on 9/09/2011. He did okay. The next day, 9/10, he was hurting too much to work.'" *Id.*

Dr. Weber took a history from Petitioner. RX3. He reported "that the date of injury was on July 24, 2011 (that date was clarified twice during the exam). He reports that he was working in his normal capacity. He was standing and turning to look over his right shoulder, and felt a small tug in his lower back and thought nothing of it." *Id.* She noted that she "did re-clarify the timing of his injury. [and that Petitioner] reported to me that he went on vacation prior to the onset of pain. at the end of his vacation, he noted initial pain in the lower back, but not when he was at work. When he first felt it was when he went from a seated position to a standing position. He reports that he had minimal pain then, but it got worse at work when he turned to look over his left shoulder. He felt right lower back pain. He had increasing severity of pain over the course of the next 2-3 weeks. He then went to the emergency room." *Id.*

After reviewing other treating medical records and examining Petitioner, Dr. Weber rendered various opinions. *Id.* Dr. Weber diagnosed Petitioner with L5–S1 degenerative disc disease with L5-S1 lumbar radiculopathy. *Id.* In opining that Petitioner's low back condition was not causally related to the alleged injury at work, Dr. Weber

noted that she spoke to Petitioner in detail about the onset of his symptoms and that his report to her of an onset on July 24, 2011 differed from various reported onsets in the medical records that she reviewed. *Id.* She concluded that, based on the inconsistencies of date of onset, changing mechanisms of injury, and lack of consistent documentation, his low back condition was not causally related to his work. *Id.*

Respondent called Dr. Weber as a witness and she provided testimony at an evidence deposition on October 23, 2013. RX2. Dr. Weber is a board certified physician specializing in sports medicine. RX2 at 4-5. Dr. Weber testified about Petitioner's lumbar spine condition, medical treatment, and she rendered various opinions consistent with those contained in her report. *See generally* RX2.

Dr. Weber testified that the care and treatment that was rendered to Petitioner was reasonable and necessary to treat his condition, but that the treatment was not related to an injury at work. RX2 at 22-23, 28-29, 36-37. She based this conclusion on the inconsistently reported onset of symptoms, varied dates of onset, and different mechanisms of injury reported. *Id.*

On cross examination, Dr. Weber conceded that if the reported mechanism of injury of looking over the shoulder involved flexion/extension with rotation or a twist it could cause a disc herniation. RX2 at 29. She also acknowledged that degenerative disc disease could be asymptomatic and aggravated by heavy lifting or twisting while carrying heavy items, which is the type of lifting described to Drs. Gerber and Kiang. RX2 at 35.

Additional Information

Regarding his current condition, Petitioner testified that when he sits down for 10-15 minutes or more he becomes stiff. Once he starts moving around he gets better and does not really experience pain then, but he does have some numbness in the upper thigh and in the bottom of his foot. Petitioner testified that he did not have these symptoms before July of 2011. Petitioner does not take any other medication, he has not seen any doctors in the last six months or so, and he suffered no other accident. With regard to the medical bills, Petitioner testified that he is not sure if the bills have been paid or remain unpaid.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

In support of the Arbitrator's decision relating to Issues (C) and (D), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent and the date of the accident, the Arbitrator finds the following:

An employee's injury is compensable under the Act only if it arises out of and in the course of the employment. 820 ILCS 305/2 (LEXIS 2003). The "in the course of employment" element refers to "[i]njuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work...." *Metropolitan Water Reclamation District of Greater Chicago v. IWCC*, 407 Ill. App. 3d 1010, 1013-14 (1st Dist. 2011). The "'arising out of' component refers to the origin or cause of the claimant's injury and requires that the risk be connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Metropolitan Water Reclamation District*, 407 Ill. App. 3d at 1013-14 (*citing Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58 (1989)). A claimant must prove both elements were present (i.e., that an injury arose out of and occurred in the course of his employment) to establish that his injury is compensable. *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 910 (1st Dist. 2006).

In repetitive-injury cases, the facts must be closely examined to ensure a fair result for both the faithful employee and the employer. *Durand v. Industrial Comm'n*, 224 Ill. 2d 53, 71 (2006). Compensation is allowable where an injury is not sudden, but gradual so long as it is linked to the claimant's work. *Durand*, 224 Ill. 2d at 66. The Court went on to highlight its *Peoria County* decision stating that "[t]o deny an employee benefits for a work-related injury that is not the result of a sudden mishap *** penalizes an employee who faithfully performs job duties despite bodily discomfort and damage." *Durand*, 224 Ill. 2d at 66 (*citing Peoria County Belwood Nursing Home v. Industrial Comm'n*, 115 Ill. 2d 524, 529-30 (1987)). "Recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor." *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 204-206 (2003) (*citing Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d 30, 36-37 (1982)).

In this case, Petitioner asserts that he sustained a repetitive trauma injury as a result of his work activities. However, the medical records contradict Petitioner's testimony about the onset of his symptoms and the mechanism of injury in significant ways. At trial, Petitioner maintained that he did not relate his physical symptoms to his work activities until speaking with a physical therapist in September. He also maintained that he experienced pain that was relatively tolerable until September 9, 2011, his last day at work. However, Petitioner's testimony at trial about his onset of pain is contradicted by the emergency room records, the physical therapy records, as well as Dr. Gerber and Dr. Kiang's records. The medical records also contradict Petitioner's testimony at trial about an onset of symptoms due to repetitive activities.

An employee claiming that he suffered a repetitive-trauma injury must still point to a date within the statutory limitations period on which both the injury and its causal link to his work became plainly apparent to a reasonable employee. *Durand*, 224 Ill. 2d at 65 (*citing Williams v. Industrial Comm'n*, 244 Ill. App. 3d 204, 209 (1st Dist. 1993)); *see also Peoria County*, 115 Ill. 2d at 531. "[B]ecause repetitive-trauma injuries are progressive, the employee's medical treatment, as well as the severity of the injury and particularly how it

affects the employee's performance, are relevant in determining objectively when a reasonable person would have plainly recognized the injury and its relation to work." *Id.*, (*citing Oscar Mayer v. Industrial Comm'n*, 176 Ill. App. 3d 607, 610 (4th Dist. 1988)).

Petitioner testified at trial that his pain was insufficient to cause him to leave work until September, but the quality of his pain and the mechanism of injury at onset as described by him at trial are contradicted by the medical records. Dr. Gerber and Dr. Kiang's medical records are the first to note any repetitive activity at work in relation to Petitioner's low back condition, and they both note his report of symptom onset in July or on July 15, 2011.

It is difficult to conclude that a reasonable person would have failed to correlate the sudden onset of severe pain as documented in Dr. Gerber and Dr. Kiang's records for months after reportedly engaging in repetitive heavy lifting at work. Petitioner had been performing his job duties for Respondent since 2007 and he sought medical treatment on two occasions in August and September at the emergency room reporting acute onsets of pain, or "on-and-off" pain, with no known trauma reported. The medical records of his own physician, Dr. Sharma, were not submitted into evidence.

If Petitioner's testimony at trial is to be believed, both he and a "reasonable person" would have plainly recognized in July that his work activities were contributing to his symptoms. The law requires an analysis of the facts to objectively determine when a reasonable person would have plainly recognized the injury and its relation to work. *See Durand*, 224 Ill. 2d at 65.

The Arbitrator finds it implausible in consideration of all the evidence that Petitioner experienced a progressively severe onset of pain due to repetitive work activities since July of 2011, as he testified at trial, while documentary evidence reflects that he was simultaneously reporting acute onsets of pain which were attributed by him to nothing in particular for months. Petitioner's inconsistent reports as reflected in these records undermine his assertion at trial that he was simply unaware of any relation between his work and low back condition until September. Moreover, the only medical opinion given regarding the mechanism of injury is offered by Respondent's Section 12 examiner, Dr. Weber. She highlights Petitioner's inconsistent histories in her report and deposition testimony, and explains the implausibility of Petitioner's allegations from a medical perspective. Given the totality of the evidence, the Arbitrator finds her opinions to be persuasive.

Based on all of the foregoing, the Arbitrator finds that Petitioner did not sustain a compensable accident that arose out of and in the course of his employment with Respondent as claimed. Thus, all remaining issues[2] are rendered moot and all requested benefits and compensation are denied.

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[2] Petitioner asserts that it was not until after speaking with a physical therapist at some point in September that he related his injury to Respondent. The physical therapist did not testify at trial and no other evidence was submitted corroborating Petitioner's testimony to this end. Assuming that Petitioner sustained a compensable injury on or about July 15, 2011, he failed to give notice to Respondent until he allegedly did so on September 24, 2011 which is more than 45 days thereafter. *See* 820 ILCS 305/6(c) (West 2000). Employees who claim to have suffered repetitive trauma injuries are not exempt from meeting the statutory notice requirement. *White v. Workers' Compensation Comm'n*, 374 Ill.App.3d 907, 910-911, 873 N.E.2d 388 (4th Ill. App. Dist., 2007) (*citing Three "D" Discount Store v. Industrial Comm'n*, 198 Ill.App.3d 43, 144 Ill. Dec. 794 (1989)). By his own testimony, Petitioner explained that he failed to give proper notice to Respondent. This issue is moot, however, as Petitioner failed to establish that he sustained an injury as a result of his repetitive activities at work as claimed on any date.

STATE OF ILLINOIS	)	☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF COOK	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Darnell Todd,

Petitioner,

vs. NO: 13WC 38350

Rush University Medical Center,

16IWCC0226

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, prospective medical care, temporary total disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 12, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 8 2016
o032316
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

[illegible]

[illegible]

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

TODD, DARNELL
Employee/Petitioner

Case# **13WC038350**

RUSH UNIVERSITY MEDICAL CENTER
Employer/Respondent

16IWCC0226

On 5/12/2015, 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 0.08% 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:

2675 COVEN LAW GROUP
LARRY COVEN
180 N LASALLE ST SUITE 3650
CHICAGO, IL 60601

2965 KEEFE CAMPBELL BIERY & ASSOC
MATTHEW IGNOFFO
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

16IWCC0226

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Darnell Todd
Employee/Petitioner

v.

Rush University Medical Center
Employer/Respondent

Case # 13 WC 38350

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 **Stephen Friedman**, Arbitrator of the Commission, in the city of **Chicago**, on **March 11, 2015**. 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. [x] 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. [x] 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. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

16IWCC0226

FINDINGS

On the date of accident, **November 17, 2013**, 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 **$51, 543.40**; the average weekly wage was **$991.20**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$13,714.15** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$5,947.20** for other benefits, for a total credit of **$19,661.35**.

Respondent is entitled to a credit of **$0.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $660.80 per week for 23 3/7 weeks from November 18, 2013 through April 30, 2014.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $113.00 to Dr. Fisher as provided in Sections 8(a) and 8.2 of the Act.

Because Petitioner failed prove that his current condition of ill-being is causally connected to this injury, Claim for any additional temporary compensation, medical and prospective medical beyond that awarded herein is denied.

Petitioner's Petition for Penalties and Fees is denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

Signature of Arbitrator

May 12, 2015
Date

ICArbDec19(b)

MAY 1 2 2015

Statement of Facts

16IWCC0226

Petitioner Darnell Todd testified that he was employed by Respondent Rush University Medical Center as a food service supervisor. He had been employed in food service for 8 years. His job entailed providing patient meal service. He described the job's physical demand as medium. For the three month period before November 17, 2013 he had been doing exercising with a trainer without problem. Petitioner testified that on November 17, 2013, he was carrying a tub of dishes when he slipped and fell onto his butt and lower back. He testified that he notified his supervisor and went to the emergency room.

The records of Rush University Medical Center were admitted as Petitioner's Exhibit A. Petitioner was seen in the Emergency Room within an hour of the injury. The history provided states Petitioner slipped in the kitchen while walking, landing on a hard floor. The point of impact was the buttocks and lower back. X-rays were taken of the lumbar spine. They were read as showing mild degenerative changes, most advanced as L4-L5. Petitioner was discharged with a prescription for tramadol and ibuprofen. The assessment was back tenderness.

Petitioner testified that he had prior issues with his back. He testified that he had a back injury in December, 2007 when he fell down a flight of stairs. He had pain in his right leg, lower back and a little in his left leg. He had surgery and returned to full duty work in May, 2009. Petitioner filed a claim for Workers Compensation as a result of this accident, claim 08 WC 01675. The settlement was approved on November 3, 2010 for 21.2% loss of use of the man as a whole. The settlement contracts confirm 73 4/7 weeks of lost time through May 10, 2009 (Rx 10).

The records of Dr. Fisher were admitted as Respondent's Exhibit 4, containing treatment from January 21, 2008 through December 21, 2009. Petitioner reported the injury on December 10, 2007 when he fell down six stairs. His complaints were of low back pain and left lower extremity radiculopathy (Rx 4, pg 1). The January 8, 2008 MRI revealed degenerative disc disease and a herniated nucleus pulposa at L4-L5 with stenosis and facet arthritis at that level. Petitioner underwent a left sided L4-L5 laminotomy and microdiscectomy in December, 2008. The January 19, 2009 record reveals Petitioner's complaints of bilateral lower extremity pain from the buttocks to the mid calf on the right and the posterior ankle on the left (Rx 4, pg 4). Dr. Fisher sent him for an MRI to evaluate for a recurrent disc herniation at L4-L5. The February 6, 2009 MRI was read as being suspicious for a recurrent disc herniation at L4-L5 and degenerative changes at L3-L4. On March 2, 2009, Dr. Fisher notes the MRI showed either recurrent disc herniation or incomplete decompression with moderate foraminal stenosis. He notes improvement in Petitioner's left leg complaints. On April 27, 2009, Dr. Fisher recommended right L4-L5 transforaminal epidural steroid injections. Petitioner was allowed to return to work with a 50 pound lifting restriction on July 13, 2009 and no repetitive bending. Petitioner underwent three epidural steroid injections per Dr. Fisher's October 19, 2009 note. Petitioner continued with right radicular symptoms and Dr. Fisher recommended a right sided discectomy and foraminotomy. On December 21, 2009 Petitioner reported increased low back pain in addition to his right sided radiculopathy. Dr. Fisher recommended an L4-L5 fusion in addition to the previously recommended right sided discectomy, facetectomy and foraminotomy to be scheduled as soon as there is insurance approval (Rx 4, pg 31-32). Petitioner testified he had no treatment between November, 2010 and September, 2012.

Petitioner testified that he had a motor vehicle accident on September, 2012, injuring his neck and lower back with pain into his right leg. Petitioner testified that this was a head on collision with air bag deployment. He had physical therapy and epidural injections following that accident on January 17, 2013, March 14, 2013 and April

25, 2013 (Rx 4 pg 37-44). The January 17, 2013 record includes the history of the accident with complaints of numbness and tingling towards the back. A further MRI dated November 20, 2012 shows L3-4 diffuse disc bulge, hypertrophy of the facet joint, bilateral narrowing moderate of the right foramen due to disc protrusion, mild to moderate left foraminal stenosis L4-5, prior surgery left laminectomy, recurrent disc bulge, diffuse with granulation around the surgical scar area which is toward the left side and L5-S1 facet joint hypertrophy, mild. The Petitioner described his pain as throbbing with numbness mainly to the right side. The physical examination notes positive straight leg raising on the left, with reduced reflexes and sensation to the left. The assessment was back pain aggravated by the motor vehicle accident and possible recurrent disc bulge with spinal stenosis and radiculopathy (Rx 4, pg 38). The March 14, 2013 note includes history that the pain improved after the first injection but started coming back towards the lower back, lumbar spine and left lower extremity (Rx 4, pg 41).

In the July 18, 2013 office note, Dr. Alzoobi notes petitioner has been maintained on Norco. Pain has started back recently since Petitioner was out of medication. Petitioner was scheduled for a sacroiliac joint injection. Petitioner testified that he last saw Dr. Fisher on September 16, 2013 when he scheduled the last epidural. Petitioner testified that he was released from care by Dr. Fisher at that time. The last epidural was on September 22, 2013 for pain in the right leg, right foot and lower back. He testified he also had minimal pain in the left foot. After the September 22, 2013 epidural, he was doing pretty well, exercising and working. He had very little pain. Petitioner testified that he had worked full duty without lost time or restrictions throughout 2012 and 2013 before his November 17, 2013 accident. Petitioner testified that he had neck surgery in February, 2015. He is pursuing legal action against the other driver as a result of the 2012 motor vehicle accident.

Michael Benison testified for Petitioner. He testified that from August, 2013 through November, 2013 he was paid by Petitioner as a personal trainer. Petitioner would train three days per week for an hour. The sessions were for low weight core and general strength building. Weight lifting was up to 15, 20 pound dumbbells. Petitioner was making steady progress. Petitioner did not make any complaints other than general soreness.

Petitioner testified that, after the November 17, 2013 fall, He experienced intense pain in his left leg going down to his foot. He never experienced pain like that before. The more activity he does, the worse the pain gets. Petitioner testified that he saw Dr. Sundaresan, his primary care physician since 2009. Petitioner saw Dr. Sundaresan on November 19, 2013. He provided a history of a slip and fall with lumbar discomfort. Petitioner had positive straight leg raising on the right with lumbar pain greater on the right than the left. Petitioner was given a Medrol dosepak. Petitioner stated he was waiting for an appointment with his orthopedic spine doctor (Px B). On December 5, 2013, Petitioner complained of lower lumbar pain and pain occasionally radiating into his right buttock and left leg (Px B).

Petitioner saw Dr. Fisher on December 6, 2013. Dr. Fisher's records were admitted as Petitioner's Exhibit C. The December 6, 2013 note states Petitioner returned to follow up on 3rd epidural steroid injection. He states he was feeling good. He reports a slip in the dish room landing on his butt. He stated increasing low back pain over the next 20 minutes and increased pain over the next 3 weeks. He reported with increased activity having numbness and tingling to the left posterior thigh and leg extending to the heel. This was not present at the time of the examination. His back bothers him more than his leg. The physical examination records tenderness of the paraspinal muscles but full range of motion, negative straight leg raising and a normal neurological exam. Petitioner was advised to take ibuprofen, begin physical therapy. The diagnosis was lumbar sprain/strain and L4-5 post laminectomy syndrome. On January 8, 2014, Dr. Fisher recommended an MRI with contrast of the lumbar spine (Px C).

Petitioner was seen by Dr. Zelby on January 3, 2014 for a Section 12 examination. Dr. Zelby testified by deposition taken December 18, 2014 (Rx 1). The report of that visit records a history of slipping and falling backwards, landing on his buttocks (Rx 1, Ex 2). Petitioner did not report a twisting motion or twisting injury (Rx 1, pg 9). Petitioner advised Dr. Zelby of his previous disc surgery and indicated he recovered completely after six to eight weeks. Petitioner stated that he had no other problems or treatment for his back until he fell in November, 2013 (Rx 1, pg 9-10, Ex 2). Dr. Zelby identified no radicular findings on exam. There was no weakness, numbness, sensory change, reflex change, or anything to suggest an abnormality related to a dermatomal or nerve root distribution. Dr. Zelby concurred with the need for an MRI (Rx 1, Ex 2).
On January 11, 2014, Petitioner had an MRI of the lumbar spine. The impression was: post-surgical changes suggestive of left sided hemilaminectomy, medial facetectomy and possibly partial discectomy on the left at L4-5; no evidence of abnormal post contrast enhancement in the left lateral recess; endplate change left lower endplate L4; broad-based posterior disc bulge at this level has decreased in thickness since 2011; moderate bilateral neural foraminal narrowing, worse on the left (Px F, Ex 2).

Dr. Zelby reviewed the January 11, 2014 lumbar MRI films. He noted degenerative disc disease with no evidence for residual or recurrent disk herniation and no persistent stenosis. There was mild stenosis that is an indication of disc degeneration (Rx 1, pg 35). Dr. Zelby indicated it would be reasonable to proceed with one or two epidural steroid injections. Based on the injury, the normal neurologic exam, and findings on MRI, Petitioner was capable of near medium physical work with lifting 30 to 40 pounds occasionally. Maximum medical improvement and regular duty job capability would be reached a few weeks after the injections (Rx 1, pg 13-14, Ex 2).

Petitioner was involved in another motor vehicle accident on March 14, 2014. He was rear ended. Petitioner described the accident as a "tap." He testified that he did not seek medical attention from the accident scene. He was seen at the emergency room and underwent a lumbar spine MRI because of that motor vehicle accident. Petitioner initially obtained an attorney for that incident (Rx 9). Petitioner testified that he dropped the matter.

Petitioner underwent epidural steroid injections on March 20, 2014 and April 10, 2014 (Px D). Petitioner was seen by Dr. Fisher on April 30, 2014 reporting a 30 to 40 pound weight gain. He advanced complaints of numbness in the left thigh and medial leg. Symptoms extend to the toes with straight leg raising with ankle extension. On May 28, 2014, Dr. Fisher notes the third injection has not been approved. Dr. Fisher again recommends authorization for physical therapy and a third injection. He also discussed the possible need for a fusion surgery. Dr. Fisher's June 27, 2014 examination notes continued complaints of low back pain and left lower extremity radiculopathy. The examination notes normal strength with decreased sensation to the left posterior thigh and leg with positive straight leg raising on the left. He has loss of patellar and Achilles reflexes. Dr. Fisher discussed surgery consisting of a revision decompression and L4-5 posterior interbody fusion (Px C). Dr. Fisher saw Petitioner for a follow up on December 17, 2014 with a restatement of his recommendations (Px C).

Petitioner testified he was seen by Dr. Ghanayem at his attorney's request for a second opinion on September 25, 2014. The history provided was a slip and fall with a twisting-type injury to his back on November 17, 2013. Pain was left sided leg pain in the buttock, posterior thigh, and calf down to the foot. Leg pain was more severe than the back pain. Petitioner reported a prior lumbar discectomy in 2008 for a disc herniation for which he did well. He was able to get back to his regular work activities. The physical examination noted a left sided

limp. He had diminished sensation on the left L4-L5 distribution. Dr. Ghanayem's impression was an aggravation of lumbar stenosis from the work incident, but the radiographic findings on the MRI, the structural entity including the stenosis and post-laminectomy changes predated the work injury. The symptoms of those findings were aggravated when he fell. He recommended a lumbar decompressive procedure at L3-4 and L4-5. As Petitioner had no significant back pain or instability patterns on MRI he did not recommend a fusion (Px E, Ex 2). At his deposition, taken October 29, 2014, Dr. Ghanayem notes Petitioner had prior conservative care, physical therapy, an injection or two. He notes short term relief from the injections. He was not aware of Petitioner's medications. He described Petitioner's symptoms prior to the November 17, 2013 accident as manageable. Petitioner's symptoms prior to the accident date were related to the surgery, lumbar stenosis or the motor vehicle accident. Dr. Ghanayem is unaware of any traumatic injuries after November 17, 2013. In the act of slipping, there is a torsional-type of act which is how you aggravate the stenosis (Px E).

On November 4, 2014, Dr. Zelby drafted an addendum report responding to Dr. Ghanayem's opinion. Dr. Zelby's opinion was Petitioner requires no surgical intervention irrespective of cause. Dr. Zelby stated that the stenosis at L3/4 and L4/5 was extremely mild and did not cause neural impingement (Rx 1, pg 20). There is no medical basis to suggest Petitioner cannot return to work. Maximum medical improvement had been reached (Rx 1, Ex 2). If there was neural impingement from preexisting degenerative changes that were aggravated as of November 17, 2013 then surgery would be a consideration (Rx 1, pg 44).

On January 5, 2015, Paramjit "Romi" Chopra, MD, at Petitioner's attorney's request, reviewed the November 28, 2012 and the January 4, 2014 MRI studies and authored a report stating he found impingement of the left lumbar nerve root at the L4-L5 level. He notes findings on the January 4, 2014 MRI of post operative changes, disc herniation to the left of midline with mass effect on the thecal sac and left nerve root, and degenerative changes. The combination of the disc herniation and the post-operative scar has led to the form of moderate to severe left foraminal stenosis. He opined that although there are some prior post-operative changes, it is clear that there is lumbar nerve root impingement and the fall would have aggravated the impingement. He recommended therapy, injections, and if conservative treatment failed, a surgery for decompression (Px F, Ex 5). He did not feel a fusion would do anything (Px F, pg 31). At his January 20, 2015 deposition, Dr. Chopra testified that the radiologist statement that the disc bulge has decreased means the disc is getting worse. It's drying up (Px F, pg 18). He did not examine Petitioner. His opinion is based upon the MRI and the subjective complaints (Px E, pg 38).He has no information on the mechanism of injury. He has not information on the specifics of the 2008 surgery or Petitioner's complaints of pain during 2013.

On January 16, 2015, Dr. Zelby drafted an addendum report (Rx 2). Dr. Zelby indicates Dr. Chopra's indication of neural impingement on the left at L4-5 is not accurate as the images show no compression on the exiting L4 nerve root, although there is some inferior foraminal stenosis. Dr. Zelby indicates there are degenerative changes, post-operative changes with mild scar tissue, and clearly no evidence for residual or recurrent disc herniation or persistent stenosis.

On February 19, 2015, Dr. Frank Phillips authored a record review report at Respondent's request (Rx 3). He had previously examined Petitioner. Dr. Phillips provided a summary of medical records from January 21, 2008 through January 16, 2015. Dr. Phillips noted Petitioner had residual low back symptoms which predated the November 2013 incident. His review of the January 2014 MRI images indicate no acute structural injury to the lumbar spine occurred in the alleged work incident. The findings on the January 2014 MRI reflect chronic degenerative changes and prior surgery and there are not acute findings to suggest any structural change that

was incurred after the work injury. Maximum medical improvement had been reached. Petitioner did not appear to be a surgical candidate as it relates to the injury in questions.

Respondent offered video of Petitioner taken in November and December, 2013 and October, 2014. The video shows Petitioner walking and driving. He was shopping and carrying some plastic grocery bags. Petitioner agreed he was not limping in the November 29, 2013 video but testified he was dragging his leg on December 11, 2013.

Petitioner testified that he last saw Dr. Fisher a couple of weeks before trial. He remains off work at the order of Dr. Fisher, Dr. Ghanayem and Dr. Sundaresan. He wants to undergo the fusion surgery recommended by Dr. Fisher.

Conclusions of Law

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

Petitioner bears the burden of proving by a preponderance of the evidence, each element of his claim including that his condition of ill being is causally connected to the work related accident sustained. Petitioner sustained an undisputed accident on November 17, 2013 when he slipped and fell. He sought immediate treatment for complaints of pain in the low back and leg.

Petitioner had a significant prior history of injury, complaints and treatment related to his low back. The medical records and prior Workers' Compensation claim confirm a prior fall down stairs causing left sided radiculopathy and resulting in surgery at L4-L5. He had extended follow up care through 2009, when Dr. Fisher recommended additional surgery. Dr. Fisher recommended an L4-L5 fusion in addition to the previously recommended right sided discectomy, facetectomy and foraminotomy to be scheduled as soon as there is insurance approval. The surgery was not performed and Petitioner settled his case. The Commission print out confirms over a year of TTD was paid. This evidence is in sharp contrast to Petitioner's histories as to his prior care and his testimony, which attempts to minimize this prior condition.

Petitioner's testimony and histories similarly underreport the extent of his September, 2012 motor vehicle accident and subsequent treatment. The Petitioner was under active treatment including an injection within weeks of the November 17, 2013 slip and fall. The records, contrary to Petitioner's testimony that he had only right leg pain from 2008 through his work injury, documents left sided neurological findings in January, 2013 and the development of left leg symptoms during March and April, 2014.

The initial medical records following his November 17, 2013 injury also are at odds with his testimony. Petitioner saw Dr. Sundaresan on November 19, 2013. He provided a history of a slip and fall with lumbar discomfort. Petitioner had positive straight leg raising on the right with lumbar pain greater on the right than the left. The December 6, 2013 note from Dr. Fisher states Petitioner returned to follow up on 3rd epidural steroid injection. He states he was feeling good. He reports a slip in the dish room landing on his butt. He stated increasing low back pain over the next 20 minutes and increased pain over the next 3 weeks. He reported with increased activity having numbness and tingling to the left posterior thigh and leg extending to the heel. This was not present at the time of the examination. His back bothers him more than his leg. The physical examination records tenderness of the paraspinal muscles but full range of motion, negative straight

leg raising and a normal neurological exam. Petitioner was advised to take ibuprofen, begin physical therapy. The diagnosis was lumbar sprain/strain and L4-5 post laminectomy syndrome.

Having viewed Petitioner's testimony, the Arbitrator found him contradicted by the records of his treating physicians, and noted his inconsistencies on cross examination. Petitioner, on multiple occasions, attempted to divert a direct response including repeatedly answering questions about whether he was having symptoms by responding that he was able to do his job and prevaricating on his legal representation for the March, 2014 motor vehicle accident. The Arbitrator finds that the Petitioner's testimony lacked credibility with respect to his prior medical treatment, other accidents and the symptoms he was experiencing.

The Arbitrator also finds the testimony offered by Michael Benison unpersuasive. The Arbitrator notes that Mr. Benison does not have any credentials to assess Petitioner's physical condition. More importantly, Mr. Benison's assessment that Petitioner was not advancing complaints must be evaluated in the context that Petitioner was still receiving injections for his back, had an ongoing prescription for Norco, and had a neck condition sufficiently serious to result in surgery within the next few months. This is further coupled with the video surveillance that, while not showing Petitioner doing anything unusually strenuous, does demonstrate that he can handle daily chores without noticeably demonstrated disability both shortly after his injury and more recently. During the viewing of the video, Petitioner testified that he was not limping, because he must be on his medication.

The medical opinions offered on the issue of causation must be evaluated in conjunction with the Petitioner's testimony and histories on his prior medical condition and subsequent motor vehicle accident. The opinions must also be evaluated against the inconsistencies between the experts' testimony.

Petitioner offered the reports and depositions of Dr. Ghanayem and Dr, Chopra. Respondent offered the multiple reports and deposition of Dr. Zelby and the report of Dr. Phillips. An expert's opinion is only as valid as the basis of the opinion. A medical opinion based upon incomplete or erroneous history is not persuasive. The reports and testimony of both Dr. Chopra and Dr. Ghanayem are based on an understanding that Petitioner's preexisting back problems were not serious before the November 17, 2013 fall. Neither doctor demonstrates a command of Petitioner's treatment and the timeline of complaints or injections shortly before the accident as demonstrated by the treating medical records. Both equate Petitioner's ability to work as a sufficient basis to presume a permanent change caused by the work accident. Neither Dr. Ghanayem nor Dr. Chopra detailed either in their reports or deposition testimony that they had reviewed and were aware of the full records of Dr. Fisher, most importantly the complaints in the left leg in March and April, 2014 and the additional complaints with additional injections and the prescription of narcotic medication in July and September, 2014. Dr. Ghanayem aiso records, for the first time, a history of twisting, a key element in his causation opinion. Neither Dr. Chopra nor Dr. Ghanayem has accurate information with respect to the subsequent 2014 motor vehicle accident or the April, 2014 MRI study.

There are also inconsistencies within the opinions which Petitioner seeks to have adopted. Dr. Fisher is recommended a fusion surgery at L4-L5, a procedure rejected by both Dr. Chopra and Dr. Ghanayem. Dr. Chopra's key opinion is the progression of the MRI findings between the November, 2013 MRI and the January, 2014 MRI, but Dr. Ghanayem testified that the findings were all preexisting and degenerative, and based his opinion on aggravation of symptoms only. Dr. Chopra's testimony is also contradicted by the MRI reports themselves which do not find a disc herniation in January, 2014.

In light of these elements, the Arbitrator finds the opinions of Dr. Ghanayem and Dr. Chopra unpersuasive. To the contrary, Dr. Zelby and Dr. Phillips have a complete medical history and record to support their opinions. While Dr. Zelby and Dr. Ghanayem disagree on the extent of the stenosis on the MRI studies, Dr. Zelby, Dr. Phillips and Dr. Ghanayem all agree that the findings on the January, 2014 MRI were not related to the November 17, 2013 work accident. The Arbitrator finds Respondent's medical experts, particularly Dr. Phillips more persuasive.

Based upon the record as a whole, including the testimony presented, the medical records, reports and depositions, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that his current condition of ill being in the low back and left leg is causally connected to the accidental injuries sustained on November 17, 2013. As more fully discussed with respect to the Arbitrator's findings with respect to Medical and Temporary Compensation, the Arbitrator finds that all treatment and lost time following April 30, 2014 is not causally connected to the accidental injuries sustained on November 17, 2013.

In support of the Arbitrator's decision with respect to (J) Medical and (K) Prospective Medical, the Arbitrator finds as follows:

Based upon the Arbitrator's decision with respect to Causal Connection, the Arbitrator finds that medical treatment after Dr. Fisher's April 30, 2014 visit in follow up to the April 10, 2014 injection is not causally connected to the accidental injuries sustained on November 17, 2013. Dr. Zelby opined in his January 20, 2014 report that the Petitioner should have one or two epidural injections and should be at maximum medical improvement within a few weeks after the injections. The Arbitrator finds that the follow up visit on April 30, 2014 was reasonable and consistent with the opinions of Dr. Zelby and Dr. Phillips. Respondent Exhibit 5 advises that all charges for services after the April 10 injection have been denied. Petitioner's Exhibit C includes the bill for Dr. Fisher. The bill shows unpaid charges for this April 30, 2014 visit at $113.00.

Based upon the record as a whole and consistent with the Arbitrator's findings with respect to Causal Connection, the Arbitrator finds that Petitioner is entitled to medical expenses of $113.00 pursuant to the fee schedule as provided in Sections 8(a) and 8.2 of the Act. All claims for further medical treatment rendered and prospective medical treatment including additional physical therapy, injections and surgery is denied.

In support of the Arbitrator's decision with respect to (L) Temporary Compensation, the Arbitrator finds as follows:

Respondent paid temporary compensation through the April 10, 2014 second epidural injection. Correspondence was sent to Petitioner advising of denial of further medical care or compensation on April 21, 2014. As more fully addressed in the Arbitrator's findings with respect to Causal Connection and Medical, the Arbitrator finds that Petitioner was undergoing reasonable, necessary and causally connected medical treatment consistent with the opinions of Dr. Zelby and Dr. Phillips through his April 30, 2014 follow up visit with Dr. Fisher.

Based upon the record as a whole and consistent with the Arbitrator's findings with respect to Causal Connection and Medical, the Arbitrator finds that Petitioner is entitled to temporary compensation for the period of November 18, 2013 through April 30, 2014, a period of 23 3/7 weeks.

In support of the Arbitrator's decision with respect to (M) Penalties, the Arbitrator finds as follows:

Petitioner filed a petition seeking penalties under Sections 19(k), 19(l), and 16. Where there is a genuine controversy as to whether Petitioner's condition of ill being is causally connected to the work related accident, it is not unreasonable for Respondent to require Petitioner to prove his case. As more fully discussed with respect to the Arbitrator's decisions with respect to Causal Connection, Medical and Temporary Compensation, Respondent has presented a good faith defense as to whether Petitioner's condition of ill being is causally connected to the accidental injuries sustained on November 17, 2013. In support of the defense raised Respondent submitted evidence of the pre existing condition including the prior work accident, and motor vehicle accidents before and after the November 17, 2013 work injury. Respondent challenged the opinions presented by Petitioner's experts both with cross examination of Petitioner's medical witnesses at deposition and with Respondent's own expert witnesses, Dr. Zelby and Dr. Phillips. In light of the evidence submitted on the issue of Causal Connection and the Arbitrator's decision with respect to Causal Connection, the Petition for Penalties is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lucia Larin,
Petitioner,
vs.

NO: 14WC 7321

Nation Pizza,
Respondent,

16IWCC0224

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, notice, medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 5, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 28 2016
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CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

[illegible]

[illegible]

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

LARIN, LUCIA
Employee/Petitioner

Case# **14WC007321**

NATION PIZZA
Employer/Respondent

16IWCC0224

On 5/5/2015, 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 0.07% 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:

2194 STROM & ASSOC
LINDSEY STROM
180 N LASALLE ST SUITE 2510
CHICAGO, IL 60601

1596 MEACHUM STARCK BOYLE & TRAFMAN
JAMES JANNISCH
225 W WASHINGTON ST SUITE 1400
CHICAGO, IL 60606

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

LUCIA LARIN
Employee/Petitioner

Case #14 WC 7321

v.

NATION PIZZA
Employer/Respondent

16IWCC0224

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 Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on April 15, 2015. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

A. ☐ Was the 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 the petitioner's employment by the respondent?

D. ☒ What was the date of the accident?

E. ☒ Was timely notice of the accident given to the respondent?

F. ☒ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☐ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☐ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☐ What temporary benefits are due: ☐ TPD ☐ Maintenance ☐ TTD?

L. ☐ Should penalties or fees be imposed upon the respondent?

M. ☐ Is the respondent due any credit?

N. ☒ Prospective medical care?

FINDINGS

- On July 29, 2013, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- In the year preceding the injury, the petitioner earned $24,128.00; the average weekly wage was $464.00.
- At the time of injury, the petitioner was 51 years of age, single with no children under 18.
- The parties agreed that there are no unpaid bills for medical services provided to the petitioner.

ORDER:

- The petitioner failed to prove that she sustained a work injury on July 29, 2013, arising out of and in the course of her employment with the respondent.
- The petitioner's claim for compensation is denied and this claim is dismissed.

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.

Robert E. Williams

Signature of Arbitrator

May 5, 2015

Date

MAY 5 - 2015

FINDINGS OF FACTS:

On December 14, 2012, the petitioner sought medical care for back and right shoulder pain at Northwest Community Hospital and on March 11, 2013, she had a right shoulder arthroscopic rotator cuff repair by Dr. Tingle. She was released to work with no use of her right arm on June 11, 2013. The petitioner testified that she used her left arm to clean bathrooms, a lunchroom, a hallway, the Quality Assurance lab and the uniform locker area that required her to wipe counters, sweep and mop. On July 24, 2013, the petitioner reported some left shoulder pain to Dr. Tingle from primarily working with her left shoulder. She had some mild discomfort in the anterior third of her left supraspinatus, a mildly positive Neer impingement sign and a full active range of motion. No lifting/carrying over three pounds and occasional overheard work were given for her right arm and exercises were recommended for her left arm.

July 29, 2013, is the date of injury the petitioner indicated in this claim for a left shoulder injury filed on March 3, 2014. On August 11, 2013, she was allowed to increase her right arm lifting/carrying to 10 pounds. The petitioner reported some increased left shoulder pain on September 11, 2013, and improved strength in her right shoulder. Her right-shoulder lifting was increased to twenty pounds.

On October 9, 2013, Dr. Tingle noted that his evaluation of the petitioner's left shoulder was as a new condition. His findings were some tenderness over her acromioclavicular joint, a mildly positive cross-body adduction test, pain with overhead-type motion and positive Neer and Hawkins impingement signs. He opined that x-rays revealed a type 2 acromion and some mild degenerative changes in her acromioclavicular joint. He gave her a Depro-Medrol injection into her left shoulder for his assessment of

impingement syndrome and exacerbation of some acromioclavicular joint arthritis. An MRI on November 6, 2013, revealed a full-thickness tear of the distal supraspinatus and the subscapularis tendons, small joint effusion and moderate acromioclavicular joint degenerative joint disease with fibrous overgrowth. The petitioner reported on November 26, 2013, that the left shoulder injection did not provide significant relief. Pursuant to Section 12 of the Act, Dr. Verma evaluated the petitioner on December 3, 2013, and opined that she had a full-thickness left rotator cuff tear, which was not caused by the petitioner's primarily below shoulder-level work duties and that she was at maximum medical improvement for her right shoulder. On January 31, 2014, Dr. Tingle stated that it was possible that light-duty work primarily using her left arm exacerbated her pre-existing left shoulder condition. He recommended surgery and gave her a 40-pound lifting restriction and no repetitive overhead lifting.

A valid functional capacity evaluation on August 24, 2014, demonstrated functional capabilities at the light physical demand level. A work status report by Dr. Tingle on February 24, 2015, recommended lifting restrictions for both arms. The petitioner elected to be evaluated by Dr. Wolin on October 21, 2014, who opined that her left shoulder condition was aggravated by the shoulder and above shoulder level activity that included placing a towel rack in bathrooms and replenishing those racks.

FINDING REGARDING WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that she sustained a work injury on July 29, 2013, arising out of and in the course of her employment with the respondent. The petitioner had a pre-existing degenerative left shoulder. She did not sustain a traumatic injury to her left shoulder and her primary

work duties of mopping floors, sweeping and cleaning toilets and sinks were performed below shoulder level. The opinions of Dr. Wolin are not consistent with the evidence and are disregarded. The petitioner's request for benefits for her left shoulder is denied and her claim is dismissed.

FINDINGS REGARDING WHETHER TIMELY NOTICE WAS GIVEN TO THE RESPONDENT:

The petitioner failed to prove that the respondent received timely notice of her left shoulder injury. The petitioner presented no evidence that she provided notice to the respondent as required by the Illinois Workers' Compensation Act. The petitioner's claim is denied and her claim is dismissed.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that her current condition of ill-being with her left shoulder is causally related to a work injury.

FINDING REGARDING PROSPECTIVE MEDICAL:

The petitioner failed to prove that she is entitled to any prospective medical care.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Alita Jones-Richard,
Petitioner,

vs. No. 97 WC 39437

Chicago Board of Education,
Respondent.

16IWCC0230

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of reinstatement of claim, causal connection, medical expenses, prospective medical care, temporary disability and permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner filed an Application for Adjustment of Claim alleging injuries following a 6/4/97 work accident. On 12/5/13 when Petitioner did not appear for specially set trial, Arbitrator Carlson dismissed her claim for want of prosecution, with prejudice. On 12/17/13 Petitioner filed a timely pro-se motion to reinstate which was heard by Arbitrator Cronin, who reinstated the claim following a hearing in which Petitioner explained that her failure to appear for trial on 12/5/13 was due to her not having a caregiver for her ill mother, who needed Petitioner to administer chemotherapy that day.

The Commission affirms and adopts the reinstatement of this claim on the basis that Arbitrators have sound discretion to do so, and not because Arbitrators are without authority to dismiss claims for want of prosecution with prejudice, as suggested in the 2/27/14 reinstatement order.

This claim was subsequently tried on all issues on 7/3/14 before Arbitrator Cronin. Petitioner, a 40-year old physical education teacher with Associates, Bachelors and Masters degrees and an administrative teaching certificate, testified that on 6/4/97, she was pushed down six stairs by a 3rd grade student, causing her to strike her knees and feet on each stair as she fell. Before this accident, Petitioner had received treatment for heel spurs and plantar fasciitis from Dr. Nanette Gormley as well as a podiatrist in 1992. Petitioner also was treated for prior injuries to her neck, spine and other body parts following a 1996 vehicle collision, and for a fractured right ring finger April 1997.

Following the instant accident, Petitioner treated with Dr. Gormley for general and specific complaints of pain to her left knee, right finger and back. A 6/5/97 x-ray was negative for acute fracture or dislocation of her right 4th digit, left knee, left ankle, and left foot, though it did show small plantar & posterior calcaneal spurs. A year later, follow up x-rays reported no change to her left foot, and documented only a small left-sided and tiny right-sided plantar calcaneal spur.

On 6/10/97, Petitioner began treatment with Dr. Herbert White. On 10/31/97, she began treatment for her knees with Dr. James Hill; he performed arthroscopic surgery on her left knee on 1/27/98 and right knee on 2/23/01. She also treated with podiatrist Dr. Dominic Andriacchi, Dr. Churl-Soo Suk, Dr. Robert Miller, Dr. Ann Ryan and Dr. Michael McDermott. Currently, Petitioner still sees Drs. Hill, White and Andriacchi, but has not returned to work; she testified that no doctors ever released her. Petitioner last underwent physical therapy in 2005.

In 1999 or 2000, Petitioner applied for two administrative positions but never received any offers in response. She also met with vocational rehabilitation counselor, Susan Rosenberg.

Dr. Herbert White, Jr., MD, testified at his 9/30/09 deposition that he never examined Petitioner's heels before 5/27/98 and he did not treat her knees or feet. His 3/25/03 diagnosis of plantar fasciitis was based on other doctors' diagnoses, and his diagnosis of left foot neuroma came from Petitioner. He deferred opinions regarding her knees and feet to her orthopedic doctor. Dr. White released Petitioner to work on 7/6/00 with the only restriction being that she should avoid stress. He then took her off work on 10/30/00 even though her condition and complaints were almost identical to those of 7/6/00. Since 9/7/04, Dr. White periodically examines Petitioner but has not provided her with any treatment or physical therapy.

Orthopedic surgeon James Hill, MD, testified at his 8/20/09 deposition that he first saw Petitioner on 10/27/97 for her left knee and that the totality of his treatment was to her knees only. He reviewed no diagnostic tests of her feet. Petitioner's left knee problems were causally related to her work accident and he performed a left knee arthroscopy on 1/27/98. Petitioner never complained of right knee pain before her 1/27/98 surgery or for 4 or 5 visits thereafter. Her first right knee complaints were on 8/12/98. He opined at that time that Petitioner's right knee condition could have been aggravated by her gait problems following her left knee surgery because that is what Petitioner told him. His records, however, documented that Petitioner had a normal gait and full ROM on several visits following her left knee surgery. On 11/30/98 he reported Petitioner could return to work with permanent work restrictions of no prolonged standing, walking, kneeling or lifting over 25 lbs. Six months after her 2/23/01 right knee surgery on 9/4/01, Petitioner's gait was normal and her knee ROM was full. Her main problems

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were with her feet, though the plantar fasciotomy surgery she had been scheduled for was not related to her accident.

Podiatrist Dominic Andriacchi testified at his 8/4/09 deposition that before Petitioner's accident she sought and received treatment for her heels with an associate in his office. After Petitioner's accident, she did not seek foot treatment until August 1998. Dr. Andriacchi himself did not examine Petitioner at any time before 1999, contrary to his 12/8/11 letter stating she had been under his care since 1997. His opinion that her heel pain was from possible trauma to her heels – hitting, bruising and hurting them during her fall – was based on Petitioner's statement, not from his exam or diagnostic testing. Dr. Andriacchi agreed that if Petitioner's history to him was incorrect, that could affect his conclusions.

Dr. Andriacchi believed Petitioner's right foot pain on 7/21/99 was related to her accident, though she hadn't reported injuring her right foot in that fall. On 1/27/00, he found Petitioner able to work light duty while seated. In 2004, he performed a left endoscopic plantar fascia release. On 2/29/06 Petitioner developed a left forefoot neuroma.

Vocational reports from Rehabilitation Works dated 11/25/98 and 11/4/99 documented that Petitioner's multiple academic degrees and Type 75 certificate qualified her for administrative positions such as principal and assistant principal. Vocational specialist Susan Rosenberg scheduled and notified Petitioner of an interview for a sedentary position as a Special Services Coordinator with IIT, administering tests to students, on 11/10/99. However, Petitioner cancelled that interview, explaining why she couldn't do that job. Ms. Rosenberg questioned Petitioner's motivation to return to any type of work.

Petitioner's 9/3/98 functional capacity evaluation documented high subjective complaints of pain with all activities as well as symptom magnification behavior. There were validity issues with the FCE report; it stated Petitioner's current physical demand level was unknown because the FCE did not reflect her maximum physical performance.

On 6/8/98, orthopedic doctor, Mitchell Krieger, MD, performed a Section 12 exam of Petitioner's knees; he documented many normal findings. Dr. Krieger diagnosed bilateral chondromalacia of patella and recommended a spine exam and right knee MRI.

Orthopedic doctor, Edward Goldberg, MD, performed a Section 12 examination of Petitioner's spine on 7/13/98 and opined Petitioner would be at MMI for her spine after a month of physical therapy, and could then return to her prior job from a lumbar spine point of view.

For Respondent, orthopedic surgeon Ira Kornblatt, MD, testified at his 3/24/10 deposition that he examined Petitioner on 11/25/2009 and took x-rays which revealed minor changes to her knees, a small left calcaneus spur and a normal right foot. He reported Petitioner walked with a normal gait. He reviewed Petitioner's 9/3/98 FCE, noting its significant inconsistencies between subjective complaints and objective findings, which he believed made that evaluation invalid. He thought it likely that Petitioner has behaved like that for many years. Dr. Kornblatt opined: Petitioner had no significant objective findings; her ongoing foot complaints were not related to her injury; there was no evidence of significant disability to her knees, and her subjective complaints were far in excess of the findings on x-rays and physical examination. Dr. Kornblatt

further opined that Petitioner needed no additional medical treatment for her feet as a result of her work injury, and was capable of carrying out her normal job activities as a gym teacher.

Dr. Kornblatt testified Petitioner's 1/27/98 left knee surgery was related to her accident but her 2/23/01 right knee surgery was not. Her right knee surgery was likely required for a degenerative process and the right knee was not compromised by the left knee injury. Her right knee findings were very minimal and her patellar chondromalacia and plica were basically normal findings in persons of Petitioner's age. If her right knee was aggravated by her accident, it would at most be a temporary aggravation that likely resolved in 3 or 4 months. Petitioner had no direct injury to her feet on 6/4/97. Dr. Kornblatt found no objective evidence of a left foot neuroma, and he "absolutely" disagreed that Petitioner was disabled and unable to return to work. Finally, Dr. Kornblatt opined that Petitioner's plantar fasciitis and spurs were pre-existing; she was MMI, and she had no significant permanent partial impairment.

The Commission finds that Petitioner proved the condition of her left knee is related to her accident, but that she failed to prove her current conditions of her right knee, feet, and back are causally related. In so holding, the Commission finds more credible the opinions of Respondent's Section 12 doctors than those of Petitioner's treating physicians, who based their opinions on incomplete, inaccurate or unsubstantiated histories provided them by Petitioner.

Petitioner's testimony, statements to her doctors and motivation to return to work are questionable. At trial, Petitioner denied that any of her doctors ever released her to work, yet at various times, Drs. Andriacchi, Hill and White each had released her with restrictions. On 8/27/98, Petitioner sought a letter from Dr. Andriacchi's office stating that her heel pain was due to her work accident; the treating podiatrist had to tell her attorney that her heel pain was pre-existing. According to Dr. Krieger, Petitioner magnified her alleged accident symptoms as early as 6/8/98; he documented her significant subjective complaints and minimal objective findings. Petitioner's 9/3/98 FCE also noted considerable validity issues making it unreliable. Dr. Kornblatt reported, following his 11/25/2009 exam, that Petitioner's subjective complaints were far in excess of her x-ray and exam findings. Petitioner implicitly acknowledged her ability to work by seeking administrative jobs with the Board of Education, but then refused to attend a an interview for a sedentary job set up by a vocational rehabilitation counselor, who reported her motivation to return to any type of work was questionable. Prior to arbitration, Petitioner was working as a caregiver for her ill mother, showing her ability to perform gainful employment.

In finding the Petitioner's foot problems unrelated, the Commission notes they were pre-existing; that Petitioner was wearing orthotics at the time of her accident, and that immediately following, she had few specific foot complaints. Dr. Hill agreed that Petitioner's plantar fasciotomy surgery was unrelated to her accident. In finding Petitioner's right knee condition not causally related, the Commission notes that Petitioner received little treatment to her right knee after her fall, and it adopts Dr. Kornblatt's opinions that Petitioner's right knee findings were very minimal, most likely age related, and that any need for the right knee surgery performed over 3½ years following her accident was related to a degenerative condition.

The Commission finds that Petitioner attained MMI on 11/30/98, when Dr. Hill first released her to work. Consequently, the Commission modifies the Arbitrator's award of temporary total disability benefits to 23-2/7 weeks, for the periods of 7/1/97 through 9/4/97, 7/1/98 through 9/4/98, and 10/31/98 to 11/30/98.

The Commission reverses the Arbitrator's award of prospective medical care. That care was awarded for Petitioner's foot problems, which the Commission finds not causally related to her accident.

For medical services, the Arbitrator awarded Petitioner the following amounts:

1.	The 6/29/08 (sic, should be 6/29/98) right knee MRI bill:	$ 950.00
2.	Physical therapy bill (2/10/98 – 11/30/98):	$4,112.00
3.	Various office visit bills of Dr. White (dates not specified):	$1,152.25
4.	Stroger Hospital bill, 6/1/06:	$2,407.00
5.	Balance of Dr. Andriacchi bill (dates not specified):	$1,910.00

The Commission agrees with the Arbitrator that the physical therapy bill (No. 2, above, in the amount of $4,112.00) was appropriately awarded to Petitioner for treatment related to her accident, and adopts and affirms that $4,112.00 award. The therapy was within 6 months of Petitioner's accident and was reasonable and necessary. The Commission finds the Arbitrator erred in awarding the other bills for medical treatment for the above items numbered 1, 3, 4, and 5. For the reasons stated above, the Commission finds that Petitioner has not proven those to be causally related to her work accident. The Commission therefore reverses the Arbitrator's decision and award as to those bills.

Finally, the Commission finds the Arbitrator erred in converting the decision to a §19(b) award and not awarding permanency. The parties stipulated at arbitration that all issues, including nature and extent, were at issue. As noted, the Commission finds that Petitioner reached MMI for her work injuries on 11/30/98, and therefore it now considers the nature and extent of Petitioner's disability. Taking into consideration her left knee injury and treatment including surgery, as well as all her other relatively minor injuries, bruises, contusions and sprains and strains, the Commission awards Petitioner 20% loss of person as a whole under §8(d)2 of the Act, for all of her injuries combined.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 20, 2015, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of temporary total disability benefits is modified, and that Respondent pay to Petitioner the sum of $695.20/week, commencing July 1, 1997 through September 4, 1997, and from July 1, 1998 through September 4, 1998, and from October 31, 1998 through November 30, 1998, totaling 23-2/7 weeks, those being the periods of temporary total incapacity from work under §8(b) of the Act.

16IWCC0230

IT IS FURTHER ORDERED BY THE COMMISSION that the award of the award of prospective medical care is reversed, and the award of medical expenses Respondent is to pay Petitioner is modified; Respondent shall pay Petitioner only the sum of $4112.00 as reasonable and necessary medical expenses as provided in §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $421.59 per week for a period of 100 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent partial disability to Petitioner to the extent of 20% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid to or on behalf of Petitioner on account of said accidental injury, including but not limited to $396,247.20 in TTD benefits heretofore paid, as reflected by the stipulation of the parties, and $15,148.55 which Respondent paid for Petitioner's foot surgery.

No bond is required for removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 8 2016

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jdl/mcp
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Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JONES-RICHARD, ALITA
Employee/Petitioner

Case# 97WC039437

CHICAGO BOARD OF EDUCATION
Employer/Respondent

16IWCC0230

On 2/13/2015, 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 0.08% 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:

1218 LAW OFFICES OF MARK SCHAFFNER
205 N MICHIGAN AVE
SUITE 2560
CHICAGO, IL 60601

0559 CHICAGO BOARD OF RDUCATION
RACHEL M GARCIA
125 S CLARK ST SUITE 700
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF **COOK**)

☐ 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

ALITA JONES-RICHARD,
Employee/Petitioner

v.

CHICAGO BOARD OF EDUCATION,
Employer/Respondent

Case # **97** WC **39437**

Consolidated cases: **N/A**

16IWCC0230

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 **Brian Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **July 3, 2014 and August 5, 2014**. 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 (1) **Prospective Medical Care**
(2) **Dismissal/Reinstatement of Claim**

FINDINGS

On **June 4, 1997**, 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 $**54,225.60**; the average weekly wage was $**1,042.80**.

On the date of accident, Petitioner was **40** years of age, *married* with **1** dependent child.

Petitioner ***has not*** 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 $**396,247.20** for TTD benefits, $**0** for maintenance benefits, and $**0** for other benefits, for a total credit of $**396,247.20**.

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

ORDER

Temporary total disability benefits

Respondent shall pay Petitioner temporary total disability benefits of $**695.20**/week for **836-3/7** weeks, commencing **7/1/1997** through **9/4/97**, **7/1/1998** through **9/4/1998**, and **10/31/1998** through **7/3/2014**, as provided in Section 8(b) of the Act.

Credit

Respondent shall be given a credit of $**396,247.20** for temporary total disability benefits that have been paid.

Medical Bills

Respondent shall pay reasonable and necessary medical services of $**10,531.25**, as provided in Section 8(a) and subject to Section 8.2 of the Act, as applicable.

Prospective Medical Care

Respondent shall authorize and pay for a surgical consultation for Petitioner's left foot with Dr. Kelikian, followed by a re-evaluation of Petitioner by Dr. Hill.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

Signature of Arbitrator

February 11, 2015
Date

FEB 13 2015

ILLINOIS WORKER'S COMPENSATION COMMISSION

ALITA JONES-RICHARDS,	)	
	)	
Petitioner,	)	
vs.	)	No. 97 WC 39347
	)	
CHICAGO BOARD OF EDUCATION,	)	
	)	**16IWCC0230**
Respondent.	)	

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This matter having come before the Arbitrator for hearing on July 3, 2014 and August 5, 2014, the Arbitrator, having heard the testimony of the parties and considered the exhibits admitted into evidence, makes the following findings in support of his award:

I. Findings of Fact

Petitioner filed an Application for Adjustment of Claim alleging she sustained injuries in the course of her employment with the Chicago Board of Education on June 4, 1997. At the time of the accident, Petitioner was 40 years of age and was employed as a physical education instructor.

Petitioner testified that she holds a Bachelor of Science Degree in physical education and health as well as a Masters Degree in school administration. She has never been employed in the area of school administration, but has worked many years as a physical education instructor. Petitioner's Illinois teaching certificate was received into evidence as Petitioner's Exhibit 38. The certification confirms the Petitioner's certificate was valid for special K-12 teaching, physical education. The subsequent teaching certificate, which was issued in June 1995, indicates it was valid for administrative K-12.

Petitioner testified that her position as physical education instructor requires her to be on her feet the entire day, requires her to demonstrate the various physical education activities to her students and requires lifting and pulling for such items as wrestling mats. Petitioner testified she was able to perform all these duties prior to the accident of June 4, 1997. Immediately prior to that date, she was not under the care of a doctor nor did she have treatment for any knee complaints. Petitioner did testify she had seen a foot doctor prior to the date of her accident, but that her foot condition was in good control for at least a year prior to the accident.

Petitioner testified that on June 4, 1997, as she was descending a flight of stairs in the school where she taught, a student pushed her, which caused her to fall forward and strike the floor after she went down approximately six steps. Petitioner described the steps as being of a hard material. A picture of the stair steps was admitted as Petitioner's

Exhibit 20. As Petitioner lay where she fell, the same student descended the stairs and stomped on her left thigh, which caused her leg "to move."

Petitioner testified that immediately following the assault, she noticed pain in her left thigh as well as pain in her neck, shoulders, arm and generally everywhere. Another employee of the Board of Education assisted Petitioner following the accident.

Petitioner completed an Employee Accident Report in which she identified the parts of the body that she injured: "BOTH ARMS, LEGS, KNEES, + BACK, BOTH ELBOWS, + NECK." She also wrote that she had a bruise on the following body parts: "ARMS, LEGS, BOTH KNEE (sic) + ?". She wrote that she had a sprain of her LEFT ANKLE and scratches to BOTH KNEES. She wrote that she had a fracture of her FINGER RGT, but also indicated that she had a broken finger prior to being pushed. *PX 1*

Following the accident, Petitioner underwent extensive medical treatment, particularly for pain in her ring finger, her left and right knees and her left and right feet. Petitioner was initially seen by her doctors at Advocate Meyer Medical. *PX 4* X-rays were ordered and were taken of her right fourth finger, left knee and left ankle and foot on June 4, 1997. *PX 4*

Petitioner then followed up with Dr. Herbert White on June 10, 1997. Petitioner testified she went to Dr. White because a relative had received treatment from him and had recommended him. Petitioner treated with Dr. White for, among other body parts, her ankles and feet. Petitioner has continued to treat with Dr. White to the present. During his treatment, Dr. White ordered a number of diagnostic studies, which included a September 26, 1997 MRI of the right knee, a June 26, 1998 order for an MRI of the right knee, a June 19, 2006 order for an MRI of the lumbar spine and left knee and a June 30, 2005 order for a MRI of the left foot. The primary treatment rendered by Dr. White has been medication for pain and swelling as well as multiple courses of physical therapy. Such therapy has included, at various times, swim therapy, massage therapy and acupuncture. *PX 6B*

The deposition of Dr. Herbert White was taken on September 30, 2009 and was admitted into evidence as Petitioner's Exhibit 6.

At the request of Respondent and pursuant to Section 12 of the Act, on June 8, 1998, Dr. Mitchell I. Krieger examined Petitioner's knees. Upon examination, the doctor found, *inter alia*, ½ inch atrophy of Petitioner's left calf when compared with her right calf. He diagnosed chondromalacia of the patella bilaterally, ordered an MRI of the right knee. If such MRI were negative, he would declare Petitioner to be at MMI. He would then order an FCE to determine whether she could return to work as a physical education teacher. Dr. Krieger further opined: "There does appear to be a significant amount of subjective complaints with minimal objective findings." *RX 9*

At the request of Respondent and pursuant to Section 12 of the Act, on July 13, 1998, Dr. Edward J. Goldberg examined Petitioner's lumbar spine. Dr. Goldberg did not find any focal neurological change to indicate that the slight atrophy in Petitioner's left calf is from her lumbar spine. Dr. Goldberg opined: "It is possible that she has been

favoring the left lower extremity due to the fact that she did have the arthroscopic surgery and had the injury to that knee." He recommended one month of formal physical therapy for her low back while she receives PT for her left knee. After that, he would find her to be at MMI for her lumbar spine and capable of returning to work as a physical education teacher. In that regard, Dr. Goldberg continued, he would defer to Dr. James Hill, who performed the arthroscopy on Petitioner's left knee. *RX 10*

The records of Meyer Medical reflect that on June 19, 1998, Petitioner complained of heel pain. On July 24, 1998, Petitioner returned to Meyer Medical. Among her subjective complaints, the physician wrote the following:

> "Hx Heel spurs – Using orthotics x 11 YR. C/O heel pain x 4 mos. - Notes Trauma 1/98 to Lt Knees 1 YR ago - Jan 98 had arthroscopy – Notes cartilage damage – Walking differently." *PX 4*

Upon examination, the physician noted bilateral tenderness to the heels, but no edema. The physician assessed Petitioner with heels spurs and ordered x-rays of bilateral heels with copies of the x-rays to be given to Petitioner. He also referred Petitioner to a podiatrist. *PX 4*

On August 12, 1998, Petitioner visited the offices of Dr. Dominic Andriacchi DPM. The Progress Note for this date indicates: "Pt. is picking up X-rays – she says she is taking them to another Dr. who did surgery on her knee." *PX 19, Resp. Dep. Ex. #3* Just above the August 12, 1998 Progress Note is a July 31, 1995 Progress Note that states:

> "Pt has x-rays – Pt had "knot" on left foot for approx. 3 mos. – has disappeared. Primary doctor stated pt. has heel spurs. Sensitivity on heels. Plantar Fasciitis. X-rays show heel spurs. Pt. to have ort's made. RTO PRN." *PX 19, Resp. Dep. Ex. #3*

After Petitioner's visit to the offices of Dr. Andriacchi on August 12, 1998, she returned to him on August 27, 1998. The Progress Note for this date indicates:

> "Pt. here to pick-up letter w/Diagnosis. Letter is for work. Also, here to inquire about Orthotics.
> S/ Pt. wants letter stating that states her heel pain is from accident.
> P/ Spoke c̄ Pt's lawyer – advised him that she had heel pain in '95 before the accident. She's to cont. c̄ current tx. RTC PRN
> *PX 19, Resp. Dep. Ex. #3*

Although Dr. Andriacchi did not personally treat Petitioner until sometime in 1999, he and his colleagues have treated Petitioner for her foot problems from August 1998 to the present. The records reflect that following Petitioner's accident, Dr. Andriacchi provided various forms of treatment, including left ankle bracing, orthotics, biofreeze, cortisone injections on multiple occasions, diagnostic ultrasound examinations and surgery. Following his evaluation of Petitioner, Dr. Andriacchi diagnosed her with aggravation of her bilateral heel spurs, plantar fasciitis and a neuroma. *PX 14, PX 18, PX 19, Resp. Dep. Ex.#1, #3 and #4*

The deposition of Dr. Dominic Andriacchi was taken on August 4, 2009, and was admitted into evidence by this Arbitrator as Petitioner's Exhibit 19.

Dr. White referred Petitioner to Dr. James Hill for treatment of her knee complaints. Dr. Hill performed left knee arthroscopic surgery on Petitioner on January 27, 1998. He found Grade III chondromalacia of the patella and Grade II changes to the lateral tibial plateau. The doctor's treatment did not resolve Petitioner's problems and she remained on work restrictions from Dr. Hill. Dr. Hill then proceeded to perform right knee arthroscopic on Petitioner on February 23, 2001, at which time he found Grade II chondromalacia of the patella. *PX 15, Deposition Exhibits*

The records reflect that on March 12, 2007, Dr. Hill offered to perform a second surgery on Petitioner's left knee, but Petitioner declined additional surgery at that time. *PX 15, Deposition Exhibits*

Petitioner testified that Dr. Hill, on various occasions, recommended she proceed with foot surgery to help her with her knee pain. Such recommendations appear in his records, including April 16, 2004. In addition to the surgical treatment to the knees, Dr. Hill prescribed various periods of physical therapy, home exercise and activity restrictions.

The deposition of Dr. James Hill was taken on August 20, 2009, and was admitted into evidence by this Arbitrator as Petitioner's Exhibit 15. At this deposition, Dr. Hill opined that if Respondent could find a job for Petitioner that is within the restrictions Dr. Hill had imposed on her, she could probably perform such job. *PX 15, pp. 31-32*

Petitioner received physical therapy from Health South from October 6, 1998 through October 14, 1998, but had to transfer to another facility due to an allergy to pool chemicals used at that facility. Petitioner received additional physical therapy at Health South from August 5, 1999 through August 21, 1999 for treatment of her foot pain and received more physical therapy from Health South in Palos Heights in August of 2001 for treatment of her knee pain. *PX 40*

On June 1, 2006, Petitioner presented to the emergency room of John Stroger Hospital with complaints of foot and knee pain. She followed up with injections to the left knee and with an offer of left knee surgery, which Petitioner again declined. *PX 30*

Petitioner testified she continued to complain of pain and has had continuous pain from the date of accident to present. The pain is most notable in her knees and feet. As a result, she uses a cane if she has to walk any significant distance. She also notes that she moves more slowly and is unable to participate in any of the sports she used to do, which previously included running, basketball and racquetball. Petitioner has not returned to work since the date of her accident.

Petitioner testified she has not received any offers of employment within the limitations imposed by her doctors. Petitioner did receive a notice to return, admitted into evidence as Petitioner's Exhibit 37. The notice to return to work was dated September 14, 2009, but erroneously referred to her medical release to return to work from her physician. As her doctors have testified, she was not released to return to work at that

time. Even if she had a release to return to work, Respondent informed her, through the notice, that her prior position had been closed and no other positions were offered to her.

Petitioner looked for work in school administration. Documentation of the Petitioner's attempt to look for administrator positions are reflected, not only in her testimony but in Petitioner's Exhibit 46, which documents an application for a position advertised in the Board of Education personnel bulletin.

The records reflect Petitioner was assigned to vocational rehabilitation with Rehabilitation Works, Inc. Petitioner testified that she only recalls one meeting with the vocational rehabilitation specialist. The reports of Susan J. Rosenberg, the vocational rehabilitation consultant hired by Respondent, were admitted as Petitioner's Exhibit 17. Ms. Rosenberg performed an initial vocational assessment in November 1998, with a recommendation to Respondent to conduct a Labor Market Survey and to work with Petitioner to develop job skills. In January 1999, Ms. Rosenberg completed a Labor Market Survey with a plan to meet with Petitioner to discuss transferable skills and to develop a rehabilitation plan. However, following the development of the Labor Market Survey, the vocational rehabilitation consultant was instructed to put a hold on additional vocational services. *PX 17*

In September of 1999, Respondent restarted vocational services, with two meetings between the vocational specialist and Petitioner. The vocational rehabilitation consultant, Ms. Rosenberg, noted that the jobs identified for Petitioner would pay her in the range of $6.50 to $10.00 per hour. Per the records of Rehabilitation Works, Inc., Petitioner refused to attend a job interview with a prospective employer. Such job was within her restrictions. Respondent then terminated rehabilitation services. *PX 17*

Rehabilitation Works, Inc., reopened the file on April 22, 2000, but then closed it on June 2, 2000 in order to seek clarification of Dr. White's off-work opinion. *PX 17*

On November 25, 2009, at the request of Respondent and pursuant to Section 12 of the Act, Petitioner submitted to an examination by Dr. Ira Kornblatt. Dr. Kornblatt specifically examined Petitioner's knees and feet. Following the examination, Dr. Kornblatt provided the following answers to specific questions:

1. Diagnosis of the patient's current condition is early degenerative arthritis, patellofemoral region, bilateral knees. With respect to her feet, she has complaints of foot pain without evidence of significant objective findings to substantiate her ongoing subjective complaints. With respect to her knees, on exam, there is no evidence of significant disability, and her subjective complaints are far in excess of the findings of the x-ray and on physical exam.

2. With respect to the question regarding whether the diagnosis of her feet is related to the work injury, it is my opinion that there is no relationship at all between her foot symptoms and the injury as described. It is my opinion that she did have documented plantar fascial symptoms and spurs prior to the injury, which she admitted to, and it is my opinion that it is not likely that the injury

as described resulted in any aggravation of her pre-existing foot problem.

3. Is any further treatment required to cure the injuries/conditions caused by the work-related injury? No.

4. Has the employee reached maximum medical improvement from this injury? With respect to permanent partial impairment, I find no evidence of significant permanent partial impairment.

5. Not applicable.

6. Does the employee have any permanent work restrictions? No.

7. Do you believe all the medical treatment to date has been necessary and directly related to the injury? No, I do not. I believe that the claimant likely reached maximum medical improvement approximately 6 months following the surgery of the left knee. It is my opinion that the surgery which was carried out of the right knee was not related to the work injury, and it is my opinion that she likely could have returned to work back in 1998. *RX 11, Dep, Ex. 2*

The deposition of Dr. Ira Kornblatt was taken on March 24, 2010 and was admitted into evidence as Respondent's Exhibit 11.

Petitioner's Exhibit (Group) 16 is a compilation of off-work slips from June 5, 1997 through February 14, 2014.

II. Conclusions of Law

IN SUPPORT OF HIS DECISION WITH REGARD TO ISSUE (F) "IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?", THE ARBITRATOR FINDS:

Petitioner described the June 4, 1997 accidental injury. She described walking down a flight of stairs, with a group of students, at the school where she worked as a physical education instructor. As she was descending the stairs, she was pushed by a student, which caused her to fall forward down half a flight of stairs. As she lay at the bottom of the stairs, the same student that pushed her descended the stairs and stomped on Petitioner's left leg.

Petitioner has had an extensive history of medical treatment, primarily from her occupational medicine physician, Dr. Herbert White; from her orthopedic surgeon, Dr. James Hill; and from her podiatrist, Dr. Dominic Andriacchi. Throughout the records of these doctors, Petitioner consistently relates her pain as starting from the date of her accident and further describes fairly constant and consistent reports of pain in her bilateral knees and bilateral feet. Given the nature of the accident, her complaints of pain are consistent with the description of the accident.

As to Petitioner's bilateral knee complaints, the Arbitrator notes that she was seen by Dr. Herbert White on June 10, 1997, which was within one week of the accident. At that time, she was complaining of pain in her ankles, knees, elbows, shoulder, neck, back, ribs and hand. *PX 6, p. 13.* Dr. White treated Petitioner after the initial visit, made various referrals to specialists and ordered an MRI of the left knee. He reported a working diagnosis as of September 26, 1997 of left knee torn cartilage and right knee pain, among other diagnosis. He therefore referred Petitioner to Dr. James Hill, an orthopedic surgeon. *PX 6, p. 19; PX 15, p. 7.*

Dr. Hill initially examined Petitioner on August 26, 1997, and offered a causal connection opinion between Petitioner's left knee condition and the June 4, 1997 accident. *PX 15, p. 12.* He performed surgery on the left knee and gave a post-operative diagnosis of chondromalacia of the patella and the lateral tibial plateau. The operation did not alter Dr. Hill's opinion that the left knee condition was causally related to the accident. Dr. Hill also treated Petitioner for her complaints of right knee pain. As of August 12, 1998, Dr. Hill diagnosed her with chondromalacia of the right knee. This treating orthopedic surgeon opined that the right knee pain was also causally related to the accident as Petitioner had an altered gait and favored her left knee. *PX 15, p. 16.* Dr. Hill continued to treat Petitioner for bilateral knee pain and ordered an MRI in 2000 that showed patella tendinitis and chondromalacia. *PX 15, p. 19.* The doctor subsequently performed arthroscopic surgery on Petitioner's right knee Petitioner on February 23, 2001. At that time, he excised the medial plica. *PX 15, p. 20.* Dr. Hill testified that since he initially evaluated Petitioner in August 1997, he has seen Petitioner regularly for her ongoing complaints of bilateral knee pain, left greater than right.

Dr. Hill offered no causation opinion with regard to Petitioner's feet.

Dr. Herbert White, who continued to treat Petitioner on a non-surgical basis, causally related Petitioner's complaints of left and right knee pain to the accident of June 4, 1997. *PX 6, pp. 19, 22, 26 and 29.*

To the extent that Respondent's Section 12 physicians have expressed differing opinions, this Arbitrator finds the explanations and foundation for opinions expressed by Dr. Hill to be more persuasive. In addition, the treating doctors have had the benefit of years of treatment and frequent contact with Petitioner to evaluate her condition and form opinions. It is therefore the finding of the Arbitrator that Petitioner's current condition of ill-being related to her right and left knees is causally related to the accident of June 4, 1997.

At trial, Petitioner continued to complain of bilateral foot pain. The record reflects she had complaints of left heel pain prior to her accident of June 4, 1997 and was seen by a podiatrist at Dr. Andriacchi's office on July 31, 1995. At that time she was diagnosed with heel spurs. She was only seen on one occasion. She did not return to Dr. Andriacchi's office for treatment until approximately 1 year after the accident.

Post-accident, Petitioner voiced complaints of foot pain to Dr. White. On May 27, 1998, Dr. White recorded complaints of worsening bilateral heel pain. Dr. White testified that Petitioner sustained an aggravation of her heel spurs. *PX 6, pp. 68-69* Dr. White further opined that Petitioner had an abnormal gait due to knee pain and back pain

that caused an aggravation of her foot pain resulting in plantar fasciitis. *PX 6, pp. 36-37* The Arbitrator accepts these opinions given the minimal treatment Petitioner received for heel pain in 1995 and the nearly two-year period prior to the accident during which she did not seek medical attention for heel or foot pain.

Petitioner returned to see Dr. Andriacchi, a podiatrist, who noted ongoing complaints of heel pain from August 1998, when his office first saw her, to the date he testified by deposition. He treated her with multiple injections, medications, orthotics and a heel brace. Dr. Andriacchi opined that this condition is causally related to the accident. *PX 19, pp. 22, 27-28*

In March 1999, Dr. Andriacchi further found the onset of plantar fasciitis, which he noted was secondary to heel trauma. *PX 19, pp. 25-6.* On September 24, 2004 Dr. Andriacchi performed surgery for treatment of the left foot plantar fasciitis. The left foot pain continued, even after surgery, and resulted in an additional diagnosis of a neuroma, which he measured to be approximately 1 cm.

Dr. Andriacchi concluded that the left and right foot conditions, for which he treated Petitioner, were causally related to the accident, and continue to be causally related as of the date he testified. *PX 19, p. 46.*

In 2009 and 2010, Dr. Kornblatt opined that neither the condition of Petitioner's right knee nor her feet are causally related to the accident of June 4, 1997. Moreover, Dr. Kornblatt opined that Petitioner was capable of returning to her job of physical education teacher.

The Arbitrator recognizes that payment of TTD benefits is no admission of liability. Yet, after Respondent had paid nearly 12-1/2 years of TTD benefits, Dr. Kornblatt examined Petitioner on one occasion, did not review all of Petitioner's treating records and rendered a 2-1/2-page report.

The Arbitrator finds the opinions of the treating physicians, in particular, Dr. Hill, to be more persuasive than those of Dr. Kornblatt. Dr. Hill is a Professor of Orthopedic Surgery at Northwestern University Feinberg School of Medicine and has a 13-1/2 page curriculum vitae. Dr. Hill performed surgery on each of Petitioner's knees.

As the Arbitrator finds Dr. Kornblatt's opinions unpersuasive with regard to Petitioner's right knee and her ability to return to her job of physical education instructor, he gives little weight to his causation opinions with regard to Petitioner's feet.

The Arbitrator puts great weight on the opinions of Dr. Hill.

Given the mechanism of injury, Petitioner's altered gait, the consistency of her complaints and the opinions of Doctors Andriacchi and White, the Arbitrator finds Petitioner's current condition of ill-being of her feet to be causally related to the accident of June 4, 1997.

IN SUPPORT OF HIS DECISION WITH REGARD TO ISSUE (J) "WERE THE MEDICAL SERVICES PROVIDED TO THE PETITIONER REASONABLE AND NECESSARY? HAS THE RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICE?", THE ARBITRATOR FINDS:

The Arbitrator has found Petitioner's bilateral knee complaints and bilateral foot complaints causally related to the accident of June 4, 1997. She received diagnostic and therapeutic services for her bilateral knee condition at St. James Hospital and Health Center, underwent an MRI on June 29, 2008, participated in physical therapy and visited Dr. White. These services fall within reasonably and necessarily prescribed services as follows:

1. June 29, 2008 MRI billed in the amount of $ 950.00;
2. February 10, 1998 through November 30, 1998 physical therapy billed in the amount of $4,112.00;
3. Various office visits with Dr. White billed in the amounts of $24.00, $262.50, $131.25, $370.50 and two visits of $182.00.

Petitioner presented to the emergency room of John Stroger Hospital on June 1, 2006 with complaints of foot and knee pain. She received an injection to her left knee from the hospital. This complaint and treatment is consistent with her complaints to Dr. James Hill and are reasonable and necessary in the billed amount of $2,407.00.

In addition to the treatment for her knee injury, Petitioner saw Dr. Dominic Andriacchi for care of her bilateral foot pain, which the Arbitrator has found to be causally related to her accident of June 4, 1997. The Arbitrator finds the unpaid balance of $1,910.00 was for reasonable and necessary treatment.

The Arbitrator orders the above medical bills to be paid, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Finally, while Respondent paid for the surgery to Petitioner's foot, they claim a credit for their payments, which is addressed below. The Arbitrator finds the surgery, as described by Dr. Andriacchi in his deposition, to be reasonable, necessary and related treatment.

IN SUPPORT OF HIS DECISION WITH REGARD TO ISSUE (K) "WHAT TEMPORARY BENEFITS ARE IN DISPUTE? (TTD)", THE ARBITRATOR FINDS:

Petitioner testified she was off work following the accident of June 4, 1997 through the date she testified. She testified that Respondent employed her as a physical education instructor. She found this to be a physically demanding job. Petitioner testified that she is required to demonstrate physical education activities to her students, which include basketball, volleyball, running and other physically demanding activities. In addition, she is responsible for setting up the facilities for the students, which would include pulling and placing wrestling mats.

All three of Petitioner's treating physicians following this accident, Drs. Hill, White and Andriacchi, testified she could not return to work as a physical education instructor. The Arbitrator finds this is significant as the opinion of inability to perform work as a physical education instructor comes from three, independent doctors.

Dr. James Hill, the orthopedic surgeon, testified that he took Petitioner to surgery on January 27, 1998 for her left knee. As of March 28, 1998, he kept her off work to help build her leg muscle. *PX 15, p. 15.* He continued Petitioner's treatment and testified that as of December 10, 1998, he still had not released her to work duties. *PX 15, p. 18.* Dr. Hill continued his treatment plan, including home exercise program and a second surgery, this time to the right knee, on February 23, 2001. The doctor testified that as of March 21, 2007, he continued her off work as a physical education instructor and imposed permanent restrictions of no prolonged standing, walking, kneeling, squatting, bending and no lifting over 25 pounds. *PX 15, p. 23.* The doctor reiterated these permanent restrictions as of November 3, 2008. *PX 15, p. 24.* Given the physical nature of Petitioner's job, these restrictions rule out her ability to perform her occupational duties from the date of her accident until the date this case was tried.

Dr. White, who followed Petitioner on a non-surgical basis, also limited Petitioner from returning to her occupational duties. When Dr. White saw Petitioner in June 1997, he certified her off work. *PX 6, p. 16.* He continued her off work through June 26, 1998. *PX 6, p. 26.* He further confirmed he held Petitioner off work continuously from June 10, 1997 through February 23, 2001. *PX 6, p. 33.* The doctor testified the off work status continued through July 2009, with the exception of one unsuccessful attempt to return to work. *PX 6, pp. 38-39.* On the date of his deposition, Dr. White concluded Petitioner continued to be unable to return to work as a physical education instructor. *PX 6, p. 41.*

Dr. Dominic Andriacchi also opined Petitioner could not work as a physical education instructor. His medical records reflect ongoing off-work certifications confirmed by his testimony. His treatment recommendations include the use of orthotics, rest, elevation of the feet and the use of compression stocking. *PX 19, p. 44.*

Since Dr. Hill, Dr. White and Dr. Andriacchi testified to their opinions in 2009, each of them has issued numerous "off work" slips. There are no "light-duty" work releases in this exhibit. *PX (Group)16*

Based on the complaints of pain in both her knees and feet, and on these off-work slips, the Arbitrator finds that has been temporarily, totally disabled from the date of her accident to the present.

The parties stipulated to payments received for full salary and TTD benefits. Based on contractual obligations, Respondent paid Petitioner her full salary for the periods of June 5, 1997 through June 30, 1997; September 5, 1997 through June 30, 1998; and September 5, 1998 through October 30, 1998. Petitioner was disabled and did not work during this period, but was entitled to full salary pursuant to the collective bargaining agreement. Petitioner is entitled to payment of TTD benefits from July 1, 1997 through September 4, 1997; from July 1, 1998 through September 4, 1998; and October 31, 1998 through July 3, 2014, the date Petitioner testified, representing a period

of 836-3/7 weeks. Respondent is entitled to a credit for TTD benefits they have paid in the amount of $396,247.20.

IN SUPPORT OF HIS DECISIONS WTH REGARD TO ISSUES (L) "WHAT IS THE NATURE AND EXTENT OF THE INJURY?", AND (O) "OTHER: PROSPECTIVE MEDICAL CARE", THE ARBITRATOR FINDS:

Based on the testimony of Petitioner and the deposition testimony of Drs. Hill and White, Petitioner sustained a traumatic injury to her left knee resulting in an aggravation of a degenerative knee condition. Dr. Hill further found Petitioner sustained an aggravation of her right knee degenerative condition as a result of an altered gait resulting from her left knee pain.

Both Dr. White and Dr. Andriacchi causally related the condition of Petitioner's feet to the accident of June 4, 1997.

The accident also resulted in the sprain of Petitioner's left fourth finger. While Dr. White felt there was a fracture, Dr. Suk found a sprain, which Petitioner reported continues to bother her.

As a result of the knee injuries, Dr. Hill, on March 21, 2007, imposed activity restrictions on Petitioner that limit her standing, walking, stooping, kneeling and lifting (to 25 lbs.). Dr. White testified in 2009 that if Petitioner were allowed undergo surgery for the neuroma on her foot, she might be able to return to some work. The later off-work slips of Doctors White and Andriacchi have simply limited Petitioner to no return to work. *PX 16 (Group)*

The Arbitrator finds that Petitioner failed to prove that she is an "odd-lot" permanent total. No doctor or vocational rehabilitation counselor has specifically opined that Petitioner is permanently and totally disabled. Moreover, Petitioner did not introduce evidence of a job search or any evidence to show that no stable job market exists for any of her services and thus failed to meet her burden that she was not capable of obtaining gainful employment.

The Arbitrator notes that Petitioner is well educated. Petitioner is not taking prescription pain medication. Under Dr. Hill's March 21, 2007 restrictions, to which he referred at the August 20, 2009 deposition, Petitioner was capable of performing, at the very least, sedentary work. At the February 11, 2014 hearing of the motion to reinstate, Petitioner stated that she has been looking after her mother during her mother's long illness.

Petitioner has also failed to prove that she is entitled to a wage differential award. Although Respondent provided vocational rehabilitation services from November 25, 1998 through May 23, 2000, the vocational consultant questioned Petitioner's motivation to return to work. Furthermore, Petitioner refused to attend an interview with a prospective employer that the consultant had arranged on November 10, 1999. The Labor Market Survey conducted in early 1999 indicated that Petitioner would likely suffer a wage loss. However, such data is 15 years old. No recent Labor Market Survey

or recent opinion of a vocational specialist was offered into evidence. No evidence was introduced to show the amount Petitioner is able to earn in some suitable employment or business. No evidence was introduced to show what Petitioner would be able to earn in the full performance of her duties in the occupation in which she was engaged at the time of the accident.

On August 20, 2009, Dr. Hill opined that if Respondent could find a job for Petitioner within the restrictions he had imposed on her, that Petitioner could probably perform such job. Thereafter, he issued no return to work slips and recommended further treatment for her foot. Petitioner's Exhibit (Group) #16 is a compilation of off-work slips, produced by Dr. Hill, Dr. White, Dr. Andriacchi, and Dr. Gormley. The first off-work slip was authored by Dr. Gormley and dated June 5, 1997. The rest of the off-work slips are authored by the other three treating physicians, which begin on February 13, 2008 and end on February 15, 2014.

Dr. Hill continues to keep Petitioner off work and has recommended that Petitioner seek a surgical consultation regarding her left foot with Dr. Kelikian, followed by a re-evaluation of Petitioner by Dr. Hill.

Based on Dr. Hill's recommendation, the Arbitrator finds that Petitioner has not yet reached MMI. Consequently, a determination as to Petitioner's permanent disability is not appropriate at this time.

Therefore, the Arbitrator orders Respondent to authorize and pay for a surgical consultation for Petitioner's left foot with Dr. Kelikian, followed by a re-evaluation of Petitioner by Dr. Hill.

IN SUPPORT OF HIS DECISION WITH REGARD TO ISSUE (M) "SHOULD PENALTIES AND FEES BE IMPOSED ON RESPONDENT?", THE ARBITRATOR FINDS:

Respondent introduced reports of physicians hired by them to perform Section 12 examinations. Respondent was entitled to rely on the opinions of their physicians, even though the Arbitrator has found the opinions of the treating doctors, to the extent they conflict with those rendered by Doctors Krieger and Kornblatt, to be more persuasive. No penalties are due Petitioner on this record.

IN SUPPORT OF HIS DECISION WITH REGARD TO ISSUE (N) "IS RESPONDENT DUE ANY CREDIT?", THE ARBITRATOR FINDS:

Respondent claims a credit for the payment of Petitioner's foot surgery. However, the Arbitrator finds that both Dr. Herbert White and Dr. Dominic Andriacchi opined that Petitioner's foot condition was causally related to the accident. In this regard, the Arbitrator adopts his findings of fact and conclusions of law as to the issue of causation. Respondent was liable for the foot surgery pursuant to Section 8(a) of the Act and is not entitled to a credit against the award herein.

IN SUPPORT OF HIS DECISION WITH REGARD TO ISSUE (O) "OTHER: DISMISSAL/REINSTATEMENT OF CLAIM", THE ARBITRATOR FINDS:

The Arbitrator made detailed findings and entered a written Order for the reinstatement of the instant case. The Arbitrator finds no reason to disturb his findings and Order. The reinstatement of this case shall stand.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☒ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Pauline Christensen,
Petitioner,
vs.

16IWCC0216

NO: 02 WC 66220

City of Chicago,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Reespondent herein and notice given to all parties, the Commission, after considering the issue of nature and extent of Petitioner's permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 15, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 24 2016
KWL/vf
O-3/21/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0216

CHRISTENSEN, PAULINE
Employee/Petitioner

Case# 02WC066220

CTIY OF CHICAGO
Employer/Respondent

On 9/15/2015, 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 0.26% 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:

0154 KROL BONGIORNO & GIVEN LTD
CHARLIE GIVEN
120 N LASALLE ST SUITE 1150
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
WILLIAM O'BRIEN
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [x] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [ ] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

16IWCC0216

Pauline Christensen
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # 02 WC 066220

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 **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **December 4, 2014**. 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. [x] 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. [x] 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 _____

16IWCC0216

FINDINGS

On **December 6, 2002**, 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 $**52,462.28**; the average weekly wage was $**1,008.89**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **0** 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 $**325,053.33** for TTD, $**0** for TPD, $**81,575.75** for maintenance, and $**0** for other benefits for a, total credit of $**406,629.08**.

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

ORDER

Respondent shall reimburse Petitioner $2,844.81 for payments she made to secure medications prescribed by Dr Konowitz. The reimbursement request was submitted as PX15. Respondent shall pay for the medical bill of Dr Konowitz submitted as PX10 in the outstanding amount of $611.00, pursuant to the Medical Fee Schedule. Respondent is entitled to a credit for all bills paid.

Respondent shall pay Petitioner permanent total disability benefits of $672.59/week for life, commencing December 4, 2014, as provided in Section 8(f) of the Act.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the *Rate Adjustment Fund*, as provided in Section 8(g) 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.

Signature of Arbitrator

September 15, 2015
Date

SEP 15 2015

RECEIVED

FINDINGS OF FACT

At the time of the injury, Pauline Christensen ("Petitioner"), was a 50 year old Motor Truck Driver for the City of Chicago ("Respondent"), in the Department of Sewers, now known as the Department of Water Management. She was hired in December of 1990.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of her employment by Respondent on December 6, 2002 and that her current condition of ill-being was causally related to the injury. Petitioner was driving Respondent's truck when she was struck head on by a motorist going the wrong way down a one-way street. Petitioner's vehicle then struck a concrete pillar and she experienced immediate pain in her right chest, back, left thigh, and right shoulder.

Medical Records

Petitioner was taken by CFD ambulance to Rush Hospital, where she received a work-up for MVA, chest pain and left thigh pain and was released. (PX1) On the day of the accident, Petitioner treated with Dr. Homer Diadula at MercyWorks. Dr. Diadula took x-rays of the right chest and lumbar spine that were essentially unremarkable and prescribed Celebrex. On December 17, 2002, Dr. Diadula recommended Petitioner undergo MRIs of the lumbar spine and cervical spine, which were performed on December 20, 2002. The MRI of the cervical spine revealed a posterior disc bulge at C5-6, while the lumbar spine MRI revealed a small posterior disc bulge at L2-3, along with an anterior disc bulge and anterior osteophytes at L2-3 and L3-4. In January of 2003, Dr. Diadula referred Petitioner to Dr. Julie Wehner (PX2).

On January 30, 2003, Dr. Wehner examined Petitioner and cleared Petitioner to return to work full duty as of February 3, 2003 (PX2).

Petitioner did return to work full duty on February 5, 2003. The work activities caused her low back pain to increase.

On February 13, 2003, Dr. Diadula took Petitioner off work and referred her to Dr. Frank Phillips, an orthopedic surgeon at Midwest Orthopedics at Rush. On February 26, 2003, Dr. Phillips saw Petitioner and referred her for physical therapy and pain management (PX2).

On May 14, 2003, Petitioner began seeing Dr. Milorad Cupic at Mercy Hospital. Dr. Cupic administered a series of epidural steroid injections to Petitioner's lumbar spine on May 14, June 16, and July 17 of 2003 (PX2).

On September 2, 2003, Dr. Phillips ordered a new lumbar spine MRI. The MRI was performed on September 16, 2003, and revealed loss of signal intensity at L2-3 and L3-4 and possible stenosis at L2-3. Dr. Phillips prescribed a discogram, which was performed on October 6, 2003. The discogram reproduced concordant pain at L2-3 and L3-4. On October 16, 2003, Dr Phillips prescribed lumbar decompression and spinal fusion surgery at L2-L4 (PX3).

On December 15, 2003, Dr. Phillips performed surgery on the Petitioner's lumbar spine, including a laminotomy at L2-3, instrumented posterior spinal fusion at L2-L3 and L3-L4, a right iliac crest bone graft, and a posterolateral fusion at L2-4 (PX3).

On January 6, 2004, Dr. Phillips prescribed a CT scan of Petitioner's lumbar spine. The CT scan was performed on January 15, 2004. On February 3, 2004, Dr. Phillips recommended surgery to revise the placement of the screws that had been placed in Petitioner's back during the fusion surgery (PX3).

On March 22, 2004, Dr. Phillips performed surgery on Petitioner's back, including revision of the right L4 pedicle screw, cadaveric allograft, and grafton supplementation of intertransverse fusion. Hardware still remained in Petitioner's back following the surgery (PX3).

Petitioner began a course of physical therapy in May 2004. On July 6, 2004, Dr. Phillips noted that Petitioner was experiencing cervical spine pain along with lumbar spine pain, and he recommended cervical physical therapy be added to her therapy plan. Petitioner was discharged from physical therapy on September 22, 2004 (PX3).

On November 30, 2004, Dr. Phillips saw Petitioner again and recommended additional surgery for her lumbar spine (PX3). Petitioner declined the surgery. Dr. Phillips prescribed a functional capacity evaluation ("FCE"), which Petitioner did undergo on December 16, 2004. The FCE was determined to be a valid test, and Petitioner tested out at the sedentary physical demand level (PX4). On January 4, 2005, Dr. Phillips released Petitioner

from treatment with the permanent restrictions set forth by the FCE and placed her at maximum medical improvement in relation to her lumbar spine (PX3).

After being released by Dr. Phillips, Petitioner underwent conservative pain management with her primary physician, Dr. Thelma Evans at Advocate Health, and used medications such as Oxycontin and Flexeril (PX11).

On October 7, 2008, Dr. Phillips examined the Petitioner and prescribed Lyrica, but did not recommend any additional medical treatment (PX3).

Petitioner was evaluated by Dr. April Fetzer, a physiatrist, on February 25, 2010. Dr. Fetzer diagnosed Petitioner with chronic pain syndrome and recommended an increase in her Lyrica dosage, a lumbar spine MRI, and a trial of epidural steroid injections at L4-5 below the fusion (PX18).

On November 24, 2010, Petitioner was examined by Dr. Howard Konowitz, a §12 independent medical examiner hired by the Respondent. Dr. Konowitz recommended a CT scan and ultrasound of the lumbar spine, as well as a treatment plan to wean Petitioner off of narcotic pain medications, including Oxycontin (PX8 and RX2).

On December 15, 2010, Petitioner underwent a CT scan of her lumbar spine. At the request of Dr. Konowitz, Petitioner underwent another CT scan of the lumbar spine on April 19, 2011. On July 13, 2011, Dr. Konowitz recommended a diagnostic ultrasound and did not recommend any further surgery (PX8 and RX2).

On November 9, 2011, Petitioner began treating with Dr. Konowitz, who discontinued her Oxycontin prescription. On January 4, 2012, Dr. Konowitz performed an ultrasound of Petitioner's lumbar spine, as well as injections to the right cluneal nerve and right S1 joint. On January 18, 2012, Dr. Konowitz recommended that Petitioner complete a physical therapy program to be followed by a FCE (PX8).

Petitioner underwent a FCE at Accelerated Rehabilitation Centers on March 2, 2012. The FCE results were determined to be invalid but the Petitioner demonstrated a physical demand level of tolerance for light-medium work (PX5). Petitioner noticed an increase in pain following the FCE.

On April 24, 2012, Andrea Lantomo, a nurse with Dr. Konowitz's office, cleared Petitioner to return to work at full duty pursuant to the FCE and prescribed an additional injection (PX8).

On May 7, 2012, Petitioner returned to work full duty and continued to work through May 9, 2012, at which point she was unable to work due to increased lumbar spine pain.

On May 9, 2012, Dr. Konowitz performed injections to the Petitioner's right S1 joint and right cluneal nerve with ultrasound. On May 14, 2012, Dr. Konowitz prescribed a new FCE (PX8).

Petitioner underwent a FCE at ATI Physical Therapy on June 11, 2012. The FCE was valid and Petitioner demonstrated the ability to function at the sedentary physical demand level, capable of occasionally lifting 10 pounds (PX6).

On August 8, 2012, Dr. Konowitz opined that Petitioner can work at the light to medium physical demand level, while still needing to take medications, including Tramadol (also known as Ultram) (PX8).

Petitioner was unable to return to work with Respondent as a Motor Truck Driver, in part because Tramadol is a Schedule IV Narcotic in Illinois. Petitioner would be unable to drive a City vehicle using her CDL while she was taking Tramadol. Dr Konowitz testified that Tramadol would remain in her system even if she only took the medication before sleeping at night (PX7). Petitioner was terminated by the Respondent in August of 2012.

On February 6, 2013, Petitioner's Tramadol dosage was increased (PX8). Petitioner has continued to treat with Dr. Konowitz through the date of the hearing, most recently on October 22, 2014. Medications prescribed at the October 22, 2014 office visit included Zanaflex, Neurontin and Tramadol (PX9).

Vocational Rehabilitation

On December 27, 2006, Petitioner had an initial vocational rehabilitation meeting with Nancy Lynn Jones, a counselor with Concentra who was hired by the Respondent. Petitioner completed vocational rehabilitation services and job placement services at the direction of Concentra through December 9, 2007, when the services were discontinued by the vocational counselor at the request of the Respondent (PX14).

On April 10, 2009, Petitioner had an initial vocational rehabilitation meeting with Joseph Belmonte ("Belmonte") from Vocamotive. Belmonte found Petitioner to be without transferability of skill. Belmonte did not recommend full vocational services and believed Petitioner's disability to be permanent and total in nature (PX13).

On February 8, 2010, at the request of the Respondent, Petitioner had an initial vocational rehabilitation meeting with Ed Steffan ("Steffan") from EPS Rehabilitation. Steffan referred Petitioner to Dr. Fetzer for medical evaluation. Steffan also provided a proposed outline of a rehabilitation plan which included job placement assistance, including vocational testing and short term training (PX18).

On May 15, 2013, at the request of the Respondent, Petitioner had an initial vocational assessment meeting with Jacqueline Bethell ("Bethell") from MedVoc Rehabilitation. Bethell opined that Petitioner was employable at an unskilled or semi-skilled position. On May 29, 2014, Ms. Bethell completed an updated labor market survey and opined that Petitioner could anticipate a mean entry-level wage of $11.38 per hour (RX1).

On July 31, 2014, Belmonte reviewed Petitioner's vocational data and completed an addendum to his initial vocational assessment. His opinion remained that Petitioner has no meaningful transferable skills and does not have access to a viable, stable labor market consistent with gainful employment (PX13).

On September 29, 2014, Bethell completed an additional addendum report. Bethell's opinion remained that Petitioner is employable in unskilled or semi-skilled positions (RX1).

From the date of the accident through the date of the hearing, Petitioner was unable to secure any alternative employment.

Petitioner's Testimony

Petitioner was not having any problems with her lumbar spine before her accident on December 6, 2002. She had treated for about two years with Dr. Evans at Advocate Health for some back pain before the accident but she was not having lumbar spine pain before the accident.

Petitioner testified that she notices significant pain in the right side of her low back with some radiation down her right leg, particularly with walking, sitting, standing, and lying down. Petitioner alternates between sitting and standing. She testified that she is able to sit for a maximum of 15-20 minutes before the pain becomes too intense. She is able to stand for a maximum of 10 minutes before the pain becomes too intense. Petitioner testified that she gets approximately 6 hours of total sleep each night, but she has to wake up and turn over every few hours to avoid pain. Petitioner has used a cane every day for the past 2-3 years to help her walk. She also uses a motorized scooter for traveling long distances. The cane and scooter were not prescribed by a doctor.

Petitioner has difficulty performing activities of daily living such as cooking, cleaning, vacuuming, doing dishes, and showering. She experiences significant pain when attempting to perform those activities, particularly while standing. She uses a bench to sit down while showering. Petitioner performs home exercises and takes medications for pain relief.

Petitioner is currently taking regular Tramadol twice per day and a separate, longer lasting Tramadol once at night. Petitioner also takes the muscle relaxer Tizanadine every time she takes Tramadol. These medications are all prescribed by Dr Konowitz. At the time of the hearing, Petitioner had another visit scheduled with Dr. Konowitz in about a month for a routine update of her medications. Dr. Konowitz testified via evidence deposition. (PX7)

Petitioner testified that her normal work hours as a Motor Truck Driver for the City of Chicago were from 7:00AM to 3:30PM, with a half hour mandatory lunch break. She worked Monday through Friday, 40 hours per week. Her duties included transporting personnel and tools in various types of trucks. She did not operate any other machinery. Petitioner was a member of Teamsters Local 700 and would currently be earning a union scale rate of $34.51 per hour, 40 hours per week, as a Motor Truck Driver for Respondent (PX17).

Petitioner graduated from Waynesburg Central High School in Waynesburg, Pennsylvania, in 1972 (PX12). She has had no additional education and has never participated in any union apprenticeship. She has no military experience. Petitioner learned how to drive a truck from her father. Respondent trained her in how to operate vehicles at the airport, but she has never had any formal training to drive a truck. Petitioner has no computer skills and has no knowledge of typing, email, internet use, or operating systems. Petitioner lives within the Chicago city limits and has access to public transportation.

Petitioner began working for Respondent as a Motor Truck Driver in 1990. Prior to her employment with Respondent, Petitioner worked as a cashier at a Mobil gas station for 6 months, as a cashier at K-Mart for 1-2 years, as a cashier at a small business for less than a year, and as a pizza delivery driver. Petitioner was a housewife and mother from 1977 through 1983. Petitioner has no supervisory or management experience.

The Parties agreed that all TTD and Maintenance benefits have been paid to Petitioner as of the date of trial. Respondent paid 604-4/7 weeks of benefits, as of December 4, 2014.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below. Petitioner's testimony is found to be credible.

J. Medical Expenses-Has Respondent paid all appropriate charges for all reasonable and necessary medical expenses?

Petitioner claimed that Respondent was liable for reimbursement for her payments for medications (PX15) and the bill of Dr. Konowitz (PX10). The same are awarded and Respondent is entitled to a credit for all bills that have been paid.

L. What is the nature and extent of the Petitioner's injury?

The Arbitrator acknowledges that an injured worker need not be reduced to total physical incapacity for a permanent total disability award to be granted. Under Illinois law, a person may be found to be totally disabled if he cannot perform any services except those for which no reasonably stable labor market exists. The Illinois Supreme Court stated in *Valley Mould & Iron Company v. Industrial Commission*, 84 Ill.2d 538, 419 N.E. 2d 1159 (1981), that if the claimant's disability is limited in nature so that he is not obviously unemployable or if there is no medical evidence to support a claim of total disability, the burden is on the claimant to establish the unavailability of employment to a person in his circumstances, but once he has established that he falls in this "odd-lot" category, then the burden shifts to the employer to show that some kind of suitable work is regularly and continuously available to claimant. In order to substantiate a claim for an "odd-lot" permanent total

disability claim, it is incumbent upon Petitioner to show that, considering her present condition in light of her age, experience, training and education, that she is permanently and totally disabled.

Petitioner has established that she falls into the "odd-lot" category. As a result of her work injury on December 6, 2002, Petitioner has received medical treatment for back pain through October 22, 2014, including two back surgeries. Petitioner still experiences back pain and disability that significantly limits her ability to perform activities of daily living. Petitioner's most recent FCE determined that she is limited to the sedentary physical demand level and is capable of occasionally lifting 10 pounds. Dr. Konowitz has opined that Petitioner is limited to the light to medium physical demand level. Petitioner was unable to return to her position as a Motor Truck Driver and her employment has been terminated by Respondent. Petitioner's medical disability clearly significantly limits her employability.

Belmonte's May 11, 2009, vocational report indicated that Petitioner has no transferable skills, is unemployable, and is totally disabled. In forming this opinion, Mr. Belmonte considered Petitioner's advancing age, indicating she would have difficulty with adaption and adjustment to vocational rehabilitation; her lack of higher education or training of any other form; her employment history that is limited to unskilled labor and miscellaneous clerical work; her physical demand capacity of a sedentary level; her extended absence from the workforce; and her limited job search experience. Belmonte also noted that unemployment levels were high nationally and within the state of Illinois. Furthermore, sedentary level positions comprised only 10-11% of all job titles, and only one-half to 1% of all jobs in the Chicago metropolitan area were both sedentary and unskilled (PX13). Petitioner's high school transcript reflects that she ranked 143rd out of 180 students and had poor grades in most subjects (PX12). Belmonte's updated vocational report of July 31, 2014 acknowledged that Dr. Konowitz had cleared Petitioner for a light to medium physical demand level of work. Belmonte opined that Petitioner still does not have access to a viable, stable labor market consistent with gainful employment. He found it doubtful that all of the physical demands of positions such as housekeeper or office cleaner would fall within Petitioner's restrictions. Belmonte also opined that Petitioner cannot return to her line of work as a truck driver unless she has passed appropriate Department of Transportation physical examination. In maintaining his opinions, Belmonte considered Petitioner's additional 4 years outside of the workforce; her advanced age; her obsolete skills; her lack of education; her poor prognosis for any rehabilitation interventions; her prescribed narcotic medication intake; her limited physical capacity and her pain complaints. (PX13) Belmonte's opinions are credible and persuasive in this case.

Bethell's May 29, 2013, vocational report found that Petitioner was employable in positions such as office cleaning, housekeeping, labeling or assembly. She based her opinion on Petitioner's work history as a truck driver and the light to medium physical demand level adopted by Dr. Konowitz. Bethell also opined that Petitioner could be considered for dispatch and customer service clerk positions if she completed minimal computer training. Based on her review of labor market data, Bethell opined that Petitioner could earn a mean wage of $11.38 per hour. Bethell's opinion remained unchanged in her updated report of September 29, 2014 (RX1). Bethell's opinions are not persuasive in this case.

As in the Appellate Court case of *City of Chicago v. Illinois Workers' Compensation Commission*, 373 Ill.App.3d 1080, 871 N.E.2d 765 (1st Dist. 2007), Petitioner has established the burden of persuasion, not through a job search, but by providing through vocational expert testimony, that because of her age, skills, training, experience, physical capacity and education, she will not be regularly employed in a well-known branch of the labor market. Having established the burden of persuasion, the burden of proof then shifts to Respondent to show that Petitioner was employable in a stable labor market and that such a labor market exists. After weighing the opinions of two vocational counselors, the Commission in the *City of Chicago* case found that the Petitioner had no access to a stable labor market.

In the present case, the Arbitrator finds that Bethell's reports are insufficient for Respondent to meet its burden. Petitioner is not capable of working in housekeeping, office cleaning, labeling or assembly, given her limitations demonstrated by her testimony and that of Dr. Konowitz.

It is telling that Respondent did not undertake a vocational rehabilitation plan in order to place Petitioner in suitable employment. Perhaps a PTD award would have been avoided had Respondent instituted re-training (computer skills at a minimum) and provided job search assistance to Petitioner. Respondent was providing some job search assistance through Concentra, but stopped these efforts in 2007. It was noted that Petitioner was pleasant and cooperative in the vocational efforts, yet Respondent chose to cease them and later obtain labor market survey evidence, which is deemed less credible due to the prior failed placement efforts.

The Arbitrator finds that Petitioner has proven that she is entitled to permanent and total disability benefits. It is interesting to note that §8(d)1 benefits in this case could amount to $661.33/week, if Petitioner could be successfully placed in suitable employment, based upon the proofs (40 hours at $9.71 = $388.40, current wages for a Motor Truck Driver are $1,380.40). PTD benefits are $672.59/week.

Accordingly, Respondent shall pay Petitioner permanent and total disability benefits of $672.59/week for life, commencing December 4, 2014, as provided in §8(f) of the Act.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in Section 8(g) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF LA SALLE)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☒ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joshua King,
Petitioner,

vs. No: 06 WC 51451

RGIS Inventory Specialists,
Respondent.

16IWCC0220

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of nature and extent of permanent disability, Section 19(k) and Section 19(l) penalties, and Section 16 attorneys' fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the Arbitrator's Decision by vacating the penalties and fees awarded under Section19(k), Section 19(l) and Section 16. Petitioner argued that Respondent is guilty of unreasonable and vexatious delay in the payment of his ongoing medical expenses, testifying in particular regarding issues of authorization of certain narcotic medications prescribed for his Complex Regional Pain Syndrome.

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After consideration of the entire record, the Commission finds that the Respondent's conduct does not rise to the level of unreasonableness, vexatiousness and bad faith envisioned under Section19(k), Section 19(l) and Section 16 of the Act. In so doing, the Commission takes note of the long, complex and evolving medical history of Petitioner's condition, as well the Respondent's efforts in procuring, and subsequent reliance on: the opinion of its Section 12 examiner, Dr. Richard Noren, two drug utilization reviews, and two "peer to peer" reports detailing recommendations discussed with Petitioner's treating physician. The Commission further notes that Respondent, which has paid six figures in benefits over the course of the years, has availed itself of the presumption of reasonableness created by its reliance on on the utilization report in its denial of benefits. *See* Jesus Chavez v. R & R Properties, 14 IWCC 506, 2014 Ill. Wrk. Comp. LEXIS 455.

Based on the foregoing, the awards of penalties and fees are vacated. All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the awards of penalties and fees under Section 19(k), Section 19(l) and Section 16 are vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay reasonable and necessary medical services totaling **$271,621.10** as reflected in Petitioner's Exhibit 7a and **$1,328.74** as reflected in Petitioner's Exhibit 12, pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Respondent is provided credit for all amounts heretofore paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner in full for the reasonable and necessary prescription medications paid out-of-pocket by Petitioner or paid on his behalf as reflected in Petitioner's Exhibit 7 and 7a, totaling **$25,184.27**.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent comply with the Commission's June 16, 2011 order holding it liable and requiring Respondent to pay for psychological counseling.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner temporary total disability benefits of **$173.32/week for 169 & 5/7 weeks**, commencing **November 21, 2008 through February 21, 2012**, as provided in Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner permanent and total disability benefits of **$420.33/week for life, commencing February 22, 2012**, as provided in Section 8(f) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner benefits that have accrued from **August 20, 2006 through January 29, 2015.**

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent be given a credit for disability benefits paid to date.

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IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under Section 19(n) of the Act, if any.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the *Rate Adjustment Fund*, as provided in Section 8(g) of the Act.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 4 2016

Joshua D. Luskin

Charles J. DeVriendt

o-02/24/16
jdl/ac
68

Ruth W. White

[illegible]

[illegible]

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
AMENDED

KING, JOSHUA
Employee/Petitioner

Case# **06WC051451**

RGIS INVENTORY SPECIALISTS
Employer/Respondent

16IWCC0220

On 4/14/2015, 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 0.10% 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:

0432 ANTHONY C RACCUGLIA & ASSOC
JAMES A McPHEDRAN
1200 MAPLE DR
PERU, IL 61354

0000 GALDO & FINTZEN
JUSTIN KANTER
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSALLE)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [x] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [ ] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
AMENDED ARBITRATION DECISION

Joshua King
Employee/Petitioner

v.

RGIS Inventory Specialist
Employer/Respondent

Case # **06** WC **51451**

Consolidated cases: **N/A**

16IWCC0220

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 **Barbara N. Flores**, Arbitrator of the Commission, in the city of **New Lenox**, on **January 30, 2015**. After reviewing all of the evidence presented, the undersigned 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. [x] 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. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

16IWCC0220

FINDINGS

On **August 20, 2006**, 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 **$16,640.00**; the average weekly wage was **$320.00**.

On the date of accident, Petitioner was **25** years of age, ***single*** with **no** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services as explained *infra.*

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

Respondent shall be given a credit for TTD benefits paid through January 12, 2015 at the TTD rate, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit for TTD benefits paid through January 12, 2015 at the TTD rate. *See* AX1.

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

ORDER

Medical Benefits

Respondent shall pay reasonable and necessary medical services totaling $271,621.10 as reflected in Petitioner's Exhibit 7a and $1,328.74 as reflected in Petitioner's Exhibit 12 (EQMD update) pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall also pay Petitioner in full for the reasonable and necessary prescription medications paid out-of-pocket by Petitioner or paid on his behalf as reflected in Petitioner's Exhibit 7 and 7a (for $13,168.75, $5,203.43, $1,144.32 and $5,667.57) totaling $25,184.27. *See* PX7 & PX7a at 49, 59, 60, 65.

Respondent shall comply with the Commission's June 16, 2011 order holding it liable and requiring Respondent to pay for "psychological counseling."

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $173.32/week for 169 and 5/7th weeks, commencing November 21, 2008 through February 21, 2012, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from August 20, 2006 through January 29, 2015, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit for TTD benefits paid through January 12, 2015 at the TTD rate for temporary total disability benefits that have been paid.

Permanent & Total Disability Benefits

Respondent shall pay Petitioner permanent and total disability benefits of $420.33/week for life, commencing February 22, 2012, as provided in Section 8(f) of the Act.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the *Rate Adjustment Fund*, as provided in Section 8(g) of the Act.

Penalties & Fees

As explained in the Arbitration Decision Addendum, Respondent shall pay Section 19(k) penalties in the amount of $1,498.00 ($2,996.00 x 50%) and Section 16 attorneys' fees in the amount of $299.60 ($1,498.00 x 20%) for its failure to pay the Fullerton-Kimball Surgical Center outstanding balance. Respondent shall also pay Section 19(k) penalties in the amount of $12,592.14 ($25,184.27 x 50%) and Section 16 attorneys' fees in the amount of $2,518.43 ($12,592.14 x 20%) for its failure to reimburse Petitioner's out-of-pocket prescription medication costs. Finally, Respondent shall pay penalties pursuant to Section 19(l) in the maximum amount of $10,000.00 (cap of unpaid benefits at $30/day) for its failure to pay Petitioner's outstanding medical bills and out-of-pocket costs.

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.

Signature of Arbitrator

April 13, 2015
Date

APR 14 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
AMENDED ARBITRATION DECISION *ADDENDUM*

Joshua King
Employee/Petitioner

v.

RGIS Inventory Specialist
Employer/Respondent

Case # **06** WC **51451**

Consolidated cases: **N/A**

16IWCC0220

FINDINGS OF FACT

The issues in dispute at this hearing include Respondent's liability for certain unpaid medical bills, Petitioner's entitlement to a period of temporary total disability benefits from November 21, 2008 through February 21, 2012, the nature and extent of Petitioner's injury, and whether penalties and attorney's fees should be imposed on Respondent. Arbitrator's Exhibit[1] ("AX") 1. With regard to the applicable rate of payment for temporary total disability, the parties have stipulated that Petitioner has received temporary total disability at the temporary total disability rate from November 21, 2008 through January 12, 2015. *Id.* However, Petitioner asserts that he is entitled to permanent and total disability payments beginning February 22, 2012 resulting in an underpayment of benefits from February 22, 2012 through January 12, 2015. *Id.*

Procedural History & Issues in Dispute

On April 30, 2008 and November 20, 2008, a bifurcated arbitration hearing was held pursuant to Petitioner's Section 19(b) and 8(a) petition. Petitioner's Exhibit[2] ("PX") 2. The arbitration decision was dated January 30, 2009. PX2. Both Petitioner and Respondent filed petitions for review. PX3. The Commission issued its decision on review on June 16, 2011. *Id.* The Commission upheld the following findings at arbitration:

(1) The medical opinions of Petitioner's treating interventional pain specialist, Dr. Tian Xia, and Petitioner's treating physicians, Drs. Ortinau and Speca, were persuasive in establishing that Petitioner had reflex sympathetic dystrophy (RSD);

(2) Petitioner's accident at work was a causative factor in the development of Petitioner's RSD condition; and

(3) Petitioner was temporarily and totally disabled from August 20, 2006 through November 20, 2008.

PX2-PX3. The Commission also modified the arbitration decision regarding the award of prospective medical treatment and found that, "*in addition to* the trial spinal cord stimulator, psychological counseling is reasonable, necessary, and causally related to the August 20, 2006 work accident such that Respondent shall be liable for payment of such psychological counseling in addition to the trial spinal cord stimulator." *Id.*, at 1 (*emphasis* added). The Commission also found "that Dr. Lazar, Respondent's independent medical examiner, did not

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party.

[2] The Arbitrator similarly references the parties' and Arbitrator's exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party. Exhibits attached to depositions will be further denominated with "(Dep. Exh. _)."

negate causation." *Id.* The arbitration decision was otherwise affirmed and adopted, including the denial of penalties and fees; albeit with additional reasoning for that denial noted by the Commission. *Id.*, at 1-3.

Petitioner's case was eventually remanded back to arbitration. The parties appeared for a hearing on January 30, 2015. AX1. All issues placed in dispute at the hearing concluded on November 20, 2008 have been definitively resolved by the Commission's decision dated June 16, 2011, which is now final.

"The rule of the law of the case is a rule of practice, based on sound policy that, where an issue is once litigated and decided, that should be the end of the matter and the unreversed decision of a question of law or fact made during the course of litigation settles that question for all subsequent stages of the suit." *Irizarry v. Industrial Comm'n*, 337 Ill. App. 3d 598, 606 (2nd Dist. 2003) (*citing McDonald's Corp. v. Vittorio Ricci Chicago, Inc.*, 125 Ill. App. 3d 1083, 1086-87 (1st Dist. 1984) (quotations omitted)). The law of the case doctrine is applicable to issues litigated before the Illinois Workers' Compensation Commission. *Ming AutoBody/Ming of Decatur, Inc. v. Industrial Comm'n*, 387 Ill. App. 3d 244, 252, 899 N.E.2d 365, 326 Ill. Dec. 148 (2008)).

Thus, the findings of fact and conclusions of law from the first arbitration hearing in this case are binding, and herein adopted and incorporated by reference. In accordance with the law of the case and the evidence presented at this hearing, the Arbitrator makes findings on the disputed issues that were not previously resolved at the first hearing as stated *infra*.

Additional Evidence of Medical Treatment after November 20, 2008

Petitioner testified that he continued to treat with Dr. Xia and Dr. Kalina for pain management about once a month after the last arbitration hearing. His mother drove him to these appointments. Petitioner testified that Dr. Xia or Dr. Kalina always examined his foot and that he was prescribed medications monthly. He explained that those medications changed depending on his needs. He also testified that he did not receive any benefits from Respondent.

The medical records reflect that Petitioner returned to Integrated Pain Management on November 25, 2008. PX4 at 155. Dr. Xia maintained Petitioner's diagnosis of CRPS referable to the right lower extremity and refilled his medications. *Id.* Dr. Xia also continued to recommend a spinal cord stimulator. *Id.* Petitioner continued to see either Dr. Xia or Dr. Kalina about once a month through September 27, 2011. *Id.*, at 123-153. During this time, Petitioner's medications were adjusted, but his CRPS diagnosis remained constant. *Id.* Petitioner's physical examinations were also noted to be essentially unchanged. *Id.*

Petitioner also testified that his foot swells, turns purplish-reddish color, and feels ice cold and as though it is being crushed in a vice all the time. Petitioner testified that he feels the pain from the ankle downward throughout the foot and that the medications help him. *Id.* The medical records corroborate Petitioner's testimony. *See generally* PX4. Dr. Xia or Dr. Kalina note Petitioner's similar complaints of pain and cold as well as their physical examinations of discoloration and cold temperature in the left foot or lower extremities. *Id.*

Petitioner testified that he ultimately had a trial spinal cord stimulator. The medical records reflect that he underwent the implantation procedure on October 22, 2011. PX4 at 121-122. Petitioner testified that he was still taking medications during this period of time and that he obtained some of the medications at Dr. Xia's pharmacy and some at the Streator pharmacy.

Petitioner returned to Dr. Xia on October 28, 2011. *Id.*, at 120. He reported that the coloration in his foot improved with the trial spinal cord stimulator, but the pain did not improve. *Id.* Dr. Xia removed the trial stimulator leads, refilled Petitioner's prescriptions, and set up a follow up visit in one week. *Id.* Petitioner testified that his pain and symptoms were about the same after the spinal cord stimulator as they were beforehand.

On February 21, 2012, Petitioner returned to Dr. Xia. PX4 at 116. Dr. Xia noted that "[a]t this point he is MMI. ... He is on multiple medications for maintenance[.]" *Id.* He maintained Petitioner's diagnosis of CRPS. *Id.*

In July of 2012, Petitioner testified that he was in an argument with his girlfriend and the police were called. Petitioner testified that he ended up on the ground and hurting his nose. He testified that he did not hurt his foot during this incident. The medical records suggest that Petitioner injured his nose, but that his condition with regard to the CRPS and foot remained unchanged. PX4 at 108.

On September 18, 2012 and October 16, 2012, Dr. Xia reiterated that Petitioner was at maximum medical improvement. PX4 at 104-105, 101-102. Dr. Xia further stated that "unfortunately, he is disabled." *Id.*

As of November 16, 2012, Dr. Xia noted Petitioner's report that the recommended Opana would be authorized to begin in December 2012. *Id.*, at 99-100. The Opana was prescribed on December 18, 2012. *Id.*, at 97-98.

Drug Utilization Review – Dr. Harsoor (Coventry)

Respondent submitted a drug utilization review report dated April 3, 2014 performed by Dr. Suneela Harsoor of Coventry. RX4. Dr. Harsoor noted that of the medical records she reviewed, there was no objective clinical, imaging or electro diagnostic evidence of radiculopathy or neuropathic pain and no functional status, pain scores or other objective measures utilized for prescribing Petitioner's medications. *Id.* She recommended discontinuation of Carisoprodol, Tramadol, Sertraline, and Lidoderm. *Id.* Dr. Harsoor also recommended that Petitioner be weaned off of OxyContin with a transition to a generic form in conjunction with drug screening. *Id.* Dr. Harsoor recommended continuation of Gabapentin and Trazodone. *Id.*

Additional Section 12 Examination – Dr. Noren

On June 20, 2013, Petitioner submitted to an independent medical evaluation with Dr. Richard Noren at Respondent's request. RX1. Dr. Noren reviewed Dr. Xia's prescriptions from January 2013, medical records from Dr. Xia from an unidentified starting date through September 2012, a record review from Dr. Suneela Harsoor, and the surgical reports from the spinal cord stimulator trial of October 22, 2011. *Id.* Dr. Noren also took a history from Petitioner, examined him, and rendered various opinions. *Id.*

Petitioner reported pain in his right foot with numbness in all five of his toes. *Id.* He explained the pain as though the foot was being crushed. *Id.* Petitioner also reported that his foot turns dark purple when it is cold outside, intermittent swelling especially when the foot is cold, slow growth of his toenails and that he does not cut them due to pain associated with touching the foot and cutting the nails. *Id.* Petitioner also reported that he is unable to bear weight on the right foot. *Id.* Petitioner reported taking various medications for pain, including Opana for the first time over the past three days because it had not previously been approved by the insurance company. *Id.*

On physical examination, Dr. Noren noted allodynia from the right ankle to the foot with no allodynia in the toes and hyperalgesia in the foot with decreased pinprick in all the toes. *Id.* Dr. Noren also noted that Petitioner's "right foot is cool compared to the left... [and] a slight blue discoloration of the right foot." *Id.* He further noted that Petitioner's "right foot turned red during this physical examination." *Id.*

Dr. Noren opined that Petitioner had complex regional pain syndrome. *Id.* He noted that the "subjective exam findings appear to be consistent throughout the physical exam. There are objective findings of changes in hair pattern and temperature differences between his extremities. In addition, there appears to be some atrophy at the left foot compared to the right consistent with his gait abnormality." *Id.* Dr. Noren also opined that "[Petitioner] does require [and 'will require further'] palliative management of his subjective pain complaints. Attempts should be made to appropriately wean the narcotic analgesics due to the possibility that his current pain symptomatology is being exacerbated by opiate induced hyperalgesia." *Id.* Finally, Dr. Noren opined that based on the gait Petitioner demonstrated on the day of his examination, he could work at the sedentary level. *Id.*

Drug Utilization Review – Dr. Khalifa (MedAllocators/ASN)

On October 4, 2013, Respondent submitted various records to Dr. Ahmed Khalifa, M.D. of MedAllocators, an ASN Company. RX2. Dr. Khalifa reviewed a right foot MRI of October 4, 2006 suggesting RSD, Dr. Kodros' December 14, 2006 Section 12 report, and Dr. Xia's November 4, 2011 progress note showing no improvement after the trial spinal cord stimulator at which time "Claimant was placed at MMI. Medications continue to be prescribed." *Id.* Dr. Khalifa also reviewed a July 18, 2013 drug utilization review completed by Coventry recommending that certain prescribed medications cease "[h]owever, the DUR has not yet been shared with the treating/prescribing physician." *Id.* Finally, Dr. Khalifa reviewed Dr. Kalina's noted from August 13 and 19, 2013 with prescriptions for Ambien, Fexmid, Ultram, Opana, and Gabapentin. *Id.*

In response to Respondent's questions, Dr. Khalifa opined that he agreed with all of the drug utilization review recommendations from Coventry except that the use of Fexmid or any other muscle relaxers was not recommended at all. *Id.* Dr. Khalifa also opined that the doses of morphine sulfate were more than double the safe daily intake limit and that the Ambien should be discontinued if the painkillers were of benefit to Petitioner. *Id.* He added that "[i]f the diagnosis RSD/CRPS is correct and with such reported severity, the continued need for painkillers probably would be expected. If diagnosis is in doubt, second opinion would be needed. Also, psychological evaluation is of benefit in such chronic cases and may be helpful in reducing dependency on the medical establishment and medications." *Id.*

Finally, Dr. Khalifa opined that "[if] the diagnosis is confirmed RSD, resolution cannot be predicted and possible it will never reach complete resolution. Obviously, prescriptions modifications as discussed earlier are needed for this case." *Id.*

On January 13, 2014, Dr. Khalifa issued a document entitled "Peer to peer with Dr. Xia" noting his conversation with Dr. Xia about the record review. RX3. Dr. Khalifa noted Dr. Xia's report that he had weaned Petitioner off of few medications like Oxycontin, which was difficult. *Id.* Dr. Xia also reported that "compliance was never an issue and there were no signs of abuse or serious side effects." *Id.* He noted that Dr. Xia was agreeable to urine drug testing to ensure compliance as well as an attempt to stop Fexmid and Ambien; however, Dr. Xia noted that he was not optimistic that Petitioner would be willing to go that set back. *Id.* Both Dr. Khalifa and Dr. Xia agreed that psychological counseling may be of benefit to Petitioner in the pursuit of decreasing medications and the perception of pain severity. *Id.* Dr. Khalifa finally noted that "[t]here is no

specific treatment plan that Dr. Xia can consider for this case other extended [sic] medication management and possible psychological counseling." *Id.*

Petitioner's Vocational Rehabilitation – Mr. Gustafson & Functional Capacity Evaluation

Petitioner testified that he has a 9th grade education, and that he was in special education. He also testified that he did not renew his driver's license in December of 2014 because it is too hard to drive using his foot and because of his medication. He explained that he cannot operate the pedals of a car safely and that he tried to drive, but had a hard time. Sometimes he would forget that he had his foot on the brake or that he had his foot on the gas and he would "rev" the car. Petitioner also testified that he could not do a sedentary job because his foot would hurt too much and because the pain affects his concentration and mood and anxiety.

Petitioner offered into evidence the October 19, 2013 vocational assessment report of Dennis Gustafson, M.S., CRC ("Mr. Gustafson"). PX5. Mr. Gustafson noted that Petitioner was an inventory worker for Respondent that developed CRPS after a right ankle/foot injury who would not be able to perform work that would require him to stand or engage in more than minimal walking. *Id.* He also indicated that Petitioner would be restricted from employment due to his inability to focus due to the high doses of medication he was taking at the time. *Id.* Ultimately, Mr. Gustafson concluded that Petitioner was "not currently capable of successfully engaging in and maintaining productive work activity and likely will not be until such time as improvement in his medical condition renders him able to adequately focus his attention on specific tasks and standards of performance required of him." *Id.*

Petitioner underwent a functional capacity evaluation on November 21, 2013 at St. Margaret's Center for Physical Rehab. PX6 at 4-17. Petitioner testified that the exam lasted about 2-3 hours and that he was allowed to sit throughout the exam. He also testified that his left foot was hurting badly and that the pain made it hard for him to concentrate. When he got home, Petitioner testified that he sat on the couch with his foot elevated for a day and a half. He experienced more pain and swelling after the functional capacity evaluation.

The evaluating physical therapist, Lanny Slevin, P.T., determined that Petitioner participated fully in the testing and that he provided an acceptable effort throughout testing. PX6 at 5. Petitioner was released to work at the medium demand level for activity and at the sedentary demand level for endurance. *Id.* The physical therapist noted that the "**[m]ain limiting factors for return to work success** are ongoing pain in the R lower leg with and without activity, decreased AROM in the R ankle, decreased isolation and functional strength in the R ankle, and inability to bear weight on the R foot, use of crutches, inability to perform higher intensity or longer duration activity due to pain and medications." *Id.*, (**emphasis** in original).

Mr. Gustafson issued a second report dated April 14, 2014 after reviewing Petitioner's functional capacity evaluation results. PX5(a). He indicated that the functional capacity evaluation "appears to add further support to my previously stated conclusion, namely that [Petitioner] is not currently capable of successfully engaging in or maintaining productive employment in any job situation." *Id.*

Medical Bills

Regarding his payment of his prescription medications, Petitioner testified that at some point he had to pay for some of his medications out-of-pocket. He explained that his mother paid for these medications and they agreed that her payments were a loan.

Petitioner's mother, Debbie King ("Mrs. King") testified at trial. She testified that from the fall of 2008 through the end of November of 2012, she paid for Petitioner's medications at the Streator pharmacy. Mrs. King testified that she had a loan agreement with her son.

Petitioner testified that Respondent did not pay for the medications at the Streator pharmacy until December of 2012 despite the June 16, 2011 Commission decision. The medical records reflect Petitioner's reports that his mother was paying for Petitioner's OxyContin and that he was not put on Opana because it was a much more expensive medication although Petitioner had an increased tolerance. PX4 at 104-105.

Petitioner also testified that there were times after December of 2012 that Respondent would stop paying for the medications again. He also testified that the payments for the Opana prescription were cut off at various points. When he did not have Opana, Petitioner testified that he got sick and felt he had to go to the bathroom all the time. Petitioner also testified that he would get cold and hot sweats and he felt like someone was dumping boiling water on his skin. Toward the end of October, 2013 the payment for his medications re-started. Petitioner testified that he was not given any explanation as to why he was cut off.

Petitioner offered into evidence approximately 30 letters sent requesting reimbursement of his out-of-pocket payments for prescriptions related to his CRPS condition dated from January 18, 2010 through August 1, 2014. PX9. Petitioner further testified that he has not been reimbursed by Respondent for the medications for which his mom paid. He also testified that he got a different type of crutches for which he paid out of pocket. On cross examination, Petitioner testified that he had a prescription drug card and tried many times to contact that company to have his prescriptions at Streator Drugs filled. He testified that he did not try to have those prescriptions filled elsewhere.

With regard to his physical therapy orders, Petitioner testified that that in 2014 he started having problems with his hands. His doctors recommended physical therapy, which Respondent finally authorized. Petitioner testified that the physical therapy was helpful.

With regard to his psychological care, Petitioner testified that he understands that Respondent will now authorize some psychological care for him. Both of his treating physicians recommended that Petitioner see a psychiatrist. Most recently on January 26, 2015, Dr. Kalina ordered a psychiatric consult for depression, anxiety and chronic pain. PX11. Petitioner testified that he understands that a nurse case manager will be assigned and that he is now going to see a psychiatrist with whom he is willing to cooperate.

Continued Medical Treatment

The medical records reflect that Dr. Xia reviewed and commented on Petitioner's functional capacity evaluation noting that "with his current use of PO medication, he is not capable of any gainful employment." PX4 at 59. Shortly after the FCE, Dr. Xia also noted that based on Petitioner's "current use of PO medication," he could not return to employment. *Id.* Dr. Xia again later opined that "the patient will not be able to return to gainful employment based on this evaluation." PX4 at 41.

With that said, on November 17, 2014, Dr. Xia conveyed his "goal is to have the patient start working again ... ." RX5. The medical records reflect that Petitioner continued to follow up with either Dr. Xia or Dr. Kalina through December 22, 2014. PX4 at 2-117.

"Peer to Peer" – Dr. Baumbach (EK Health)

Respondent offered into evidence a letter dated December 18, 2014 from Dr. Neal Baumbach of EK Health Services. RX5. Dr. Baumbach notes his telephone conversation with Dr. Xia on November 17, 2014 and "[a]s noted in our conversation, we have been asked by our client, Traveler's/Gallagher Bassett, to review [Petitioner's] treatment course to possibly facilitate further rehabilitation from his industrial injuries. This peer to peer correspondence is part of our Next Step Medical Advisory Program(sm) and is not specific to any Utilization Review request or determination. Our goal is to provide you with additional information to consider with a goal of improving function." *Id.*

Dr. Baumbach understood Petitioner's medications at the time to include N-2 Fluriprofen 10%, Tramadol 5%, Gabapentin 4%, Amitriptyline 2%, Lidocaine 5%, Clonidine 0.2% apply QID, Gabapentin (Neurontin) 300 mg #120 QID, Ultram Er 150 mg BID prn, and Opana Er 40mg BID. *Id.* Dr. Baumbach recommended regular drug screens, to speak with Petitioner to explain the focus of cognitive behavioral therapy would be to minimize medications and reduce pain, and that Dr. Kalina be updated on the discussion as he was also primarily treating Petitioner. *Id.*

Disability Opinion – Dr. Xia

On January 26, 2015, Dr. Xia indicated that Petitioner "is under my care[, and he] remains totally and permanently medically restricted due to his work related injury." PX10.

Petitioner testified that he has fully complied with Dr. Xia's and Dr. Kalina's recommendations and that they have not allowed him to return to work. He also testified that he saw Dr. Kalina a week before trial and he was still restricted from work.

Additional Information

Petitioner testified that after the last hearing through the present, he sits at home and watches television, plays video games, or reads books. He explained that he keeps his foot elevated and he experiences more pain and swelling when his foot is low. With the medications, Petitioner testified that his foot pain is usually at a level of 5-6/10. Without the medications, Petitioner testified that his pain is at a level of 10/10.

Petitioner also testified about his psychological state. He explained that he often has mood swings, difficulty concentrating, and becomes depressed, irritated and agitated easily. Petitioner testified that he has little if any appetite and that he will go days without eating. He does not sleep well and does so only a couple of hours per night. With regard to his foot, Petitioner testified that he does not wear anything other than a sock on his foot. He explained that he consistently experiences crushing pain and that his foot is cold to the touch. On cross examination, Petitioner testified that he takes prescription medication every day.

Since August of 2006, Petitioner testified that he has not looked for employment or additional training. He only saw the vocational person. He explained that he did not sign up for community college or have any additional vocational rehabilitation or educational testing other than what he did with Mr. Gustafson. Petitioner denied that Dr. Xia has encouraged him to go back to work or school.

Petitioner also testified that he has not had any in-patient drug counseling. Petitioner acknowledged that Dr. Xia raised the issue of drug counseling, but told him there would be no benefit to undergoing drug counseling.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

In support of the Arbitrator's decision relating to Issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

"Under section 8(a) of the Act (820 ILCS 305/8(a) (West 2006)), a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of her employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury." *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill. App. 3d 463, 470 (4th Dist. 2011) (*citing University of Illinois v. Industrial Comm'n*, 232 Ill. App. 3d 154, 164 (1st Dist. 1992)). Whether a medical expense is either reasonable or necessary is a question of fact to be resolved by the Commission, and its determination will not be overturned on review unless it is against the manifest weight of the evidence. *F&B Manufacturing Co. v. Industrial Comm'n*, 325 Ill. App. 3d 527, 534 (1st Dist. 2001).

As explained more fully above, the Arbitrator finds that Petitioner's condition in the right foot is causally related to his accident at work relying on Petitioner's credible testimony as well as the opinions of his treating physician, Dr. Xia. The medical bills submitted into evidence relate to Petitioner's CRPS condition and its *sequelae*, and are for the reasonable and necessary medical treatment rendered to Petitioner to address his work-related condition. Thus, the Arbitrator awards these medical bills incurred by Petitioner that remain unpaid to be paid by Respondent as provided in Sections 8(a) and 8.2 of the Act.

Additionally, the Arbitrator notes that the Commission expanded the award issued at the first arbitration hearing and ordered Respondent to pay for additional care in the form of "psychological counseling is reasonable, necessary, and causally related to the August 20, 2006 work accident such that Respondent shall be liable for payment of such psychological counseling in addition to the trial spinal cord stimulator." At the time of this arbitration hearing, Petitioner testified that he had yet to receive the psychological counseling ordered by the Commission on June 16, 2011. No evidence was presented by Respondent explaining the lack of authorization for such care as previously ordered by the Commission. However the only treating order for such care appears to have been given by Dr. Kalina shortly before this arbitration hearing. Thus, the Arbitrator notes the Commission's June 16, 2011 decision ordering psychological counseling which is consistent with Dr. Kalina's January 26, 2015 order.

In support of the Arbitrator's decision relating to Issue (K), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

In light of the causal connection analysis explained above, the Arbitrator addresses Petitioner's claim that he is entitled to temporary total disability benefits for the disputed period beginning November 21, 2008 through February 21, 2012.

"The period of temporary total disability encompasses the time from which the injury incapacitates the claimant until such time as the claimant has recovered as much as the character of the injury will permit, i.e., until the condition has stabilized." *Gallentine v. Industrial Comm'n*, 201 Ill. App. 3d 880, 886 (2nd Dist. 1990). The

dispositive test is whether the claimant's condition has stabilized, i.e., reached MMI. *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC at *28 (opinion filed June 26, 2014); *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 760 (4th Dist. 2003).

In this case, the record reflects that Petitioner was undergoing active medical treatment and placed off work by Dr. Xia or Dr. Kalina as it related to the CRPS condition during the claimed temporary total disability period. The independent medical evaluation or Dr. Noren, the utilization review reports, and the peer to peer recommendations made by Dr. Baumbach all support, if not directly confirm, Dr. Xia's diagnosis and Petitioner's need for ongoing medication management and psychological treatment related to the symptoms of his undisputed CRPS condition. There is no evidence in the record that Petitioner was able to work during this period of time. Moreover, no evidence was submitted to controvert Dr. Xia's orders keeping Petitioner off work either from a medical or vocational rehabilitation expert. While Dr. Noren opined that Petitioner was able to perform sedentary work as of June 20, 2013, as explained in the permanency analysis below, the Arbitrator finds Dr. Noren's opinion on this point to be unpersuasive.

Based on all of the foregoing, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits as claimed.

In support of the Arbitrator's decision relating to Issue (L), what is the nature and extent of Petitioner's injury, the Arbitrator finds the following:

The parties assert several theories in furtherance of their positions that Petitioner is or is not permanently and totally disabled. First, Petitioner contends that he is permanently, totally disabled based on the opinions rendered by his treating physician, Dr. Xia. He further argues that he would be permanently and totally disabled under an "odd-lot" theory of recovery. Respondent refutes Petitioner's claim of permanent and total disability under either theory asserting that he has failed to prove as much, and further refutes Petitioner's entitlement to permanent and total disability benefits because he sustained only the loss of one foot, and not both feet, pursuant to Section 8(e)18 of the Act such that the statute should be interpreted to exclude permanent and total disability for loss of only one foot, *expressio unius est exclusio alterius* (the mention of one thing implies exclusion of another). After careful review of the evidence in this case, taken in light of the binding Commission decision entered June 16, 2011, the Arbitrator finds that there is sufficient credible evidence of permanent and total disability based on the opinion of Petitioner's treating physician, Dr. Xia.

After the first arbitration hearing, Petitioner continued to treat with Dr. Xia and Dr. Kalina for pain management. Their medical records reflect no substantive change in Petitioner's condition or any improvement over many years. As of February 21, 2012, Dr. Xia repeatedly pronounced that Petitioner was at maximum medical improvement. On that date, he noted that Petitioner was on medications for "maintenance." As of September 18, 2012 and October 16, 2012, Dr. Xia reiterated that Petitioner was at maximum medical improvement and stated that "unfortunately, he is disabled."

Over the next few years Dr. Xia reiterated Petitioner's CRPS diagnosis and noted substantively unchanged physical examinations. He refilled or adjusted Petitioner's pain medication regimen, but maintained the opinion that Petitioner was at maximum medical improvement. By January 26, 2015, Dr. Xia specifically articulated the conclusion he had been alluding to in his earlier chart notations for several years (e.g., that Petitioner was at maximum medical improvement, "disabled" and unable to work); that is, Dr. Xia stated that Petitioner "is under my care[, and he] *remains* totally and permanently medically restricted due to his work related injury." PX10 (*emphasis* added). Notably, no contrary medical opinion is contained in the record.

Even Respondent's Section 12 examiner, Dr. Noren, had previously agreed with Dr. Xia on June 20, 2013 with regard to Petitioner's CRPS diagnosis and his need for ongoing palliative care. He noted objective evidence corroborating Petitioner's subjective symptoms on physical examination including a temperature difference when comparing the right and left foot, as well as allodynia, lack of sensation in the toes, a slight blue discoloration of the right foot, and reddening of the right foot during the exam. Consistent with the findings of Dr. Xia and Dr. Kalina throughout their treatment—and the opinions given by every physician that has examined Petitioner before the first arbitration hearing and before this arbitration hearing—Dr. Noren opined that Petitioner had complex regional pain syndrome.

Given that the Commission previously found the opinions of Dr. Xia to be persuasive and that Dr. Noren's opinions support the opinions of Dr. Xia, based on the foregoing evidence alone the Arbitrator finds sufficient credible evidence to support a finding that Petitioner is permanently and totally disabled as opined by Dr. Xia. Notwithstanding, the Arbitrator notes additional evidence offered by Respondent which it contends mitigates a finding of permanent and total disability.

First, the Arbitrator addresses the argument that Petitioner could work in some capacity. Petitioner offered the vocational rehabilitation opinion of Mr. Gustafson. On October 19, 2013, he opined that Petitioner was "not currently capable of successfully engaging in and maintaining productive work activity *and likely will not be until such time as improvement in his medical condition renders him able to adequately focus his attention* on specific tasks and standards of performance required of him." PX5 (*emphasis* added).

Petitioner then underwent a functional capacity evaluation that released him at the medium demand level for activity and at the sedentary demand level for endurance. The evaluating physical therapist noted that the "**[m]ain limiting factors for return to work success** are ongoing pain in the R lower leg with and without activity, decreased AROM in the R ankle, decreased isolation and functional strength in the R ankle, and inability to bear weight on the R foot, use of crutches, inability to perform higher intensity or longer duration activity due to pain and medications." PX6 (**emphasis** in original). The results of the functional capacity evaluation were valid.

Mr. Gustafson then issued a second report dated April 14, 2014 in which he indicated that the functional capacity evaluation "appears to add further support to my previously stated conclusion, namely that [Petitioner] is not currently capable of successfully engaging in or maintaining productive employment in any job situation." *Id.* Notably, no contrary vocational rehabilitation expert opinion was offered into evidence explaining how Petitioner could perform work under any circumstances and the medical records show that Dr. Xia's diagnosis and Petitioner's ongoing medical treatment remained fairly constant. Petitioner continued to require medication to manage his severe pain. But, Respondent did offer the opinion of Dr. Noren that Petitioner could work at the sedentary level.

Dr. Noren essentially, if not specifically, agreed with Dr. Xia's diagnosis, course of treatment, and Petitioner's future need for medical care as indicated by Dr. Xia with one exception: he opined that Petitioner could work at the sedentary level. However, "[e]xpert opinions must be supported by facts and are only as valid as the facts underlying them." *Gross v. Ill. Workers' Comp. Comm'n*, 2011 IL App (4th) 100615WC, *16-17, 960 N.E.2d 587, 594 (4th Dist. 2011) (*citing In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003)). Dr. Noren did not have any job description or knowledge of Petitioner's duties at work and he based his opinion that Petitioner could work at the sedentary level on the gait Petitioner demonstrated on the day of the evaluation, his review of limited medical records, and one physical examination.

Dr. Noren's opinion about Petitioner's capacity to work is not reflective of Petitioner's physical capabilities on most days as observed by his treating physician Dr. Xia or his partner, Dr. Kalina, over years of treatment and after a multitude of physical examinations. Moreover, Dr. Noren lacked relevant information about Petitioner's job duties when he rendered this opinion. Given the lack of information on which Dr. Noren based his opinion, the Arbitrator finds Dr. Noren's opinion that Petitioner could work at some level to be unpersuasive.

Next, the Arbitrator addresses the two utilization review reports finding that Petitioner's medication regimen was not entirely necessary. However, the record consistently reflects the opinions of both Petitioner's treating physicians and Respondent's evaluating physicians alike that Petitioner has CRPS with subjective symptoms correlated by objective medical evidence. Neither Dr. Harsoor of Coventry nor Dr. Khalifa of MedAllocators/ASN examined Petitioner at any time. Moreover, neither physician appears to have had all of Petitioner's medical records at the time he rendered opinions regarding the appropriateness of Petitioner's medication regimen. In this context, the Arbitrator is not persuaded by the opinions of Dr. Harsoor or Dr. Khalifa about the appropriate course of medication management for Petitioner.

Finally, the Arbitrator addresses Dr. Baumbach's "peer to peer" recommendation report. Dr. Baumbach reviewed a portion of Petitioner's treating medical records and then made recommendations to Dr. Xia after a conversation with him about Petitioner's ongoing course of care. As reflected in his report, Dr. Baumbach lacks a complete understanding of Petitioner's clinical presentation over many years. The report does not reflect that he had all of Petitioner's medical records at his disposal. Moreover, Dr. Baumbach never examined Petitioner when he rendered advice to Dr. Xia about how to manage Petitioner's ongoing pain and CRPS condition. In this context, as with Drs. Harsoor and Khalifa, the Arbitrator is not persuaded by the opinions of Dr. Baumbach about the appropriate course of medication management for Petitioner.

The medical records dated after the first arbitration hearing show no substantive change or improvement in Petitioner's condition despite medication adjustments over many years. Respondent's proposition that adjusting Petitioner's medications to less expensive generic options or weaning him off of a narcotic medication might allow him to work in some capacity is not persuasive given the totality of the medical evidence. Moreover, the propriety of any treating physician's orders for use of one medication over another must be addressed in the context of the medical evidence as a whole. Respondent could have sent Petitioner to another independent medical evaluation with the entirety of Petitioner's medical records and inclusive of a physical examination to opine on Petitioner's long-term medication management needs. Respondent did not do so. Given all of the foregoing, the Arbitrator is not persuaded that Dr. Harsoor, Dr. Khalifa, or Dr. Baumbach were in as advantageous a position as Dr. Xia to determine the most appropriate course of medical treatment for Petitioner or, by extension, that he would somehow return to work if his medications were managed as described by Drs. Harsoor, Khalifa, or Baumbach who never physical examined him.

Ultimately, there is no evidence of improvement or substantive change in Petitioner's physical condition after the first arbitration hearing in this case, and certainly since he was placed at maximum medical improvement by Dr. Xia on February 21, 2012. Every treating and evaluating physician agreed that Petitioner has CRPS and that he requires long-term medication management and psychological treatment to address his ongoing symptoms as related to the condition. A review of the medical records and even Dr. Noren's report shows that Petitioner reached maximum medical improvement long ago.

The Commission previously found the opinions of Dr. Xia to be persuasive in its June 16, 2011 decision and no further appeals were taken. No physician disputes Petitioner's diagnosis of CRPS. Nothing in the medical

records, or in any evaluations performed at Respondent's request, suggests that Petitioner's condition has improved or substantively changed. When Dr. Xia opined that Petitioner was permanently and totally disabled, he specifically noted that Petitioner remained, and had not just become, so disabled. No contrary medical opinion was offered and no contrary vocational opinion was offered establishing that Petitioner could work in any capacity despite years during which to attempt to obtain such opinions.

Based on all of the foregoing, the Arbitrator finds that Petitioner has established through credible and persuasive evidence that he is permanently and totally disabled as of February 21, 2012 when he reached maximum medical improvement.

In support of the Arbitrator's decision relating to Issue (M), whether penalties or fees should be imposed upon Respondent, the Arbitrator finds the following:

Finally, the Arbitrator finds that additional compensation is due to Petitioner and shall be imposed upon the Respondent pursuant to Sections 19(l), 19(k) and 16 of the Act. Section 19(k) of the Act provides in pertinent part:

> In case where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which do not present a real controversy, but are merely frivolous or for delay, then the Commission may award compensation additional to that otherwise payable under this Act equal to 50% of the amount payable at the time of such award. Failure to pay compensation in accordance with the provisions of Section 8, paragraph (b) of this Act, shall be considered unreasonable delay. 820 ILCS 305/19(k) (Lexis 2006).

Section 19(l) provides in pertinent part:

> If the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In the case of demand for payment of medical benefits under Section 8(a), the time for the employer to respond shall not commence until the expiration of the allotted 60 days specified under Section 8.2(d). In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $ 30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $ 10,000. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay. 820 ILCS 305/19(l) (Lexis 2006).

Section 16 of the Act provides for an award of attorney fees where an employer, its agent, service company or insurance carrier "has been guilty of delay or unfairness towards an employee in the adjustment, settlement or payment of benefits due such employee within the purview of the provisions of paragraph (c) of Section 4 of this Act; or has been guilty of unreasonable or vexatious delay, intentional under-payment of compensation benefits, or has engaged in frivolous defenses which do not present a real controversy, within the purview of the provisions of paragraph (k) of Section 19 of this Act, the Commission may assess all or any part of the attorney's fees and costs against such employer and his or her insurance carrier." 820 ILCS 305/16 (Lexis 2006).

In this case, Respondent offers no credible explanation, if any, as to its failure to pay certain outstanding medical bills awarded at the first arbitration hearing in a timely manner or for its failure to otherwise comply with provisions of the Commission's June 16, 2011 order. Respondent was aware of substantial outstanding medical bills including an outstanding balance to Fullerton-Kimball Surgical Center for a total of $2,996.00 for services on July 16, 2008 and October 22, 2011. The record does not indicate any effort by Respondent to address these bills despite the Commission's June 16, 2011 decision. Moreover, Respondent's argument that it is unclear from the record whether Petitioner tendered bills containing "substantially all the required data elements necessary to adjudicate the bills" as required by Section 8.2 of the Act is unconvincing.

Respondent appears to reference the decision in *Springfield Urban League* noting that "[i]f the claim does not contain substantially all the required data elements necessary to adjudicate the bill, or the claim is denied for any other reason, in whole or in part, the employer or insurer shall provide written notification, explaining the basis for the denial and describing any additional necessary data elements, *to the provider* within 30 days of receipt of the bill." *Springfield Urban League v. Ill. Workers' Comp. Comm'n*, 2013 IL App (4th) 120219WC *P38 (4th Dist. 2013) (*emphasis* added) (citing 820 ILCS 305/8.2(d)(2) (West Supp. 2011)). However, there is no evidence in this record that Respondent made any efforts to get any additional information it now claims was necessary to pay the bills from the providers as indicated in *Springfield Urban League*, or Petitioner for that matter, which were refuted resulting in its delay in payment over years. To the extent that Respondent contends it asked Petitioner for additional information, no such evidence was submitted at trial. To the contrary, Petitioner testified that he was never asked for anything additional to assist Respondent in payment of awarded medical bills or causally related medical bills and Petitioner's mother testified that their inquires to have prescriptions paid were met with flat, unexplained denials. Respondent offered no letters, testimony, or other evidence of its reasonable efforts to pay for medical services awarded by the Commission.

Respondent was also aware of unreimbursed prescription expenses claimed by Petitioner. From January 18, 2010 through August 1, 2014, Petitioner repeatedly requested payment of such expenses. PX9. Respondent offered no letters, testimony, or other evidence of its reasonable efforts to pay for these prescriptions. While Respondent obtained utilization reviews and a "peer to peer" report suggesting that Petitioner should use generic medications where possible and completely discontinue use of other medications, as explained above, none of these reviewers had all of Petitioner's medical records at their disposal and none of these physicians examined Petitioner. Even so, Respondent offered no evidence suggesting that Petitioner should have been off of all of the medications prescribed to him. Given the Commission's June 16, 2011 decision finding causal connection followed by Dr. Noren's June 20, 2013 report that Petitioner indeed has CRPS requiring current and future palliative care, Respondent's refusal to pay for Petitioner's prescription medications was unreasonable.

Based on all of the foregoing, the Arbitrator awards Section 19(k) penalties in the amount of $1,498.00 ($2,996.00 x 50%) and Section 16 attorneys' fees in the amount of $299.60 ($1,498.00 x 20%) for Respondent's failure to pay the Fullerton-Kimball Surgical Center outstanding balance. The Arbitrator also awards Section 19(k) penalties in the amount of $12,592.14 ($25,184.27 x 50%) and Section 16 attorneys' fees in the amount of $2,518.43 ($12,592.14 x 20%) for Respondent's failure to reimburse Petitioner's out-of-pocket prescription medication costs. Finally, the Arbitrator awards penalties pursuant to Section 19(l) in the maximum amount of $10,000. The record contains dozens of pages of requests and demands to Respondent for payment. Petitioner's testimony at trial confirms that he sought payment of his outstanding bills and for prescription medications to no avail.

STATE OF ILLINOIS	)	☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF COOK	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CARLOS ANDINO,

Petitioner,

16IWCC0215

vs.

NO: 07 WC 06194

TEMPLE STEEL,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causal connection, medical expenses, temporary total disability, permanent partial disability, and evidentiary ruling, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

At the time of arbitration, Petitioner made an oral motion to amend the Application for Adjustment of Claim (hereinafter "Application") in this matter, to amend the date of accident from November 1, 2006 to February 19, 2007, "to conform to the proofs." (T45). Petitioner's attorney argued that the correct manifestation date was February 19, 2007, based upon the evidence adduced at trial, and that he should be allowed to amend the Application to reflect same. (T48-49). The Arbitrator denied Petitioner's oral motion to amend the Application, finding that while Respondent's witness, Rhonda Pencak, testified that she became aware of the alleged accident on February 19, 2007, Pencak did not testify as to a "manifestation" date of February 19, 2007. (T49).

In McLean Trucking v. Industrial Commission, 96 Ill.2d 213(1983), the Court found that there was no error by the Commission in allowing the claimant to amend his Application to conform to the proofs, by amending the date of the accident. The Court noted that the

Respondent had ample opportunity to meet the change because the change did not require additional evidence but was simply a motion to amend the pleading to conform to the evidence already in the record. The Court noted:

> ""In pleadings under a compensation act, calling things by wrong names, or bringing a petition under a wrong title, or making other harmless mistakes as to details such as dates, are immaterial if the intention of the pleading is clear.' (3 A. Larson, Workmen's Compensation sec. 77A.42 (1983)). Larson goes on to state: 'As to variance between pleadings and proof, wide latitude is allowed." (3 A. Larson, Workmen's Compensation sec. 77A.45 (1983).)"'

The Court found that the Commission's finding that the Respondent had ample opportunity to meet the change in date of the accident, that the change did not require additional evidence, and that it was simply a motion to amend the pleadings to conform to the evidence already in the record, was not against the manifest weight of the evidence. The Court noted that of importance was that the employer was not prejudiced by the amendment, and that any complaint McLean Trucking had to the amendment was waived by its failure to object to the motion.. McLean v. Industrial Commission, 96 Ill.2d 213, 219(1983).

Based upon the Court's ruling in McLean v. Industrial Commission, 96 Ill.2d213(1983), the Commission finds the Arbitrator erred in denying Petitioner's oral motion to amend the Application to reflect a new date of accident, as there was no basis for the denial of the motion to amend, no showing of a prejudice to Respondent, and no objection by Respondent to the oral motion to amend. Accordingly, the Commission reverses the Arbitrator's ruling as to Petitioner's motion to amend the date of accident from November 1, 2006 to February 19, 2007. However, the Commission finds the Arbitrator's error was harmless error, as Petitioner failed to prove accident or causal connection with regard to either date of accident, November 1, 2006 or February 19, 2007.

With regard to the initially alleged date of accident of November 1, 2006, the Commission affirms and adopts the Arbitrator's finding with regard to Petitioner's failure to prove an accidental injury arising out of and in the course of his employment with Respondent.

With regard to the amended alleged date of accident of February 19, 2007, the Commission finds Petitioner failed to prove accidental injuries arising out of and in the course of his employment, or a causal connection between the alleged injury and his current condition of ill-being. In so finding, the Commission relies on the more credible testimony of Rhonda Pencak, the contemporaneous medical records, the employee health record, and the more persuasive opinions of Dr. Coe.

Petitioner testified his job duties as a machine operator required him to pick up 60-70 lbs of metal, every 2 or 3 minutes, to put them in a box, tie them up rapidly with wire, and pliers in his right hand, lift them up, and put them in a box. Petitioner testified he performed these duties all day long, and that he also was required to oil the machine and check on pieces. (T9-15). Petitioner testified that as he performed these job duties in 2006, he noticed that when he "put the piece here" he felt lot of pain in neck and both elbows. Petitioner testified he then called the

Disclaimer:

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company nurse, Rhonda, his personnel boss, and the head of personnel, and that those three individuals then came to him to talk to him. Petitioner testified he then sought medical care with Dr. Esperanza Flores on October 24, 2006, and then with a chiropractor at Quiropracticos. Petitioner testified the chiropractor provided him with physical therapy to his hands and neck, but that it provided no benefit at all, and that he was then referred to Dr. Padron. Petitioner testified he was laid off by Respondent on November 17, 2006, that he began receiving unemployment thereafter, and eventually he began working for new employer, Wheatland Tube, and that he is presently working for a new employer, inspecting small plastic pieces. (T16-20).

A review of the record as a whole indicates Petitioner testified or alleged multiple dates of accident, including the following: 1) the original Application filed February 11, 2007 reflected a date of accident of November 1, 2006; 2) the February 21, 2007 "Request for Treatment" form from Los Quiropracticos reflects he "was injured at work on 11-17/16"(PX1); 3) the February 21, 2007 Patient Questionnaire and Consultation visit note from Los Quiropracticos both reflect a date of injury of "11/17/06"(PX1); 4) on cross examination, Petitioner admitted he was claiming he sustained an accident with Respondent on October 24, 2006, the date he sought treatment with Dr. Flores at Advocate Health Centers(T21); and, 5) the initial treating records from Dr. Flores of October 24, 2006 and November 20, 2006 contain no history of a work related injury or mechanism of injury(PX2).

Although Petitioner testified he advised Dr. Flores, with whom he initially sought treatment, that he had suffered a work-related injury, the records from October 24, 2006 office visit and from his November 20, 2006 office visit, for bilateral hand complaints, fail to reflect any mention of a work-related condition or of any mechanism of injury. (T21, PX3). Petitioner admitted on cross examination that Dr. Flores' records were silent with respect to a history of work-related injury. Petitioner also admitted that at the time of his initial office visit with Dr. Flores on October 24, 2006, the doctor only examined his hands, and no treatment was rendered with respect to his back, neck, or elbows, and he was diagnosed with mild arthritic changes of his hands at that time. (T21-25).

The Commission gives significant weight to the testimony of Rhonda Pencak, who was previously employed as Respondent's Health and Safety Administrator from June 2005 through February 2015, and Petitioner's Employee Health Record (RX3), which contains numerous entries for non-related medical issues over the years, but which was void of any mention of any work-related condition on or about November 1, 2006 or February 19, 2007, with respect to his neck, hands or elbows. Pencak testified while she was employed by Respondent as the Health & Safety Administrator, she was responsible for health and safety, OSHA compliance, workers compensation, various other training issues, and that as a an Illinois licensed paramedic, she also was responsible for administering first-aid for any work-related or non-work-related injuries and illnesses at that plant. Pencak testified all of Respondent's employees were required to report all injuries right away to her, and/or their supervisor or manager of the department. She further testified she kept a log with respect to the employees that came to see her for medical treatment, and that Petitioner's health record reflects the dates he came into first aid area for treatment, dating back to November 9, 1987. Pencak testified that anytime an employee was seen for a work-related or non-work-related injury she recorded it on the log. Pencak testified that Petitioner's Health Record log (RX3) reflects she saw him on May 10, 2006 for a blood pressure

check, and that to her recollection she did not see him in the first-aid department after that May 10, 2006 date. Pencak further testified that neither Petitioner nor any of his supervisors ever came to her to tell her that Petitioner had suffered a work related injury to his elbows, hands, neck or back, and that the first time she learned that Petitioner was claiming a work-related injury was when she received the Application in the mail, which was on or about February 19, 2007, when she completed the First Report of Injury for this claim. Pencak testified she completed the Form 45 on February 19, 2007, correlating with the date she received the Application. (RX2, T32-40).

Petitioner argues that Petitioner's current condition of ill-being with respect to his right arm, right hand and neck manifested itself on or about February 19, 2007, the date the injury was reported to Respondent. Petitioner, citing Durand v. Industrial Commission, 224 Ill.2d 53(2006), argues that based upon the evidence presented at hearing, the manifestation date should have been February 19, 2007, "when it was apparent to a reasonable person that a causal connection existed between Petitioner's work duties and his work." Petitioner argues that he sought treatment two days later, on February 21, 2007, and that at that date, for the first time such relationship was proffered by a doctor noting that Petitioner's neck, elbow, and wrist pain was due to "accumulative trauma. Petitioner argues that while he was initially alleging a manifestation date of October 24, 2006, the medical records do not clearly show that he was crediting his work activities for his condition for which he sought medical care that day, that Dr. Flores merely diagnosed arthritis in the hands that day, and that the records show Petitioner believed his condition was work-related on February 19, 2007 when his injury was first reported to his employer.

While Pencak admitted on cross-examination that it appeared that Petitioner's first complaint to her about any hand or neck problems was on February 19, 2007, when she received the Application, and that would be the "manifestation date," the Commission finds Pencaks' admission was the date she was made aware of Petitioner's claimed work-injury, the date she took possession of the Application, and not an admission as to when Petitioner's medical condition manifested itself. (T43-44).

Although Chiropractor Vargas opined Petitioner's cumulative trauma injury was caused by his work (PX1), the Commission finds no evidence within the record to reflect that Chiropractor Vargas had an understanding of Petitioner's work duties or the alleged mechanism of injury, and this causal connection opinion was offered 12 days after Petitioner signed the Application for Adjustment of Claim. Petitioner subsequently sought treatment with Dr. Padron, during which time Petitioner provided a history of long standing neck discomfort that became progressively worse over 9 years. Dr. Padron specifically noted that Petitioner denied any inciting trauma, and that it was a slow insidious progression of discomfort of pain that became significant in November of 2006. The Commission finds significant that Dr. Padron's office notes contain no opinion on the issue of causal connection, is void of any mention of Petitioner's work duties, and contains no information as to the alleged mechanism of injury. (PX2).

In further support of the Commission's finding that Petitioner failed to prove a causal connection between the alleged work-related injury of February 19, 2007 and his current condition of ill-being, the Commission finds persuasive the opinions of Respondent's Section 12

CANCELLED

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examiner, Dr. Jeffrey Coe, who examined Petitioner on June 19, 2007. Dr. Coe recorded a history that Petitioner was employed by Respondent as a punch press operator for 18-1/2 yrs, that his work required daylong repetitive use of his upper extremities, that he was responsible for moving parts in and out of machines at a fast pace, that he began to have pain in his neck, hands and right elbow region, and that he then sought treatment with a chiropractor, who referred him to Dr. Padron. Dr. Coe opined that based upon Petitioner's findings on examination, he was unable to identify any injury or abnormality that could or might have arising from Petitioner's work for Respondent. Dr. Coe further opined that Petitioner's current findings of mild bilateral lateral epicondylar tenderness was nonspecific, that his symptoms did not improve even though away from work for 7 months, that Petitioner was not injured at work for Respondent, that he has no impairment or disability from work as a machine operator, and that he requires no medical treatment for any condition that might have arisen from work for Respondent. (RX4).

Based upon a review of the record as a whole, the Commission finds Petitioner failed to prove accidental injuries arising out of and in the course of his employment on February 19, 2007.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 18, 2015 is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Petitioner's Motion to Amended his Application for Adjustment of Claim from a date of accident of November 1, 2006 to February 19, 2007 is hereby granted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 4 2016
KWL/kmt
O-03/07/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0215

ANDINO, CARLOS
Employee/Petitioner

Case# 07WC006194

TEMPEL STEEL
Employer/Respondent

On 5/18/2015, 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 0.08% 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:

0147 CULLEN HASKINS NICHOLSON ET AL
JOSE M RIVERO
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0445 RODDY LAW LTD
PAUL SCHUMACHER
303 W MADISON ST SUITE 1500
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ 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

16IWCC0215

CARLOS ANDINO
Employee/Petitioner

v.

TEMPEL STEEL
Employer/Respondent

Case # **07 WC 6194**

Consolidated cases: _____

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 **Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **April 9, 2015**. 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 _____

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FINDINGS

On November 1, 2006, 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 not*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was not*** given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**38,480.00**; the average weekly wage was $**740.00**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **0** dependent children.

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

Respondent has paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $0.00 for other benefits, for a total credit of $0.00.

Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

The petitioner has failed to prove, by a preponderance of the evidence, that he sustained an accident that arose out of and in the course of his employment with Respondent; therefore no benefits are awarded, pursuant to the Illinois Worker's Compensation 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.

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FINDINGS OF FACTS

The disputed issues in this matter are: 1) accident; 2) notice; 3) causal connection; 4) medical services: 5) temporary total disability; and 6) the nature and extent of Petitioner's injuries. *See,* AX1.

Carlos Andino, ("Petitioner"), was an employee at Tempel Steel ("Respondent") for 19½ years and was a machine operator/punch press operator for those years. The petitioner worked with a punch press, which involved bringing the metal product to the machine, pressing and binding it, then putting it in its proper place. The metal was 12 inches long and was cylindrical. It had a diameter of approximately one centimeter. Once the product was punched, the cylinders were bound together into a six-inch bundles, which would vary in weight, depending upon the metal that was being pressed.

The petitioner would then tie the bundles with wire, then put them in a box. In addition to utilizing the punch press, the petitioner was also set up the press, oiled the machine and cleaned his work area. The petitioner has alleged that as a result of these activities, he suffered injuries to his back, neck and elbows and he filed a workers' compensation claim.

Petitioner's treatment

On October 24, 2006, the petitioner sought medical care from Dr. Esperanza Flores however; he did not provide a work-related history for the care. The petitioner complained of pain in his hands and Dr. Flores diagnosed him as suffering from osteoarthritis of his hands. PX3.

The petitioner continued to work as a machine operator/punch press operator until he accepted an early retirement from Tempel Steel, on November 17, 2006, signing a document with respect to his early departure. RX5.

The petitioner applied for and received unemployment benefits. The petitioner did not find work for approximately two years after his departure from Tempel Steel.

On February 21, 2007, the petitioner next sought treatment from Los Quiropracticos LLC and specifically, Dr. Gavin. At this facility, the petitioner received physical therapy for his hands, arms and neck. The petitioner testified he received no benefit from any of the care from this facility. PX1.

The petitioner was examined and evaluated by Dr. Jeffrey Coe, a board certified occupational medicine physician, by request of the respondent. Based on the findings of the examination, Dr. Coe could not "identify any injury or abnormality that could or might have arisen from Mr. Andino's work at Tempel Steel. His current finding of mild bilateral lateral epicondylar tenderness is nonspecific and his symptoms have not improved even though he has been away from work for seven months." It is Dr. Coes' opinion that the petitioner was not injured at work and had no impairment or disability due

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to work as a machine operator; and did not need medical treatment for any conditions that could or might have arisen from his work for Respondent. RX4.

Testimony of Rhonda Pencak

Rhonda Pencak testified on behalf of Tempel Steel. Ms. Pencak was the health and safety representative from Tempel Steel. She testified that she never received any notice of a work-related injury or accident from this petitioner. Ms. Pencak identified, as did the petitioner, the records from the health and safety department, which indicated that the petitioner had been to that department on prior occasions; and there was no entry for a visit on or about October 24, 2006 or November 17, 2006.

The last time the petitioner went to the health and safety department, he had his blood pressure checked on May 10, 2006. Ms. Pencak testified that the first time she became aware of a work-related claim was when she took receipt of Petitioner's Application for Adjustment of Claim in February of the following year, 2007. Ms. Pencak testified that at no time did the petitioner ever provide her notice of a work-related condition or accident, nor did anyone from Tempel Steel ever inform her of an accident by the petitioner. RX1 & 3.

Petitioner subsequently moved that he be allowed to change the date of accident after the testimony of Ms. Pencak, claiming that the date that she became aware of the accident was the manifest date of the accident. This oral motion was denied by the Arbitrator.

CONCLUSIONS OF LAW

C. Did an accident occur which arose out of and in the course of Petitioner's employment by Respondent?

A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v Industrial Commission*, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a casual connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v Industrial Commission*, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin vs. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec. 1,

437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).

It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); *see also, Hansel & Gretel Day Care Center v Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

The petitioner testified that as a result of operating his machine or punch press, he suffered injuries to his elbows, neck and back. The petitioner failed to testify as to a specific accident date. The petitioner has alleged multiple dates of accident, which are evidenced by the petitioner's initial Application for Adjustment of Claim, which alleged an accident of November 1, 2006. Thereafter, an accident was alleged of October 24, 2006, and ultimately, February 17, 2006. Petitioner's medical records from Dr. Flores are devoid of any work related history. The health and safety records have no entry of petitioner advising of an accident or an injury at the work place, however, petitioner was well aware of where this department was and had been there on multiple occasions including the earlier visit where petitioner had his blood pressure checked. Ms. Pencak specifically testified that she was unaware of any accident or injury at the work place until Tempel Steel, the following year, took receipt of petitioner's Application for Adjustment of Claim.

The petitioner's treating records from Drs. Gavin and Padron contained histories that the petitioner began to experience neck discomfort, approximately nine years prior to the date of accident and the symptoms had become worse in November 2006. Once again, there is no mention of a traumatic event, at the onset of these symptoms. Dr. Padron, Petitioner's treating physician, concluded that the petitioner had the insidious progression of neck discomfort over the ensuing years and was now responding to therapy, as treatment was being provided. Once again, the histories are devoid of any specific work-related trauma.

The Arbitrator finds Petitioner has failed to prove, by a preponderance of the evidence, that he sustained an accident, which arose out of and in the course of his employment by Respondent. In that the petitioner has not proven that an accident occurred, the remaining disputed issues are moot and will not be addressed.

16IWCC0215

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
07WC6194
SIGNATURE PAGE

L Thompson Smith
Signature of Arbitrator

May 18, 2015
Date of Decision

MAY 18 2015

STATE OF ILLINOIS	)	☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF COOK	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ADAM BARKER,

Petitioner,

16IWCC0217

vs.

NO: 07 WC 29614

WAL-MART,

Respondent.

DECISION AND OPINION PURSUANT TO SECTIONS 19(h) and 8(a)

This claim comes before the Commission on Petitioner's Petition for Review under Sections 19(h) and 8(a), filed February 10, 2014. Commissioner Basurto conducted a hearing in this matter on May 28, 2015, at which time counsel for Petitioner and Respondent were present and a record was made. Oral arguments were heard in this matter on February 8, 2016, at which time Petitioner withdrew the Petition for Review under Section 19(h).

After considering the issues, including medical expenses, temporary total disability, prospective medical, and permanent partial disability, and being advised of the facts and law, the Commission denies Petitioner's Petition for Review under Sections 19(h) and 8(a), finding that Petitioner failed to prove a material increase in his disability since the date of Arbitration, August 4, 2008, and that Petitioner failed to prove his current condition of ill-being is causally related to his work related injury of June 23, 2007. Petitioner's demand for an award of medical expenses, temporary total disability benefits, and increased disability is denied.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. On July 3, 2007, Petitioner filed a workers' compensation claim, alleging accidental injuries arising out of and in the course of his employment with Respondent on June 23,

2007, when his hand became wedged between the handle of a hand operated fork-lift and a steel cabinet in the freezer. On August 4, 2008, this matter proceeded to arbitration before Arbitrator Mathis. Petitioner was represented by counsel at the time of hearing.

2. On June 23, 2007, Petitioner, a 25 year-old stocker sustained a left index finger and left hand injury when his left hand became wedged between the handle of the hand operated fork-lift and a steel cabinet in the freezer, with Petitioner sustaining a near amputation of his left index finger. Petitioner was diagnosed with a crush injury to the left hand and left index finger, an open fracture of the left second phalanx of the index finger, and a fracture of the second metacarpal bone of the left hand. Petitioner then underwent a left index finger amputation on October 29, 2007. His treating doctor, Dr. Brown, then released him to return to work full duty, and discharged him from care, as of December 7, 2007. Petitioner was subsequently seen in follow up by Dr. Brown on one final occasion, May 9, 2008, with complaints of pain in his volar forearm and a report of one episode of tremulous shaking of his left upper extremity. At the time of his May 9, 2008 office visit, Dr. Brown noted a normal clinical exam, and again discharged Petitioner from care and released him to return to work without restrictions.

3. At the time of the August 4, 2008 arbitration hearing, Petitioner testified that he had continued to work for Respondent without restrictions since his December 4, 2007 return to work, that he had not undergone any additional treatment to date, that he had complaints of occasional pain in his left hand and left middle finger, and some discoloration in his finger when he goes into the freezer. Petitioner testified that his ongoing symptoms were gradually improving. (08/04/08 Transcript, p. 26-28).

4. On October 8, 2008 the Arbitrator issued a Decision, finding that Petitioner sustained accident injuries arising out of and in the course of his employment on June 23, 2007, that Petitioner provided timely notice of the accident, that Petitioner's current condition of ill-being is causally related to the accident, that necessary medical expenses have been provided by Respondent, and that Respondent shall pay permanent partial disability benefits of $264.02 per week for 63.5 weeks because the injury sustained caused the 100% loss of use of the left index finger and 10% loss of use of the left hand.

5. Neither party sought review of the October 8, 2008 Arbitration Decision.

6. On February 10, 2014, Petitioner filed a Petition for Review under Section 19(h) and 8(a). On May 28, 2015, a hearing on Review was held before Commissioner Basurto, at which time both parties were present and a record of the proceedings was made.

7. At the time of the hearing on Review, Petitioner's counsel represented that Petitioner underwent additional medical treatment related to his work injury-sympathetic mediated pain syndrome, that Petitioner is entitled to an award of medical bills incurred and an award of prospective medical treatment, that Petitioner is entitled to an award of additional temporary total disability benefits from November 9, 2011 through January 30, 2012, and that Petitioner is entitled to an additional permanent partial disability award of 20% loss of use of the man as a whole due to ongoing mediated pain syndrome and an

award of 20% loss of use of the left hand as a result of his surgery for ulnar abutment syndrome and a TFCC tear.

8. Petitioner testified that after his finger amputated in late 2007, his left hand and wrist and all the way up his upper arm felt horrible, and turned black and flue. He testified that following his release from Dr. Brown's care in 2008, his hand and wrist were still very painful, and turned black and blue, with most pain while stocking and working in freezers at work. He further testified he continued to work for Respondent from the date of his full duty release up until the present. (T29-36).

9. Petitioner testified he eventually returned to Dr. Brown for treatment in October 2010, and then again on May 3, 2011, and that he waited so long to return to Dr. Brown as he thought it would get better, but it did not improve. (T36-37). On May 9, 2011 he underwent a bone scan of the left hand, revealing an abnormal uptake of the medial aspect of the proximal carpal bones, and an EMG of the left upper extremity, revealing mild median mononeuropathy in the left wrist. (PX8, PX9). On November 3, 2011, an MRI of the left hand revealed a cyst with some low-level bone marrow edema of lunate and triquetral bone likely related to degeneration, as well as partial tears involving the base of the TFCC, and very mild, early arthritis of 1st carpal-metacarpal joint with some early degeneration of the ligaments. (PX10).

10. On November 9, 2011, Dr. Brown performed a left wrist arthroscopy with arthroscopic wafter procedure. Dr. Brown's post-operative diagnosis was left wrist pain with probable ulnar abutment syndrome. (PX11). Petitioner testified and the parties stipulated he was authorized off work from November 9, 2011 until January 31, 2012. Petitioner testified that his left hand pain did not cease after that, that it was actually worse, and that while post-operative physical therapy strengthened his left hand he still had pain and noticed his hand turned black and blue when working in coolers at work. (T38-39).

11. Petitioner testified that on March 7, 2013, he sought a second opinion with Dr. Oakey because he did not think he was getting the best medical care with Dr. Brown. Dr. Oakey recorded a history of left hand and wrist pain that began around the time of his forklift accident in 2007, and that despite his recent wrist arthroscope and ulnar wafer surgery in November, Petitioner reported no relief of his symptoms. Petitioner complained of pain over ulnar aspect of his wrist, worse w/ movement and use, and with pain radiating proximally and distally, and swelling. Dr. Oakey diagnosed ulnar sided wrist pain, possible ECU tendonitis or extensor carpi ulnaris. Dr. Oakey opined that he did not "think this has any relationship to the pain he has from his ray resection," and performed an injected of the left ECU tendon sheath. (PX4 at T12, PX14). Petitioner was seen in follow up on April 16, 2012 and on May 31, 2012, with complaints of no relief from the injections. On May 31, 2012 Dr. Oakey recommended Petitioner undergo a functional capacity evaluation and pursue long term pain management. (PX14).

12. On July 16, 2012, Petitioner returned to Dr. Oakey, at which time the doctor noted: "main issue with this is causality. He had a forklift injury to his left hand resulting in amputation in 2007. He reports being pinned behind the forklift. Very likely given his

lack of preoperative symptomatology that he did have his TFCC tear and potentially even traumatic ulnar carpal abutment from this, which are both seen by Dr. Brown on the scope and MRI. I do believe this is causally connected to that injury." At that office visit, Dr. Oakey again recommended a functional capacity evaluation.

13. On April 8, 2013, Petitioner returned to Dr. Oakey with continuing complaints of left wrist pain in the ulnar aspect of wrist that radiated proximally and distally, aggravated by repeated gripping and pulling activities. Dr. Oakey performed an additional ECU tendon sheath steroid injection, and referred Petitioner to Dr. Naour for his current lumbago complaints and his arm. (PX14).

14. Petitioner testified that he had not undergone the FCE as of the date of hearing, but that he was seen by Dr. Naour on April 8, 2013, and that he continues to treat with him for mediated pain syndrome, receiving pain medication. Petitioner testified he if he does not take the medications prescribed by Dr. Naour, he has hand pain and his hand turns black and blue. Petitioner testified the pain medications assist him with performing his work duties, and that currently he has no lingering pain in his hand. (T40-44).

15. On cross examination, Petitioner admitted that he injured his left hand and left index finger at the time of his 2007 work injury, and that prior to the August 4, 2008 arbitration hearing, his last office visit with his doctor was on May 9, 2008. Petitioner admitted that at the time of that 2008 hearing he testified to some ongoing pain in his fingers and some discoloration of his hand, but that he could not recall if he testified to having any pain in his wrist. Petitioner admitted that if the arbitration transcript from 2008 indicated he did not testify to any left wrist pain, then that would be correct. Petitioner also admitted that after the 2008 arbitration hearing, he did not seek treatment with Dr. Brown until March 23, 2010, and that at that office visit his complaints were of about the first web and long finger. Petitioner also admitted that he sought no additional treatment then until May of 2011, and that from the date of the August 4, 2008 arbitration hearing until May of 2011, he worked full duty without restrictions. Petitioner further testified he was unsure if he reported any new complaints or a new work injury at his May 2011 office visit. (T44-49).

16. Petitioner admitted that on August 17, 2011, he went to see his attorney about his complaints, and filed a new Application for Adjustment of Claim for a repetitive trauma claim, 11 WC 32259 for date of accident of May 9, 2011. (T49-58, RX1). Petitioner admitted that when he was seeking benefits in 2007, it was for his left hand and left arm. Petitioner admitted he returned to Dr. Brown on 09/27/11, but that he was not sure if the his treating records reflect that the first time he complained of ulnar-sided wrist pain was at the time of his September 27, 2011 office visit with Dr. Brown. Petitioner admitted that after he filed the new Application in August 17, 2011, his attorney sent him back to his employer to report a new work injury, and that he then completed a written report concerning that accident. Petitioner admitted that RX3 is the written statement he completed on August 22, 2011, and that his 2011 claim is still pending. (T49-58).

17. Petitioner testified on cross examination that he was unable to comment on whether his

treating physician, Dr. Brown, stated in a March 5, 2012 letter that he could not say whether work caused his ulnar abutment syndrome, that he could not remember that letter. However, Petitioner admitted that he first sought treatment with Dr. Oakey on March 7, 2012, two days subsequent to the March 5, 2012 letter from Dr. Brown. (T59-66).

18. On March 5, 2012, Dr. Brown issued a letter to Petitioner's Attorney, in response to his letter, summarizing Petitioner's treatment with him, for ulnar abutment syndrome and TFCC care. Dr. Brown stated that ulnar abutment syndrome is generally related to ulnar positive variance, and that because of that, there is an increased risk of degenerative wearing out of the TFCC and abutment of the ulnar head into the lunate. He further stated that "this is indeed what we found at the time of his [Petitioner's] arthroscopy and was the reason for his arthroscopic wafer procedure. Because ulnar abutment syndrome is mostly related to a congenital discrepancy in the length of the 2 forearm bones, I cannot say that his work caused this problem, especially without a given history of a direct injury to that area. If he does indeed do a lot of ulnar deviating of the wrist with his various activities at work, it could be an aggravating cause at most. However, again, this would depend on what kind of actual activities are occurring with his wrist during his job."

19. Petitioner admitted on cross examination that at the time of his initial arbitration hearing he testified to pain in his fingers and discoloring on his hands. Petitioner further admitted that he no longer has pain in his fingers, temperature changes in his hands, or discoloration, and that he continues to work full duty without restrictions. (T66-72).

20. On August 14, 2014, Petitioner underwent a Section 12 examination with Dr. Dunteman, pursuant to Respondent's request. Dr. Dunteman testified Petitioner does not have chronic regional pain syndrome, or sympathetic mediated pain, and that he found significant inconsistencies on examination and symptom magnification. He opined that the symptoms that Petitioner reported to Dr. Naour and to him at his examination were not causally related to the June 23, 2007 work injury based upon the duration of time where he was essentially well-controlled. (RX6, T44-48).

21. On April 23, 2013, Dr. Beyer conducted a record review, including review of Petitioner's Application for Adjustment of Claim, his August 22, 2011 written statement, Respondent's job description, a two page email from Jason Driver discussing Petitioner's job duties, treating and examining medical records, and diagnostic films. Dr. Beyer testified that he also reviewed the medical records from his June 23, 2007 work injury, including the operative report and treating records, showing Petitioner sustained a significant hand injury, but not a wrist injury, and that the primary injury was to the second metacarpal with a semi-degloving and fracture, and then subsequent ray resection. Dr. Beyer opined that Petitioner's injury on June 23, 2007 was a hand injury, to the radial side of the hand, not the radial side, and was not a wrist injury, with the trauma distal to the carpal canal. (04-14).

22. Dr. Beyer testified that the May 9, 2008 office visit note reflects that Petitioner's

complaints were of some volar forearm pain, nonspecific, meaning it was the palm side of the forearm proximal to the wrist, and there was no reference to ulnar wrist pain at that office visit. He testified that at the time of Petitioner's May 23, 2010 office visit, his pain was on the radial side of the hand and the first web space and pain up the radial forearm, and some irritation w/ superficial radial nerve was suspected, and he opined that those symptoms are distinctly different than carpal tunnel symptoms, and those symptoms were on the wrong anatomical location and on complete opposite side of the wrist compared to the ulnar side. He further testified that he identified no findings of ulnar wrist pain from his prior injury in any of the records he reviewed prior to May 2011. (T14-15). Dr. Beyer further testified that Petitioner's 2007 work injury was primarily an injury to the MCP joint, which is a hand injury, and Petitioner's 2011 wrist pain and focal increased uptake at the ulnocarpal joint at the wrist, where the bony bump at your wrist on the small finger side, where a watch sits, is a considerable distance from his MCP joint injury. Dr. Beyer opined Petitioner's ulnocarpal abutment syndrome was due to a congenital condition. Dr. Beyer testified that Petitioner's June 23, 2007 work injury had nothing to do with what is going on currently, as it was in a distinctly different area of the upper extremity, and Petitioner went several years without any ulnar-sided wrist complaints, and then all of the sudden, years later he claimed that was the cause of his symptoms. (T40-58).

The Commission concludes it has no jurisdiction to review this award under Section 19(h) of the Act or issue additional temporary total disability or permanent partial disability benefits, given that the Petition for Review under Section 19(h) was not filed until 63 months after Arbitration decision was entered, which was clearly well beyond the 30 months set out by the Act for an award providing compensation in installments. Section 19(h) provides that an award providing for compensation in installments "may be with any time within 30 month, or 60 months in the case of an award under Section 8(d)1, after such agreement or award be reviewed by the Commission at the request of either the employer or the employee on the ground that the disability of the employee has subsequently recurred, increased, diminished or ended." 820 ILCS 305(19(h)) 11/16/2005. Furthermore, Petitioner voluntarily withdrew the Petition for Review under Section 19(h) at the time of the February 8, 2016 oral arguments in this matter.

Based upon a review of the record as a whole, the Commission finds Petitioner failed to prove his ulnar abutment syndrome, mediated pain syndrome, or carpal tunnel syndrome are causally connected to his June 23, 2007 work-related injury. Accordingly, the Commission finds Petitioner is not entitled to the relief requested under Section 8(a). In so finding the Commission relies upon the treating records, which fail to reflect any left wrist ulnar sided complaints or ongoing pain complaints to the left hand and wrist from the date of the prior arbitration hearing in August of 2008 through May of 2011, other than one office visit on March 23, 2010 for complaints about the first web and long finger, the lack of a causal connection opinion from the treating surgeon, Dr. Brown, the significant four years following his full duty release during which time Petitioner worked full duty, and the more persuasive opinions of Drs. Byer and Dunteman.

Petitioner's treating medical records prior to the August 4, 2008 arbitration hearing date fail to reference any left ulnar sided wrist pain, or support the any diagnosis of abutment syndrome, TFCC tear, or carpal tunnel syndrome. The sole reference to ulnar sided wrist pain came in the June 23, 2007 emergency room record of Dr. Bell, wherein the doctor documented ulnar sided hand pain, without reference to the left wrist. Subsequent to that emergency room visit, Petitioner was examined by Dr. Brown on at least seven times prior to the August 4, 2008 hearing date and there is no mention of any ulnar sided hand or wrist pain. Following the August 4, 2008 hearing date, Petitioner returned to Dr. Brown's office on May 23, 2010 with complaints of pain in his radial forearm, without mention of any ulnar sided wrist complaints. In addition, at that may 23, 2010 office visit, Petitioner did not report "ongoing problems" since his prior work injury, but instead reported that "in the past year [he] has started having problems again," suggesting a new onset of complaints. The office visit note fails to reflect any symptoms or examination findings related to the ulnar side of Petitioner's left wrist. The Commission notes that the first mention of any ulnar sided wrist pain or positive ulnar sided wrist pain was on November 27, 2011, more than four years after the June 23, 2007 work injury. The Commission finds most significant that Petitioner's treating surgeon, Dr. Brown, tendered no opinion causally connected his lunar abutment syndrome of TFCC tear to his June 23, 2007 work injury. Instead, in a March 5, 2012 letter addressed to Petitioner's attorney, Dr. Brown opined because ulnar abutment syndrome is mostly related to a congenital discrepancy in the length of the two forearm bones, he could not say that Petitioner's work caused this problem, especially without a given history of a direct injury to that area.

Although Dr. Oakey testified Petitioner's ulnar abutment syndrome was causally connected to his June 23, 2007 work injury, he also admitted that he did not seen Petitioner prior treating records from his 2007 work injury, and that he was basing his opinion on Petitioner's description of the accident and Petitioner's history as to the onset of the symptoms. In addition, Dr. Oakey admitted on cross examination that the delayed onset of Petitioner's ulnar sided wrist complaints could change his opinion, and that if Petitioner was performing his same job duties for Respondent for four years after the accident, the onset of lunar sided wrist pain four years later may or may not be consistent with a traumatic injury. The Commission finds the causal connection opinion of Dr. Oakey to be to be based upon an incomplete medical history, and less than persuasive.

The Commission relies upon the opinion of Dr. Beyer, who unlike Dr. Oakey, possessed a complete set of Petitioner's medical records at time of his records review. Dr. Beyer testified he found no evidence within the treating medical records from 2008 through May of 2011 that Petitioner had any ulnar sided wrist pain. Dr. Byer testified Petitioner's ulnar abutment syndrome was congenital, which is consistent with the opinion of Dr. Brown. Furthermore, Petitioner presented no evidence that his TFCC tear was sustained on the date of accident, and the only diagnostic study finding a tear was four years later.

With regard to Petitioner's alleged sympathetic mediated pain syndrome diagnosis, the Commission finds Petitioner failed to prove any causal connection to his June 23, 2007 work injury, as the opinions of Dr. Oakey and Dr. Naour are based on an incomplete understanding of Petitioner's medical history. Dr. Naour admitted he did not have copies of Petitioner's medical records pertaining to his treatment prior to his initial May 7, 2012 office visit with Dr. Oakey.

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Dr. Naour also admitted his causal connection opinion was solely based on Dr. Oakey's evaluation and Petitioner's history that his symptoms started on the date of accident the then the pain existed in varying degrees afterwards. Dr. Dunteman, based upon his review of prior medical records and examination of Petitioner, opined Petitioner did not have RSD or CRPS, as Petitioner lacked symptoms of welling, sweating, skin/hair changes, prolonged pain after stimulation or significant limited range of motion. Dr. Dunteman's causal connection opinion was based upon his review of Petitioner's medical records dating back to his 2007 work injury, and his opinion, that Petitioner in fact did not have ongoing complaints, is well supported by the medical records.

With regard to Petitioner's Section 8(a) Petition, the Commission denies Petitioner's demand for an award of medical expenses based upon Petitioner's failure to prove his current condition of ill-being is causally related to his work related injury of June 23, 2007.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition under Section 8(a) is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Petition under Section 19(h) is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove a causal relationship exists between the accident of June 23, 2007 and Petitioner's condition of ill-being, his claim for compensation is hereby denied.

DATED: MAR 2 4 2016
KWL/kmt
O-02/08/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

STATE OF ILLINOIS)	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF)	☒ Reverse Causal connection	☐ Second Injury Fund (§8(e)18)
SANGAMON		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Doyle Collins,

Petitioner,

vs. NO: 09 WC 8264

Freeman United Coal Mining Company,

16IWCC0204

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident as the result of exposure to an occupational disease, causal connection and permanency, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Findings of Fact

Petitioner, a 55 year old warehouse worker at the time of his alleged exposure on 8/31/07 (his last day of employment), testified that he worked in the coal mining industry for 33-1/2 years and spent a total of approximately 12-1/2 to 13-1/2 of those years working underground. (T.10). He agreed that during those years he was exposed to coal dust, silica dust, roof bolting glue fumes, smoke from coal fires, and diesel fumes. (T.10). He indicated that his date of last exposure was 8/31/07 and that his last job was classified as warehouse clerk for Respondent at its Crown III mine. (T.10-11). Petitioner testified that he was exposed to coal mine dust on that day. (T.11). He indicated that 8/31/07 was his last day because the mine shut down and the new owners took over and did not hire him back. (T.12). He has not worked anywhere since. (T.12).

Petitioner testified that he started his mining career as a rodman in 1973 for Peabody Coal at the Eagle II mine. (T.12). He explained that a rodman was a helper for the main person and

16IWCC0204

that they would set sights in the mine to assist in the direction of the mining. (T.13). He noted that this job was performed underground. (T.13-14).

Petitioner indicated that his next job was that of surveyor in the engineering office for a couple of years, and that he also filled in as a rodman when anyone was off. (T.14). As a result, he would work both on the surface and down below in the mine. (T.14). Petitioner testified that he was employed at the Will Scarlett mine, which is a strip mine in Stonefort, Illinois. (T.15). He indicated that he worked as a crew leader and instrument man at the time where he did surveying work. (T.16). Petitioner testified that this was a dusty environment, noting that the roads were made out of "gob" and had to be watered to keep the dust down. (T.16-17). He stated that he performed this job for 7 years. (T.17).

Petitioner indicated that he was then transferred to the Pawnee Illinois Mine 10, which is an underground coal mine. (T.17). He noted that he was the surface surveyor and also filled in for the underground surveyors when someone wasn't there. (T.17-18). He indicated that on the surface he did all the coal stock pile measurements, and that he worked in this position for 12 years, from 1982 until 1994, when the mine shut down. (T.18).

Thereafter, Petitioner testified that he did reclamation work as a "kind of surveyor field engineer" as part of an effort to reclaim old mine sites. (T.18). This involved surveying and staking out areas for drainage as well as covering slurry ponds with dirt. (T.19). Petitioner indicated that these mines were still dusty, mainly from the trucks and dozers dumping and pushing dirt around. (T.19-20). He noted that he worked in this job for four years, from 1994 to 1998. (T.20).

Petitioner then started working as a rodman and crew leader for Freeman in 1999, taking care of both the Crown II and Crown III mines. (T.20). He noted that he worked every day underground in this job and that he "... was in the return a lot and that that's where [he] got where the miner and the rock dust and the diesel engines and stuff, all that went by [him] where [he] was working." (T.22-23). He agreed that he would be right in the middle of an incredible amount of rock and coal dust and that there would be diesel fuel coming through there as well. (T.23). Petitioner noted that it would become overwhelming at times and "[s]ometimes we would just have to quit. We would have to stop and just wait until it cleared out some." (T.24). He indicated that he did that every day for 6-1/2 years. (T.24).

Petitioner testified that his next and last job was in the warehouse as a third shift warehouse clerk where he received and distributed supplies, checked out parts to go underground and cleaned the warehouse. (T.25). He noted that he was offered the job because he was losing his hearing. (T.25). Petitioner testified that he had to sweep the floors every night and then in his spare time clean the shelves. (T.26). He indicated that the shelves at Crown III hadn't been cleaned in 5 or 6 years and "[i]t was just thick dust everywhere." (T.26). Petitioner agreed that it was almost like being inside the mine due to the fact that the big door at the warehouse stayed open and "... any time anything went by that dust would come in." (T.26). Petitioner testified that he thought "... it was nastier than actually being in the mine. I think I got dirtier cleaning those shelves than I did actually... working in the mine..." (T.27).

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When asked when he first started noticing breathing problems, Petitioner testified that "[i]t just kind of gradually came upon [him] over the years" and that he noticed "... things were getting harder for [him] to do... [He] would start getting out of breath easier, and it just gradually has gotten worse and worse." (T.27). He noted that from the time he first noticed his symptoms until he left the mine they "... didn't get any better. They were probably a little worse." (T.28). When asked about his symptoms since he left the mine, Petitioner indicated that he "... thought they were staying the same but this past year they have really got really bad on [him]. There is stuff that [he] ha[s] noticed that the weather especially, like cold weather and real hot weather and stuff, [he] can't take it anymore. [He] can't stay out and take it. It just makes [him] short of breath." (T.28). He indicated that he can probably walk on level ground at a normal pace for two or three blocks or climb a flight of stairs before becoming short of breath. (T.28-29). He noted that he does not currently take any breathing medications, but that he is "... probably going to be starting here." (T.29).

Petitioner testified that because of his breathing problems he no longer goes out fishing, hiking or to paint pictures. (T.29). He indicated that he can no longer do the lawn/landscaping as well as maintenance work around the house and has to hire someone to do it. (T.29-30). He also noted that he cannot exercise because he "... get[s] out of breath too quick trying to do that" and experiences a "tightness." (T.30).

Petitioner testified that he has never smoked. (T.31). He indicated that he "...had ulcerated colitis for 20 some years and they ended up taking [his] colon out ... [And] a year after that the autoimmune system attacked [his] hearing and [he] lost [his] hearing in both ears, about 75 percent in both ears in 6 months." (T.31). As a result, Petitioner now has two cochlear implants, one for each ear. (T.31-32). He currently does not take any medications for his hearing, but does take medication to control his bowel movements, for his cholesterol and for his anxiety. (T.32).

On cross examination, Petitioner agreed that everyone at the Crown III mine was laid off on 8/31/07, and that but for being laid off he would have reported to work for his next shift. (T.32-33). He noted that he took the job in the warehouse when it became available because of his hearing loss. (T.34). He indicated that he got his first cochlear implant in 2006 and that he could not go back underground because the batteries in the implants weren't approved by IMSHA. (T.34-35). As to the reasons or basis for his application for Social Security disability, Petitioner testified that it was "... for my colon problem where I had to go to the bathroom so much, my hearing, and my breathing." (T.35-36). He noted that he is limited as to the amount that he can walk due to possible bowel seepage, which he has if he does a lot of physical stuff, as well as the breathing. (T.36). He also indicated that he suffers blockages from time to time and has to watch what he eats, or else he ends up in the hospital. (T.37). Petitioner testified that he has never looked for work or worked anywhere since he was laid off at Crown III. (T.37).

The record shows that Petitioner has treated with gastroenterologist Dr. Richard L. Smith with respect to his inflammatory bowel disease (ulcerative colitis) since 12/7/82. (RX3).

An office note by Dr. Ralph Gauen (presumably Petitioner's PCP at the time) dated 3/12/91 recorded that Petitioner had a history of intermittent cough for 2 to 3 months that was occasionally productive of greenish sputum with a wheezy, raspy sensation in the left upper

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chest. (RX3). Dr. Gauen noted that Petitioner had "[p]neumonia many years ago in the right lung. Can't recall his last chest x-ray... Works at the coalmine, but is mostly above ground. No shortness of breath." (RX3). Dr. Gauen recommended chest x-rays and that Petitioner discontinue chewing tobacco. (RX3).

A chest x-ray dated 3/12/91 noted "[p]atchy infiltrate within the lingual compatible with an acute infiltrate. No evidence of consolidation or cavitation of the infiltrate. No evidence of empyema. No other infiltrates are identified..." (RX3). The impression was "[l]ingula infiltrate compatible with a pneumonia and please correlate clinically." (RX3).

In an office note dated 7/30/93, Dr. Gauen recorded that Petitioner had done a lot of painting two days ago and "... then developed pain in the right side of his chest, it feels very positional and also very plueritic, every time he would move from side to side or raise his arm it would hurt, also with deep breaths it would hurt. He experienced no SOB or cough, never had a blood clot, never had similar pain before, it is much improved today." (RX3). The diagnosis was "[p]robable resolving muscle soreness." (RX3).

In an office note dated 6/28/94 Dr. Gauen recorded that Petitioner had had a cough for 3-4 weeks that was somewhat productive of mucous in the morning. (RX3). Upon exam, Dr. Gauen noted that the lungs were clear and that Petitioner had a mild cough with no sinus tenderness. (RX3). Dr. Gauen noted an impression of "[c]ough, subacute and chronic" and recommended a chest x-ray. (RX3).

In chest x-rays dated 6/28/94 it was noted that an "[i]nfiltrate is again noted in the lingular segment of the left upper lobe in a similar pattern to [the x-rays performed in] 1991... The lung markings in the right lung base remain increased. There is some bronchial wall thickening and raises the possibility that some of these increased marking represent bronchiectasis. Mild hyperinflation continues to affect the fields. Calcified granulomas are present in both lungs. The lateral view of the chest shows the infiltrate to be more extensive on the current chest radiograph." (RX3). In the summary section of the report, the radiologist noted "[d]oes the patient have any history of bronchiectasis?" (RX3).

In a Springfield Clinic "Prompt Care" note dated 4/7/97, it was recorded that Petitioner presented with nasal congestion and a productive cough with greenish phlegm at times on and off for the past month. (PX9). It was noted that chest x-rays revealed "... what appears to be some scarring at the bases, no definite infiltrate." (PX9). The impression was "[a]cute bronchitis with URI." (PX9).

Chest x-rays dated 4/8/97 noted that "[t]he heart and mediastinal structures, pulmonary vasculature, and pleural space are normal. There is a left lower lobe infiltrate. Elsewhere the lungs are clear." (RX3).

In a Springfield Clinic "Prompt Care" note dated 6/23/97, it was recorded that Petitioner reported a return of his symptoms once finishing his antibiotic. (PX7). It was noted that chest x-rays revealed persistent left lower lobe infiltrate. (PX7). The impression was persistent left lower lobe pneumonia. (PX9).

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Chest x-rays dated 6/23/97 noted that "[a]t the time of the old exam [on 4/7/97] there was considerable infiltrate in the left lower lobe. This remains on the current exam. I am not certain whether this infiltrate has persisted over a 2 ½ month period or whether this cleared and this is a recurrent pneumonia. Certainly this is worrisome for an underlying neoplasm or other process. The left upper lobe and right lung field are clear..." (RX3).

Petitioner visited his family physician, Dr. Brewer, on 6/24/97. (RX3). At that time Dr. Brewer noted Petitioner had been told that he had pneumonia in April and had visited Prompt Care on 6/23 with a low grade fever and cough. (RX3). Dr. Brewer noted that upon exam Petitioner "does not look terribly ill. He does have some crackles in the left base." (RX3). Dr. Brewer's assessment was "[p]robable pneumonia, left lower base." (RX3). Petitioner returned to Dr. Brewer on 7/11/97 and was diagnosed with resolving pneumonia. (RX3).

Chest x-rays performed on 7/31/97 noted "... some interstitial infiltrates in the left lower lobe ... [that] have remained stable since the exam dated 06-23-97... The interstitial infiltrate in the left base represent chronic fibrotic changes ..." (PX7).

A CT scan of the chest on 8/7/97 showed "[l]eft lower lobe infiltrate and some infiltration of the right middle lobe and lingual suspected to be probably chronic in view of overall appearance on CT scan and relative lack of change on recent chest films from the Springfield Clinic..." (PX9).

Petitioner visited his gastroenterologist Dr. Smith with respect to his ulcerative colitis on 12/21/99. (RX3). At that time, Dr. Smith noted that Petitioner "... has noticed some occasional wheezing in the fall time. He said that [Dr. Brewer] had evaluated him with a chest x-ray a few years ago and there was a 'scar'. He was supposed to get back to [Dr. Brewer] then but apparently did not since he moved out of town at that time. He now has moved back to town. I have suggested that he contact [Dr. Brewer] and see [him] regarding this pulmonary complaint. He does have some wheezing ..." (RX3). Upon exam, Dr. Smith noted a few rhonchi in the left base and mild expiratory wheezes. (RX3).

In an office note dated 3/16/00, Dr. Brewer recorded that Petitioner presented with a cough that he had had for most of the winter, and that he occasionally coughs up some green phlegm. (RX3). Upon exam, Dr. Brewer noted some scattered rhonchi in the lungs and "[p]erhaps a little slightly decreased breath sounds, left base, compared to the right." (RX3). The assessment was "[p]ossible bronchitis." (RX3). In addition, Dr. Brewer noted that in "perusing the chart" he noticed "an abnormal chest x-ray back in 1997, with persistent infiltrate on the left side. CT did not show any mass, but they recommended a follow up x-ray, which he has not had..." (RX3).

In a Springfield Clinic "Prompt Care" note dated 4/18/00, it was recorded that Petitioner had developed a sore throat with sinus pressure and had been coughing up some green discharge. (PX9). The assessment was acute sinusitis. (PX9).

Chest x-rays performed on 4/18/00 revealed "... some increased density in the middle lung base which [the radiologist] interpret[ed] to be fibrosis. [The radiologist] [did] not believe that the patient has an acute infiltrate. Minimal left costophrenic angle blunting may represent some

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pleural thickening..." (RX3). The impression was "[n]o acute findings." (PX3).

In a Springfield Clinic "Prompt Care" note dated 2/18/01, it was recorded that Petitioner presented with a fairly frequent cough which was now productive of some colored sputum. (PX9). It was also noted that "... for the past two years or so, he has had a bout of bronchitis in the winter, but generally his lungs are healthy." (PX9). The assessment was bronchitis. (PX9).

Dr. Brewer subsequently saw Petitioner on 2/20/01 and noted that the "[l]ungs have some bilateral rhonchi." (RX3). Dr. Brewer's assessment was "[u]pper respiratory illness, probably viral." (RX3).

In a Springfield Clinic "Prompt Care" note dated 3/11/01, it was recorded that upon examination Petitioner presented with coarse breath sounds and rhonchi, with a few wheezes in all lung fields and no rales heard. (PX9). He was diagnosed with bronchitis. (PX9).

In an office note dated 3/16/01, Dr. Brewer recorded that Petitioner had some sharp pain in the left chest the day before, after having had a little feeling of pain in the right chest previously, and that he still had a cough productive of green mucus. (RX3). Upon exam, Dr. Brewer found the chest to be symmetrical with no shortness of breath noted, although he did have some inspiratory and expiratory rhonchi throughout the lung fields. (RX3). The assessment once again was bronchitis. (RX3).

In a Springfield Clinic office note dated 9/11/01, it was recorded that Petitioner had had a fairly persistent cough for the past 2-3 months, and that he coughs up "some thick stuff" that is sometimes green. (PX7). It was also noted that Petitioner works in a coal mine 3-4 hours a day and does not wear a mask. (PX7). In addition, it was related that Petitioner "[s]ays has had some problems in the past with his lungs." (PX7). Dr. Brewer's assessment was "[p]ossibly allergic rhinitis, maybe some aggravation from coal dust." (PX8).

Chest x-rays performed on 9/11/01 noted "... interval increase in the left basilar infiltrate and blunting of the left costophrenic angle. It is indeterminate if this represents progression of fibrosis in this region and chronic pleural reactive ranges or an active pneumonitis or atelectasis superimposing fibrosis..." (PX7).

Chest x-rays performed on 10/12/01 noted that "[i]nfiltrate in the left lung base with associated pleural reaction left costophrenic angle again seen. Degree of infiltrate similar to before with slight increase in pleural reaction (chest x-ray otherwise unchanged and otherwise unremarkable for age)." (PX9).

In a letter dated 2/21/02, gastroenterologist Dr. Smith noted that Petitioner's chest was "[s]ymmetrical and clear to palpation. However on auscultation at the height of inspiration there is a coarse sound and a small amount of wheezing that appears to be confined in the left lower lobe." (RX3). Furthermore, Dr. Smith recorded that Petitioner "... relates that [Dr. Brewer] got a chest x-ray last year because of some abnormal sounds but this is really quite prominent today and I feel uncomfortable in dealing with this as a gastroenterologist and have suggested that he get back to [Dr. Brewer] about this and told him that [Dr. Brewer] might want to at least repeat

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the chest x-ray or perhaps even get a CT scan. He told me that [Dr. Brewer] found a 'scar' on the x-ray but that it had been unchanged from previous x-rays." (RX3).

In a Springfield Clinic "Prompt Care" note dated 7/20/02 it was recorded that Petitioner presented with a two month plus history of cough productive of colored sputum and nasal congestion, colored nasal drainage. (PX9). It was noted that he had a history of pneumonia in the past as well as chronic bronchitis. (PX9). Chest x-rays were interpreted as revealing a left lower lobe infiltrate with probable emphysema. (PX9). The impression was left lower lobe pneumonia. (PX9).

Chest x-rays performed on 7/20/02 showed "[b]ronchiectasis and fibrosis in the lingual and left lower lobe. There is probably a more subtle involvement of the right middle lobe as well. There is new left basilar opacity when compared to 4-18-00. This is probably due to a combination of progression of bronchiectasis/fibrosis along with superimposed acute pneumonia..." (RX3).

In an office note dated 7/29/02, Dr. Brewer recorded that Petitioner was in for a recheck on pneumonia. (RX3). Dr. Brewer also noted that Petitioner "[d]oes work in a coal mine. Lungs do reveal some rhonchi still noted in the left upper lobe. Does have decreased breath sound in the left side compared to the right. No wheezing noted..." (RX3).

Chest x-rays performed on 8/22/02 were interpreted as showing "[i]nfiltrates in the left lower lung show[ing] essentially the same distribution and density as on the left films dated 10/12/01. The amount of associated pleural density at the left lung base appears a bit less prominent now, similar to the 9/11/01 study..." (PX9).

In an office note dated 2/18/03, gastroenterologist Dr. Smith once again noted that on examination the chest was "[s]ymmetrical and clear to palpation. However on auscultation at the height of inspiration there is a coarse sound and a small amount of wheezing that appears to be confined in the left lower lobe." (RX3). Dr. Smith's impression was ulcerative colitis in good control and "[a]bnormal breath sound on auscultation. Questionable etiology." (RX3). Dr. Smith went on to note that "[t]he chest finding was noted last year and has been noted by Dr. Michael Brewer previously and apparently he had a 'scar' on x-ray but there were no changes from previous x-rays." (RX3).

Chest x-rays performed on 4/22/03 were interpreted as showing "[i]ll-defined infiltrative opacity overlying the left lower lobe with blunting on the left costophrenic angle and sulcus identified." (RX3). The impression was "acute versus chronic infiltrate and acute versus chronic pleural effusion on the left as described..." (RX3).

A CT of the abdomen and pelvis performed on 7/10/03 in response to abdominal pain noted an incidental finding of bronchiectasis in the lung bases. (RX3).

In a Springfield Clinic "Prompt Care" note dated 2/10/05, Dr. Phillips noted that Petitioner presented at that time with a 2-3 day history of cough productive of green sputum and clear rhinorrhea and that "[h]e states that he has had a lot of problems with chronic bronchitis and

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recurrent pneumonias in the past." (PX9). Dr. Phillips indicated that chest x-rays obtained on that date "... show[ed] probably a lot of chronic scarring in the left base. He might have a right middle lobe pneumonia however, on exam." (PX9). Dr. Phillips' assessment was "[p]robable early pneumonia." (PX9).

Chest x-rays dated 2/10/05 noted that "[t]here has been interval clearing of left basilar infiltrate since the prior examination. Density within the lingual and possibly right middle lobe persist. Given the apparent stability over time, this most likely represents fibrotic change. A short interval followup may be beneficial to exclude some degree of more acute infiltrate. Pleural thickening on the left appears stable. Fibrotic changes within the left base are again noted." (PX9).

In a Springfield Clinic office note dated 4/11/05, Dr. Brewer indicated that Petitioner was in for follow up of pneumonia. (PX9). He noted that Petitioner "works around a lot of dust" and "...works in coal mines as an inspector... He has had multiple chest x-rays and CTs in the past." (PX9). Dr. Brewer stated that "[c]hest x-ray from February 10 showed a left basilar fibrosis and infiltrate in the left base, which has cleared. Persistent density in the lingual in the right lower lobe but it appeared stable. I repeated the x-ray today. He still has infiltrate in his lower lobe, maybe also still in the lingual and the right middle lobe." (PX9). Dr. Brewer's assessment was persistent infiltrate and productive cough. (PX9).

Chest x-rays performed on 4/11/05 were interpreted as showing "[s]table and chronic pleural parenchymal changes in the left lung base with some stable fibrotic changes suggesting the lingual and perhaps the right middle lobe. There is an area of increased density either in the lingual or right middle lobe, suggesting an acute infiltrate superimposed upon chronic fibrotic changes with perhaps some improvement since the examination performed 2/10. Continued radiographic follow-up is suggested. Underlying COPD is present, radiographically stable. Small nodular opacity in the right pulmonary apex is unchanged, dating back to 2002." (RX3).

A CT of the chest was performed on 4/14/05. (PX9). In a report on that date, it was pointed out that comparison of this study was made with plain chest films performed on 4/11/05. (PX9). The present study noted "[c]hronic appearing infiltrative process in the right middle lobe, suggesting fibrosis. There is a band of scarring in the lingual. Moderate fat in the anterior mediastinum around the heart accentuating the density in the lung bases, seen on the plain film of the chest. There is a chronic appearing infiltrative process in the left lung base posteriorly. Some bronchiectatic changes are noted. Nothing acute is noted." (PX9). The conclusion was "[c]hronic infiltrates in the right middle lobe and left lower lobe, suggesting bronchiectasis. Fibrosis in the left chest and lingual. Prominent epicardial fat. There is nothing acute noted." (PX9).

In a Springfield Clinic office note dated 5/13/05, Dr. Brewer indicated that Petitioner had a one degree fever and was "... coughing up green stuff still." (PX9). He also indicated that "[l]ungs have a few scattered rhonchi, but he has this chronic lung disease that we confirmed with CT scan last time." (PX9). Dr. Brewer's assessment was "1) possible acute bronchitis and 2) underlying chronic disease." (PX9).

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In a Springfield Clinic office note dated 7/27/05, Dr. Pick noted an impression, among other things, of "[c]hronic left basilar fibrosis with associated bronchiectasis." (PX9).

A chest x-ray report by Dr. Russell Bruney at Radiological Associates of Decatur, denoting "Freeman Mine Crown III", noted "... blunting of the left costophrenic angle without significant change compared to the 12/21/04 radiographs. An infiltrate is again seen in the lingual and shows no change when compared to the previous examination. Bilateral apical pleural thickening is noted. The cardiac silhouette is normal in size. The interstitial lung markings are mildly prominent in the lung bases." (RX3). The impression was "1. No change in the lingular infiltrate. 2. No change in the blunted left costophrenic angle, which is likely secondary to scarring." (RX3).

In a Springfield Clinic "Prompt Care" note dated 5/14/06 it was recorded that Petitioner "... has had sinus [complaints] for about five days, sore throat, post nasal drainage, rhinorrhea of clear to yellow color, and headache in the right maxillary region. Cough is productive of a dark sputum, but no chest pain or shortness of breath." (RX3). Upon examination, the lungs were noted to be clear with no signs of consolidation or tachypnea. (RX3). The assessment was sinus infection. (RX3).

In a Springfield Clinic office note dated 10/10/07, it was recorded that Petitioner was "... in today for disability checkup. He has some papers he needs filled out." (PX8). Dr. Brewer noted Petitioner's history of ulcerative colitis and colectomy as well as his subsequent development of autoimmune hearing loss. (PX8). Dr. Brewer indicated that Petitioner's previous employer was unwilling to make accommodations for his disabilities – including an inability to talk on the phone or wear a hardhat due to his cochlear implant as well as problems with his bowels such as frequent oozing of stool from his pouch with activity -- and that he was therefore applying for disability. (PX8). Dr. Brewer's assessment was hearing loss and stool incontinence secondary to J pouch. (PX8).

Chest x-rays performed on 3/12/08 showed "... evidence of chronic pleural and parenchymal fibrotic changes evident in the left hemithorax similar in appearance to prior study. Right lung remains clear. Mild apical pleural thickening remains unchanged..." (PX9). The impression was "[s]table pleural and parenchymal fibrotic changes. No acute abnormalities identified." (PX9).

In a Springfield Clinic office note dated 3/12/08, it was recorded that Petitioner was "... working on disability due to his total colectomy due to Crohn's or due to ulcerative colitis, and also partial deafness." (PX8).

In a Springfield Clinic office note dated 3/28/08, it was recorded that Petitioner was "... in today to get some disability papers filled out. He does not feel that he can work now at all because of his hearing and because of his frequent diarrhea." (PX8). The assessment was severe diarrhea and decreased hearing. (PX8).

A Social Security "*Disability Report – Adult – Form SSA-3368*" form notes the following in response to the question "[w]hat are the illnesses, injuries, or conditions that limit your ability

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to work?":

"Ulcerated colittis [sic] resulting in colon removal and J pouch, Auto Immune Sensory Neuroal Hearing Loss, Anxiety, Loss of balance, Lung heavily scarred, Chronic Diarrhea." (RX4).

In this same report, in response to the question "[h]ow do your illnesses, injuries, or conditions limit your ability to work?", Petitioner noted:

"I HAVE DIFFICULTY HEARING. I CANNOT LIFT AND CARRY HEAVY OBJECTS DUE TO COLLECTOMY [sic]. DUE TO SIDE AFFECTS [sic] OF COLLECTOMY [sic] I AM HIGHLY DEPENDENT UPON IMMEDIATE ACCESS TO RESTROOM FACILITIES. I HAVE FREQUENT OCCURANCES OF LOSS OF BODILY FLUIDS." (Emphasis in original) (RX4).

In a Social Security "*Disability Report – Appeal –Form SSA-3441*" form Petitioner once again set forth his hearing loss and prior history of ulcerative colitis with eventual colectomy and j-pouch, and the need for frequent bathroom visits and occasional blockages due to the latter. (RX4). Petitioner's claim for Social Security disability was originally denied and then subsequently approved. (PX8, RX4).

A CT of the abdomen and pelvis dated 11/26/08 noted, among other things, "... chronic scarring and atelectasis in the lingual. Some chronic scarring with bronchiectasis is seen at the left lung base. These were seen in the prior chest CT. There is also some scarring and atelectatic changes in the right middle lobe which is new..." (PX9). The impression, among other things, was "[c]hronic scarring, atelectatic changes, and bronchiectasis changes at the lung bases, as discussed." (PX9).

X-rays of the abdomen dated 11/26/08 noted that the lung bases revealed mild atelectasis and possible mild left pleural effusion. (RX3).

Abdominal x-rays also performed on 11/26/08 noted that "[t]he lung bases reveal mild atelectasis. Possible mild [ef]fusion on the left." (PX9). The impression included, among other things, "[p]ossible mild left pleural effusion." (PX9).

A CT of the abdomen and pelvis dated 1/13/09 noted, among other things, "[a]reas of fibrosis and bronchiectasis ... reidentified within the right middle lobe, left lower lobe, and lingual. Nodular infiltrates likely related to prior granulomatous infection are seen within the medial aspect of the right lower lobe, stable from prior. Postinflammatory calcification is present bilaterally. There is an additional nodule within the left lower lobe seen on image 40m which is stable from prior. No pleural fluid collections are present." (PX9). The summary included, among other things, "[c]hronic appearing changes bilateral lower lung zones, stable from prior[,] likely related to prior." (PX9).

In an office note dated 3/13/09, Dr. Brewer recorded that Petitioner was being seen for a physical and that he had recently passed a kidney stone. (RX3). Upon examination, his lungs were noted to be clear. (RX3). The assessment was "[s]eems to be doing reasonably well." (RX3).

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A CT of the abdomen and pelvis dated 4/9/09 noted, among other things, "[s]table fibrosis and bronchiectasis within the right middle lobe, lingual, and left lower lobe. These are stable. Stable 6 mm nodule within the left lower lobe. Prominent subpleural fat deposition in the left lower lobe..." (PX9). Under impressions, it was noted "[c]hronic appearing changes within the lower lung zones bilaterally, stable from prior" and "[s]table 6 mm nodule within the left lower lobe." (PX9).

In a Springfield Clinic office note dated 12/1/09, it was noted that Petitioner had been coughing for about five or six months, including "coughing up green and brown stuff", that he thought was due to allergies and would go away with an antibiotic. (PX8). The assessment was possible persistent bronchitis. (PX8).

In an office note dated 2/18/10, Dr. Brewer recorded that Petitioner was being seen for a physical and that he was retired and not getting a whole lot of exercise. (RX3). Upon exam, his lungs were noted to be clear. (RX3). The assessment was "[s]eems to be doing reasonably well." (RX3).

A CT of the abdomen dated 6/1/10 noted, among other things, "[i]mages through the lung bases demonstrate[ing] bronchiectatic changes in the inferior aspect middle lobe[,] lingual and more extensively left lower lobe with areas of pleural and parenchymal scarring. These findings were present on the prior study [dated 4/9/09]." (PX9).

In an office note dated 2/21/11, Dr. Brewer recorded that Petitioner was being seen for a physical and that he was not working and on disability. (RX3). The history also noted that Petitioner had never smoked but that he had used Skoal for a while six or seven years earlier. (RX3). Dr. Brewer noted that about three weeks ago he "had a little episode in the morning ... [where] [h]e spit up some blood with a cough. He has not had any problems since then. He said he had been working out in the cold air and he is wondering if that could have been a factor..." (RX3). Upon examination, his lungs were noted to be clear. (RX3). The assessment was "[i]t sounds like overall he is doing reasonably well." (RX3).

Chest x-rays performed on 2/21/11 noted "[b]ibasilar scarring and chronic pleural scarring..., left greater than right." (PX9).

A CAT scan of the abdomen and pelvis performed on 3/2/11 noted, among other things, "[c]hronic-appearing benign pleural thickening in the left base with some scarring, atelectasis and bronchiectasis within the left lower lobe." (PX9).

In an office note dated 3/9/12, Dr. Brewer recorded that Petitioner was being seen for a physical and that he was doing reasonably well. (RX3). Upon examination, his lungs were noted to be clear. (RX3). The assessment was "[o]verall, [he] seems to be doing reasonably well. Needs more exercise." (RX3).

In a report dated 4/4/12 (following his examination on 1/12/10), Dr. Cohen diagnosed coal worker's pneumoconiosis and chronic bronchitis. (CohenDep, PX2). Dr. Cohen noted that Petitioner had moderate impairment due to restrictive lung disease from his CWP. (CohenDep,

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PX2). Dr. Cohen went on to opine that "... the sum of the medical evidence in conjunction with this patient's work history indicates that Mr. Collins' more than 33 years of coal mine dust exposure was significantly contributory to the development of his positive CXR for pneumoconiosis. His exposure to coal mine dust is also significantly contributory to his restrictive lung disease, diffusion impairment, and altered gas exchange with exercise." (CohenDep, PX2).

In an office note dated 3/11/13, Dr. Brewer recorded that Petitioner was being seen for a physical and that he was doing reasonably well. (RX3). Upon examination, his lungs were noted to be clear. (RX3). The assessment was "[o]verall, [he] seems to be doing reasonably well." (RX3).

In an office note dated 4/16/13, Dr. Brewer recorded that Petitioner was "... in today to discuss his respiratory and pulmonary symptoms. He does have a productive cough every morning. When he gets up he feels like he has drainage down the back of his throat and feels like it is accumulating in his upper chest. Once he gets that out, then he is usually pretty good for the day but if he exerts himself then he will cough and he will cough up some yellow stuff at that time... If he walks briskly he can go a couple of blocks before he gets short of breath. One or sometimes two flights of stairs will cause him shortness of breath. He does not use any bronchodilators. He does have the constant nasal drainage and the cough in the morning and the Flonase has helped that to some degree which he uses on as needed basis throughout the year." (RX3). Dr. Brewer's assessment was that Petitioner "[p]robably does have some components of allergic rhinitis and COPD with frequent cough and changes of emphysema in his last chest x-ray." (RX3).

A pulmonary function test report dated 5/13/13 noted the "[s]pirometric data did not meet the strict diagnostic criteria for obstructive ventilator defect..." but that "[b]ody plethysmo[-] graphy demonstrated restrictive ventilator defect with a total lung capacity of 69% predicted and residual volume of 46% predicted." (PX10). In addition, bronchial provocation with metha[-] choline challenge was also found to be negative for airway hyperactivity. (PX10).

A CT of the abdomen and pelvis performed on 6/24/13 revealed, among other things, "[s]ome bands of atelectasis in the lingual and right middle lobe. A few bands of atelectasis in the left lower lobe also. There is a 12 mm nodule in the right lower lobe seen on series 2 image 2. There are a few adjacent nodules in the right lower lobe. Findings are suggestive of an inflammatory process." (PX11).

A Springfield Clinic office note dated 6/27/13 indicates Petitioner was in for a one-year follow-up pouchoscopy. (RX3). A review of symptoms (ROS) at that time revealed no pulmonary symptoms, and his breathing was noted as appearing normal and unlabored. (RX3).

Chest x-rays performed on 8/26/13 were interpreted as revealing "[s]table blunting of the left costophrenic angle likely related to scarring or pleural thickening. There is mild scarring in the right medial lower lung. No airspace consolidation, pleural effusion, or pneumothorax." (PX11). The impression was "[c]hronic changes. No acute pulmonary findings." (PX11).

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In an office note dated 8/24/14, Dr. Brewer recorded that Petitioner was in for a physical and "... is doing reasonably well. He is a little bit short of breath, if he tries to exert too fast or too much..." (RX3). Upon examination, it was noted that his lungs were clear. (RX3). The assessment was that "[o]verall, [he] seems to be doing reasonably well." (RX3).

Dr. Robert Cohen examined Petitioner at the request of the latter's attorney on 1/12/10. Dr. Cohen is a B-reader who is currently a clinical professor of environmental and occupational health sciences at the University Of Illinois School Of Public Health. (PX1, pp.4-5). In addition, he is a professor of medicine and director of occupational lung diseases at Northwestern University Feinberg School of Medicine and a consultant for NIOSH, the U.S. National Institute of Occupational Safety & Health. (PX1, p.5). Dr. Cohen also serves on a task force created by MSHA (Mine Safety Health Administration) and is the medical director of the National Coalition of Black Lung Clinics. (PX1, p.5). Furthermore, Dr. Cohen has served as a reviewer for the fifth and sixth editions of the AMA Guides to Permanent Impairment regarding respiratory disability. (PX1, p.8).

Dr. Cohen testified that he reviewed the 1/15/09 chest x-ray and noted scars or opacities that were consistent with coal workers' pneumoconiosis, q/p in shape and size and present in the upper and mid lung zones at a profusion of 1/0. (PX1, p.26). On cross examination, Dr. Cohen agreed that there is no lower profusion rating than 1/0 that would be considered positive for pneumoconiosis. (PX1, p.50). However, Dr. Cohen believed Petitioner had significant physiologic pulmonary impairment that can be measured on objective testing and that "... the cause of that is his 33 years of exposure to coal mine dust." (PX1, p.26). Based on his diagnosis of CWP and chronic bronchitis, Dr. Cohen did not feel Petitioner could have any further exposure to the environment of a coal mine without endangering his health. (PX1, pp.26-27). He also agreed that by definition someone with CWP has "... lost normal functioning lung tissue ..." (PX1, pp.30-31).

Dr. Cohen conceded that x-ray correlation with impairment is poor, and that "... the best way to measure impairment is to measure lung function studies." (PX1, p.50). He also noted that CWP won't progress once the exposure ceases. (PX1, p.53). Furthermore, Dr. Cohen stated that "[n]egative x-rays in and of themselves do not rule out mine dust lung disease." (PX1, p.62). However, he conceded that there is no pathologic evidence of coal workers' pneumoconiosis in this case, which he agreed just means that Mr. Collins hasn't had a biopsy or autopsy. (PX1, p.65).

Dr. Michael Brewer is Petitioner's current family physician. Dr. Brewer noted that he is board certified with the American Board of Family Medicine. (PX2, p.7). He indicated that during the course of his practice he has had occasion to care for and provide treatment to current and former coal miners and has treated patients for lung diseases. (PX2, pp.5-6). Dr. Brewer testified that he has treated Petitioner "[p]robably since about 2003." (PX2, pp.7-8). However, on cross, after being shown the records, he acknowledged that he first saw Petitioner on 6/24/97 for a low grade fever and cough with an assessment of probable pneumonia left lower lobe. (PX2, pp.15-16). Dr. Brewer also agreed that a CT scan performed on 8/8/97 showed infiltrates in the lower lobes, or evidence of scarring and emphysema in his lungs. (PX2, p.17). A CT of the chest performed on 4/13/05 likewise showed fibrosis or scarring. (PX2, p.28).

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Dr. Brewer opined that Petitioner suffers from chronic bronchitis, allergic rhinitis, COPD, coal workers' pneumoconiosis and restrictive lung disease, that said conditions were caused and/or aggravated by his occupational exposure as a coal miner, and that further exposure to the environment of a coal mine would present a risk to his health in the form of an increased potential for the progression of the disease. (PX2, pp.8-13; See also BrewerDep, PX2). Dr. Brewer also opined that Petitioner no longer has the pulmonary capacity to perform the labor required of a coal miner and that he considers his lung disease to be a causative factor in his disability from all work. (PX2, p.13; See also BrewerDep, PX2). Dr. Brewer acknowledged that he did not know the environment Petitioner worked in the last three years on the job, or what his last job was, but he did recall that it was something easier and that he was able to have some accommodation by his employer. (PX2, pp.81-82). Dr. Brewer stated that he did not have this more recent job in mind when he was asked whether Petitioner had the pulmonary capacity to perform the labor required as coal miner. (PX2, p.81).

On cross examination, Dr. Brewer agreed that his records show Petitioner visited him on 4/16/13 with complaints about his breathing. (PX2, p.66). At that time Petitioner noted that he had a productive cough every morning, that he felt like he had drainage down the back of his throat and that it felt like it was accumulating in his chest. (PX2, p.67). Dr. Brewer believed that may have been the first time Petitioner related such a history to him. (PX2, p.67). He noted that Petitioner had "... problems when he's exerting himself, anyway without the cough, and sometimes cough, you know, ... you can have cough or you can have wheeze, but sometimes either one of those would be a problem with exertion. And he gets short of breath when he walks", which he agreed was a non-specific complaint and which can be associated with de-conditioning. (PX2, p.68). However, Dr. Brewer conceded that his notes did not document shortness of breath with exertion at the time Petitioner left the mine. (PX2, p.82).

Dr. Brewer's assessment was "[a]llergic rhinitis and COPD, frequent cough, and changes of emphysema on his last chest x-ray." (PX2, p.69). Dr. Brewer noted that the pulmonologist who interpreted the test performed on 5/3/13 found that it did not reveal any obstruction, but there was evidence of a restriction. (PX2, pp.70-71). He also agreed that the diffusion capacity and methacholine challenge tests were normal, and that Petitioner did not have a reactive airways disease. (PX2, p.71).

Dr. Brewer agreed that he never restricted Petitioner from work due to his allergic rhinitis, and that Mr. Collins continued to have said problem after he left the mine. (PX2, p.77). However, he noted that Petitioner still has a functional problem with that condition in the form of excess mucous production and congestion. (PX2, p.77). Dr. Brewer opined that it could be due to "... any number of allergens. It could be something that he's allergic to outdoors..." (PX2, p.78). When asked whether he had ever told a coal miner that he can't work as a coal miner because of this condition, Dr. Brewer responded: "I have not done that." (PX2, p.78).

When asked about his diagnosis of chronic obstructive pulmonary disease (COPD), Dr. Brewer noted that Petitioner "... doesn't have obstructive disease, but he has restrictive disease", and that he's had it since the beginning, per the initial CT scan. (PX1, p.78). Dr. Brewer also agreed that he is not an expert in reading CTs, that he does not know what is required to make a diagnosis of CWP and that he has never interpreted chest films involving Petitioner as positive

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for CWP. (PX2, p.79). In addition, Dr. Brewer noted that fibrosis is "... probably the result of an inflammatory process" as is pneumonia. (PX2, pp.80-81). On redirect, he agreed that he considered CWP to be a scarring process of the lungs (PX2, pp.84-85).

Dr. Henry K. Smith, a board certified radiologist and NIOSH certified B-reader, interpreted x-rays dated 7/31/97 as evidencing "[s]imple coal-worker's pneumoconiosis with small opacities, primary p, secondary s, upper, mid and lower zones involved bilaterally, profusion 1/1. Mild chronic pleural thickening at the left lateral CP angle." (PX4).

In addition, Dr. Smith interpreted x-rays dated 10/12/01 as evidencing ""[s]imple coal-worker's pneumoconiosis with small opacities, primary p, secondary s, upper, mid and lower zones involved bilaterally, profusion 1/1. Diffuse pleural thickening in the lateral left lower lung with obscured lateral CP angle and ill-defined hemidiaphragms with associated plaque, suggestive of associated pneumoconiosis-related pleural disease. Cannot exclude possible infiltrate or mass including pneumonitis vs occult neoplasm by this exam." (PX4).

Likewise, Dr. Smith interpreted x-rays dated 2/10/05 as evidencing "[s]imple coal-worker's pneumoconiosis with small opacities, primary p, secondary s, upper, mid and lower zones involved bilaterally, profusion 1/1. Chronic pleural thickening along the lateral left lower lung with obscured lateral CP angle and diaphragmatic plaque extent 3, findings consistent with pneumoconiosis-related pleural disease." (PX4).

Dr. Smith also interpreted x-rays dated 4/11/05 as evidencing "[s]imple coal-worker's pneumoconiosis with small opacities, primary p, secondary s, upper, mid and lower zones involved bilaterally, profusion 1/1. Associated pleural changes with diffuse pleural thickening along the lateral left lower lung with obscured lateral CP angle and diaphragmatic plaque extent 3, findings consistent with pneumoconiosis-related pleural disease." (PX4).

Dr. Smith was asked by Petitioner's counsel to "re-read" the CT chest scan of Petitioner dated 4/14/05. Dr. Smith noted that the films were of sufficient high quality technique necessary for evaluation of CWP, and that the findings were "... consistent with changes associated [with] simple coal-worker's pneumoconiosis with small opacities, primary p, secondary s, upper, mid and lower zones bilaterally of a profusion of 1/1, associated chronic pleural parenchymal scarring in the left lung base with associated left diaphragmatic plaque and mild diffuse pleural thickening and circumscribed plaque of the left lateral chest wall; there are no associated pleural changes in the right lung and consideration is given to the possibility of unilateral Coal-worker's pneumoconiosis-related pleural disease vs other associated chronic pleural parenchymal scarring process. The lungs are mildly hyperinflated related to early mild COPD changes." (PX4). Dr. Smith went on to point out that "[a]lthough there are no specific guidelines for administering or interpreting a CT scan for evaluation of coal-worker's pneumoconiosis and, for which reason is considered 'other medical evidence'[,] the consensus by the medical profession including myself as a board certified radiologist is that this procedure is a medical acceptable test for diagnosing the presence or absence of coal-worker's pneumoconiosis, as well as grading the degree of involvement ... [T]his is a very common imaging modality utilized in my practice approximately 6-8 times daily, which I have been utilizing for the past 20-25 years in my medical practice both within hospitals and in my own private practice of Radiology..." (PX4).

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Furthermore, Dr. Smith interpreted x-rays dated 3/12/08 as evidencing "[s]imple coal-worker's pneumoconiosis with small opacities, primary p, secondary s, upper, mid and lower zones involved bilaterally, profusion 1/1. Associated diffuse pleural thickening and chest wall plaques face-on left mid to lower lung, obscured lateral CP angle and left hemidiaphragmatic plaque, findings consistent with associated pneumoconiosis-related pleural disease. The lungs are mildly hyperinflated related to mild COPD changes." (PX4).

Finally, Dr. Smith interpreted x-rays dated 1/15/09 as evidencing "[f]indings consistent with coal-worker's pneumoconiosis with interstitial fibrosis of classification s/p, mid to lower zones involved, profusion 1/0; chronic scarring in the lung bases with associated diffuse pleural thickening/obscured lateral CP angle, left greater than right side." (PX4).

In a report entitled "Pneumoconiosis Chest Film Interpretation" dated 10/1/12, Dr. Michael S. Alexander noted that his impression of chest x-rays performed on 1/15/09 was "Coal Worker's Pneumoconiosis, category p/q, 1/0, id, ih." (PX6). The Commission notes that Dr. Alexander is in fact a B-reader, as evidenced by his CV, contrary to what the Arbitrator stated at p.17 of her decision.

At the request of Respondent, Dr. James R. Castle performed a medical records review. (RX1, p.21). Dr. Castle is board certified in internal medicine and the subspecialty of pulmonary disease, and has been a B-reader since 1985. (RX1, pp.4,12). Following his review of the records, Dr. Castle was of the opinion that Petitioner "... does not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure." (RX1, p.65). Dr. Castle testified that he did not believe that the chest x-rays and CT scans showed evidence of coal workers' pneumoconiosis but instead demonstrated evidence of significant bronchiectasis due to his inflammatory bowel disease or ulcerative colitis. (RX1, pp.65-72). Likewise, in reviewing the pulmonary function studies, Dr. Castle felt that the changes noted therein were consistent with bronchiectasis due to ulcerative colitis and not coal mine dust-induced lung disease or coal workers' exposure. (RX1, pp.71-72).

On cross examination, Dr. Castle agreed that Petitioner had worked a sufficient time in and around the coal mining industry to develop CWP, chronic bronchitis and restrictive ventilator defect. (RX1, p.74). In addition, he acknowledged that Petitioner suffers from a fairly significant restrictive ventilator defect. (RX1, pp.74-75). Dr. Castle also conceded that that is one of the findings that can be seen with CWP, and that the disease can be multi-factorial in etiology in that each of the contributors could add to the total abnormality. (RX1, p.75). He indicated as well that it was possible it could apply at the same time to chronic bronchitis and a restrictive defect due in part to bowel disease or ulcerative colitis. (RX1, pp.75-76). Dr. Castle testified that chronic bronchitis is part of what is considered to be COPD, but that he did not believe Petitioner's chronic cough with sputum production was due to chronic bronchitis "... because the primary problem this man suffers from is bronchiectasis, which causes a more severe form of cough and sputum production." (RX1, pp.76-77). However, he conceded that it was possible to have bronchiectasis and chronic bronchitis at the same time. (RX1, p.77).

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However, Dr. Castle felt any diagnosis of COPD was incorrect "... because this man doesn't have obstruction, and COPD means chronic obstructive lung disease or chronic obstructive pulmonary disease, and there is no evidence in this case to indicate that he had an obstruction per se..." (RX1, p.79). However, he agreed that fibrosis can be consistent with CWP, in the proper context, and that CWP is considered to be a type of interstitial lung disease. (RX1, pp.81-82). In addition, he acknowledged that a productive cough every morning would be consistent with chronic bronchitis. (RX1, pp.84-85). Dr. Castle also agreed, based on the physiologic studies and arterial blood gas studies done by Dr. Cohen, that Petitioner is totally disabled from all work. (RX1, pp.86-87). Dr. Castle also conceded that he would not rule out the possibility that Petitioner could have CWP that could be found pathologically or at autopsy. (RX1, pp.94-95). Likewise, he acknowledged that there have been studies that have shown that as much as 50% of long-term coal miners have pathological CWP that was not appreciated by a radiographic study during their life. (RX1, p.96). In addition, he agreed that repeated exacerbations of asthma can make asthma worse and in fact can cause a remodeling of the airways so that a portion of the reactive component becomes a fixed obstructive problem, although he qualified this statement by noting that "... it's not necessarily the exposure per se but it's the presence of an ongoing inflammation in the airway that causes the remodeling..." (RX1, p.99). In addition, he conceded that by definition if a person has CWP, they would have impairment in the function of the lungs at the site of the scarring and emphysema. (RX1, pp.109, 110).

Furthermore, Dr. Castle agreed that a person can have radiographically significant CWP yet have normal spirometry, normal pulmonary function in all areas, normal blood gasses, normal physical exam of the chest and maybe even no complaints, and if they do have complaints shortness of breath is the most likely one. (RX1, p.112). He also noted that CWP can progress after cessation of mining, but that it is very uncommon. (RX1, p.113). In addition, he agreed that the official position of the American Thoracic Society is that once a person has been diagnosed with CWP there is no safe level of exposure to coal mine dust. (RX1, p.118).

When asked whether CWP is permanent, once you get it, and will not regress, Dr. Castle noted that "[p]eople can have some minimal change in their X-ray as there may be some coalescence and less obvious appearance of things and depending upon what happens with other exposures people may have, their function may actually get better..." (RX1, pp.118-119). However, he agreed that there is no cure for CWP. (RX1, p.119). In addition, he noted that it was possible that a highly susceptible host could require a relatively low dose of coal mine dust to develop the disease, while a less susceptible person might require quite a deal more exposure. (RX1, p.119).

On re-direct, Dr. Castle testified that "[b]ronchiectasis is an autoimmune, inflammatory process in the lungs ..." and that "... the bronchiectasis we see today most frequently is going to be associated with things such as genetic disorders disease like cystic fibrosis, autoimmune disorders disease like inflammatory bowel disease and other types of problems like that. Coal dust is not a cause of or an aggravation of or a contributor to bronchiectasis. It occurs in individuals with these types of processes." (RX1, p.150). Dr. Castle went on to state that "... this man clearly has significant disease manifested both by physical examination, clinical examination, X-rays and physiologic testing to go along with that. This disease does cause a

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restriction and it can cause a reduction in the diffusing capacity. It can also cause airway obstruction. In this case it did not. And I think all those findings are entirely and unequivocally due to this man's bronchiectasis." (RX1, p.153). He also noted that recurrent pneumonias are "part and parcel" to the bronchiectasis disease process. (RX1, pp.153-154). In addition, he agreed that recurrent pneumonias can cause scarring and thus fibrosis, although he noted there are other causes of fibrosis, including the drugs used to treat it, such as methotrexate and sulfasalizine. (RX1, pp.154-155).

At the request of Respondent, Dr. Jerome Wiot reviewed films in this matter. (RX2, p.48). Dr. Wiot was born in 1927, left the service in 1946, started medical school in 1949 and has been board certified in radiology since 1959. (RX2, pp.4-6; WiotDep, Ex.1). Dr. Wiot became an assistant professor of radiology at the University of Cincinnati and did general radiology after he finished his residency in 1959. (RX2, p.7). He became a full professor at the university in 1966 and was director of the University of Cincinnati Medical Center's department of radiology from 1968 to 1992 and its chairman from 1973 to 1992. (RX, pp.9-10). Dr. Wiot indicated that he was eventually named professor emeritus in 1998. (RX2, p.7). He stated that he is currently still teaching and that he is still engaged in the clinical practice of diagnostic radiology, reading about 50 or 60 films a day. (RX2, pp.8-10).

In addition, Dr. Wiot noted that he is past president of the American Board of Radiology as well as the American College of Radiology, and has served and continues to serve as an examiner on the former board with respect to the oral portion of the exam. (RX2, pp.11-13). He also noted that he was one of the trustees who originally drafted the written portion of the examination, which changes every year. (RX2, pp.12-13). Dr. Wiot was also part of the original task force set up through ALOSH, the predecessor to NIOSH, to develop a program to teach individuals about the ILO system and occupational lung disease, what is now commonly known as the B-reader program. (RX2, pp.14,19). He has remained on the task force ever since and continues to teach in the program. (RX2, p.14). In addition, he has co-authored numerous chapters and textbooks on radiology and has acted as editor of several medical periodicals. (RX2, p.46). Dr. Wiot has been a B-reader since the program started in the 1970's. (RX2, p.26).

Dr. Wiot indicated that coal worker's pneumoconiosis and silicosis invariably begins in the upper lung fields, and more often than not begins on the right side. (RX2, p.33). He noted that it will then move to the mid and lower zones, and that "... if you look at it real hard, you'll see that it's almost invariably worse at the top than it is at the bottom." (RX2, p.33). In addition, he indicated that "... [c]oal worker's [dust] and silica don't cause pleural change ..." and as a result there is absolutely no concern with pleural involvement for CWP. (RX2, p.34). He also noted that the ILO B-reading classification scheme applies to posterior/anterior chest x-rays only, and that there is no classification scheme for CAT scans at this time. (RX2, p.35). Dr. Wiot noted that while he felt that CAT scans provide additional understanding of what's going on in the lungs, he did not believe that they ever will devise a scheme to classify CAT scans because "[t]he ILO is worried about Third World countries. And CAT scans in Third World countries are essentially nonexistent." (RX2, p.35).

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Dr. Wiot reviewed the following films regarding Petitioner – PA and lateral chest x-ray dated 7/31/97, PA and lateral dated 3/12/08 from Springfield Clinic, film dated 10/12/01 and 4/11/05 from Wabash Medical Center, 1/15/09 films from Harrisburg Medical Center, and a set of CT scans of the chest dated 4/14/05 from Springfield Clinic. (RX2, p.48). He noted that all of the above were of Quality 1 diagnostic quality. (RX2, p.48). Based on his review of these films, Dr. Wiot found no evidence of coal worker's pneumoconiosis. (RX2, p.49). He noted that the 7/31/97 films "... showed changes at the left base, which subsequently proved to represent an inflammatory process with some changes within the lingular segment of the left upper lobe." (RX2, p.49). He indicated that the 10/12/01 study "... showed similar changes at the left base, and there was now a small left pleural effusion" and that the 4/11/05 study was similar. (RX2, p.49). He noted that the 3/12/08 study showed no change and that the 1/15/09 study "... showed extensive pleural thickening at the left base and changes at the left base, which probably represented a manifestation of an old inflammatory process." (RX2, p.49). With respect to the CT performed on 4/14/05, Dr. Wiot indicated that "... there was no evidence of coal worker's pneumoconiosis. There was bronchiectasis involving the right lower or right mid-lobe lung fields – or lobes ... And there was significant diffuse left pleural thickening, which was, I felt, related to post-inflammatory process." (RX2, pp.49-50). Dr. Wiot noted that you would not see these findings as a result of dust exposure. (RX2, p.50). He also agreed that pneumonia or recurrent pneumonia can result in the changes he observed in Petitioner's lungs, noting that it was "... a most likely cause of the changes with the pleural disease or related to the inflammatory process of the pneumonia." (RX2, p.50).

Dr. Wiot testified that "... any time you get scarring or emphysema, it's permanent ... for any reason" and that emphysema and scar tissue do not have normal function. (RX2, p.66). Dr. Wiot also agreed that "theoretically" if a person has CWP they would have impairment in the function of their lungs at the site of the scar tissue and emphysema even though that impairment may not be able to be measured by pulmonary function testing. (RX2, pp.66-67). Likewise, he agreed that the most common defect caused by emphysema would be obstructive. (RX2, p.67). In addition, he noted that while CWP can be progressive with continued exposure, it tends not to be progressive most of the time after exposure ceases, but he has seen it progress. (RX2, pp.67-68). However, he indicated that the progression would not be expected to be big. (RX2, pp68-69).

On cross examination, Dr. Wiot agreed that a person can have CWP by x-ray and still have normal physical exam of the chest, normal pulmonary function testing and normal arterial blood gas testing. (RX2, p.70). He indicated that he did not know if shortness of breath was the most common complaint of those with CWP. (RX2, p.70). When asked whether a person could have CWP with no shortness of breath at all, Dr. Wiot stated that "[t]heoretically you shouldn't have any shortness of breath unless you're a smoker and have emphysema, but, you know, I don't know that. That's not my bag." (RX2, p.70). Also, while he did not know whether Petitioner had sufficient exposure to cause CWP in a susceptible host, he "ma[d]e the assumption that he has ..." (RX2, p.71). Likewise he agreed with the proposition that each miner may have a distinct and unique response to his coal dust exposure, and that that is true of any disease process. (RX2, p.71). He also noted that the rate of progression of CWP may vary from miner to miner as well as within a particular miner over time. (RX2, p.72). In addition, he testified that "... most of the time large opacities occur in the upper lung fields ..., but I have seen large

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opacities in the lower lobes. I have seen large opacities every place: Middle lobes and so on." (RX2, p.74). He also indicated that "[y]ou can't look at a radiograph and tell with any element of certainty whether an individual's got coal worker's pneumoconiosis or silicosis." (RX2, p.77). He likewise noted that "[y]ou can have coal worker's pneumoconiosis and have perfectly normal chest x-rays and CTs." (RX2, p.87).

On redirect, Dr. Wiot indicated that an individual with "subradiographic" CWP would have no clinical significance. (RX2, p.87). However, on recross, he agreed that if a person has pathologically significant CWP, it has been shown that they are susceptible to coal dust deposition and ensuing reaction and creation of nodules. (RX2, p.88).

Conclusions of Law

An occupational disease is defined as "... a disease arising out of and in the course of the employment or which has become aggravated and rendered disabling as a result of the exposure of the employment. Such aggravation shall arise out of a risk peculiar to or increased by the employment and not common to the general public." 820 ILCS 310/1(d).

The Occupational Diseases Act ("OD Act") also states that "[a] disease shall be deemed to arise out of the employment if there is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work is performed and the occupational disease. The disease need not to have been foreseen or expected but after its contraction it must appear to have had its origin or aggravation in a risk connected with the employment and to have flowed from that source as a rational consequence." 820 ILCS 310/1(d).

In addition, the OD Act provides that "[a]n employee shall be conclusively deemed to have been exposed to the hazards of an occupational disease when, for any length of time however short, he or she is employed in an occupation or process in which the hazard of the disease exists... ***If a miner who is suffering or suffered from pneumoconiosis was employed for 10 years or more in one or more coal mines there shall, effective July 1, 1973 be a rebuttable presumption that his or her pneumoconiosis arose out of such employment.***" (Emphasis added) 820 ILCS 310/1(d).

Furthermore, §1(e) of the OD Act states that "disablement" means "... an impairment or partial impairment, temporary or permanent, in the function of the body or any of the members of the body, or the event of becoming disabled from earning full wages at the work in which the employee was engaged when last exposed to the hazards of the occupational disease by the employer from whom he or she claims compensation, or equal wages in other suitable employment; and 'disability' means the state of being so incapacitated." 820 ILCS 310/1(e).

Finally, the OD Act provides that "[n]o compensation shall be payable for or on account of any occupational disease unless disablement, as herein defined, occurs within two years after the last day of the last exposure to the hazards of the disease, except in cases of occupational disease caused by berylliosis or by the inhalation of silica dust or asbestos dust and, in such cases, within 3 years after the last day of the last exposure to the hazards of such disease..." 820 ILCS 310/1(f).

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Based on the above, and the record taken as a whole, the Commission reverses the Arbitrator and finds that Petitioner proved by the preponderance of the credible evidence that he was exposed to and suffers from the effects of an occupational disease, as that term is defined in the OD Act, in the form of coal worker's pneumoconiosis (CWP) as well as chronic bronchitis based on the opinion of Dr. Cohen. Along these lines, the Commission also relies on the opinions of fellow B-readers Drs. Smith and Alexander (the latter of whom the arbitrator incorrectly labeled as not being a B-reader) and the opinion of primary care physician Dr. Brewer, who noted multiple chest x-ray and CT scan findings consistent with simple CWP, although admittedly at the low end of the spectrum, as well as a history of chronic bronchitis. The Commission finds the contrary opinions offered by Respondent's record reviewers, Drs. Wiot and Castle, to be unpersuasive.

The Commission further finds that since Petitioner was employed in the mining industry for ten or more years a rebuttable presumption exists that his CWP condition arose out of his employment. The record shows that Petitioner is a non-smoker and that he worked for various mining and reclamation operations from 1973 through 2007, or a total of 33-1/2 years, an estimated 12-1/2 to 13-1/2 years of which he spent working underground.

Furthermore, the Commission finds that Petitioner's current condition of ill-being relative to the aforementioned occupational diseases is causally related to his employment and his 33-1/2 years of on-the- job exposure to coal dust, silica dust, roof bolting glue fumes, smoke from coal fires, and diesel fumes. This finding is based on the opinions of Drs. Cohen, Brewer, Smith and Alexander. Once again, the Commission is not persuaded by the opinions of Respondent's record reviewers, Drs. Wiot and Castle, who appear all too willing to minimize the significance of Petitioner's work environment in order to attribute Mr. Collins' pulmonary impairment to his underlying condition of inflammatory bowel disease. Indeed, even Dr. Castle conceded that Petitioner had worked a sufficient time in and around the coal mining industry to develop CWP, chronic bronchitis and restrictive ventilator defect. (RX1, p.74).

In addition, the Commission finds that Petitioner sustained his burden of proving disablement within two years after the date of the last exposure to the hazards of the disease, given that Mr. Collins last worked for Respondent on 8/31/07 and subsequently filed his Application for Adjustment of Claim on 2/25/09. This finding is based not only on Petitioner's physical impairment but also in light of his inability to return to work in the coal mining industry or otherwise find suitable employment due to his impairment. Along these lines, Dr. Cohen testified that based on his diagnosis of CWP and chronic bronchitis, he did not feel that Petitioner could have any further exposure to the environment of a coal mine without endangering his health. (PX1, pp.26-27). Dr. Brewer likewise was of the opinion that Petitioner no longer had the pulmonary capacity to perform the labor required of a coal miner and that he considered his lung disease to be a causative factor in his disability from all work. (PX2, p.13; See also BrewerDep, PX2).

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With respect to the nature and extent of disability, the Commission notes that at the commencement of trial, Petitioner expressly elected to proceed under the "man-as-a-whole" provisions of §8(d)2 of the Act, thereby waiving any potential claim pursuant to §8(d)1 of the Act. (T.6).

In making this award, the Commission relies on the medical record taken as a whole, including the opinion of Dr. Cohen who testified that Petitioner "...does not have the pulmonary capacity to perform heavy manual labor, specifically the labor of his last coal mining job, nor could he perform significant amounts of manual labor in any kind of job. I do believe that he retained the capacity to perform any job that was sedentary and didn't require him to do significant amounts of manual labor... based solely on the lung function and cardiopulmonary exercise testing." (PX1, pp.21-22). Dr. Cohen went on to opine that Petitioner's "... pulmonary impairment is a major significant contributor to his inability to do more than sedentary labor." (PX1, p.25). The record shows that Petitioner has neither worked nor sought work, sedentary or otherwise, since he was last employed by Respondent on 8/31/07.

For his part, Petitioner testified that since leaving the mine his shortness of breath has gotten "really bad", especially in cold and hot weather. (T.28). He indicated that he can probably walk on level ground at a normal pace for two or three blocks or climb a flight of stairs before becoming short of breath. (T.28-29). He also noted that he does not currently take any breathing medications, but that he is "... probably going to be starting here." (T.29). He testified that because of his breathing problems he no longer goes out fishing, hiking or to paint pictures. (T.29). He indicated that he can no longer do the lawn/landscaping as well as maintenance work around the house and has to hire someone to do it. (T.29-30). He also noted that he cannot exercise because he "... get[s] out of breath too quick trying to do that" and experiences a "tightness." (T.30).

Based on the above, and the record taken as a whole, the Commission finds that Petitioner suffered the permanent partial loss of use of 20% person-as-a-whole pursuant to §8(d)2 of the Act.

All else otherwise affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $628.86 per week for a period of 100 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused permanent partial disability to the extent of 20% person-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

T6IWCC0204

16IWCC0204

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $63,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 3 2016

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

o: 2/8/16
TJT/pmo
51

A 0S6053187

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

COLLINS, DOYLE
Employee/Petitioner

Case# **09WC008264**

FREEMAN UNITED COAL MINING COMPANY
Employer/Respondent

16IWCC0204

On 2/10/2015, 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 0.08% 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:

0755 CULLEY & WISSORE
KIRK CAPONI
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

1662 CRAIG & CRAIG
KENNETH F WERTS
115 N 7TH ST PO BOX 1545
MT VERNON, IL 62864

16IWCC0204

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DOYLE COLLINS,
Employee/Petitioner

v.

FREEMAN UNITED COAL MINING COMPANY,
Employer/Respondent

Case # **09** WC **8264**

Consolidated cases: _____

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 **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **1/22/15**. 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. [x] 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. [x] 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. [x] 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. [x] Other **Sections 1(d)-(f) of the Occupational Disease Act**

FINDINGS

On **8/31/07**, 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 not*** sustain an accident that arose out of and in the course of employment.

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

In the year preceding the injury, Petitioner earned **$52,405.16**; the average weekly wage was **$1,048.10**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **no** dependent children.

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$00.00**.

Respondent is entitled to a credit of **$00.00** under Section 8(j) of the Act.

ORDER

Petitioner has failed to prove by a preponderance of the credible evidence that he sustained an occupational disease that arose out of and in the course of his employment by respondent on 8/31/07. Petitioner's claim for compensation is denied.

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.

Signature of Arbitrator

2/7/15
Date

ICArbDec p. 2

FEB 10 2015

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 55 year coal mine engineer, alleges that he sustained an occupational disease that arose out of and in the course of his employment by respondent 8/31/07. Petitioner graduated high school and received an Associate's Degree from Southeastern Illinois University. He also went back to school and took more classes in mining technology. Petitioner spent 33.5 years in the coal mining business. Petitioner was a non-union employee for respondent. Petitioner was exposed to silica, roof bolting fumes, smoke from coal fires, and diesel fumes while working for respondent.

Petitioner last worked for respondent on 8/31/07. He stopped working that day because that was the day the mine closed. On that day petitioner was working as a warehouse clerk and was exposed to coal mine dust. Petitioner testified that if the mine had not shut down on that day he would have returned to work the next day. After being laid off petitioner did not look for any alternate work.

Petitioner started working in the mines in 1973 when he was hired by Peabody Coal as a rod man. A rod man was a helper for setting the direction of where the mine should be coaled. He made sure miners stayed straight when mining. After this, petitioner worked in the engineering office for a few years. The engineering office was above ground.

After petitioner worked as an engineer he began working in the Will Scarlett Mine. He worked as a crew leader and instrument man for 7 years. This job involved surveying work. Petitioner would work wherever they needed him. He would stake things out, and measure where the miners took the coal out. Petitioner testified that this work took place in the strip mine which was a dusty environment. Petitioner testified that the roads were made of gob, and they were watered down regularly to keep the dust down. Despite these efforts petitioner testified that the roads were often very dusty.

Petitioner was next transferred to Pawnee Illinois Mine 10, which was an underground coal mine. Petitioner worked as a surface surveyor for 12 years. In this position he would take measurements of the coal in stock piles. He also filled in for the underground surveyor at times.

Petitioner next performed reclamation work in the old mines for 4 years. His position in the old mines was that of a surveyor/field engineer. Petitioner would survey for drainage and stake it out. He would also cover slurey ponds that were full of coal with dirt. Petitioner testified that the old mines were still dusty from the trucks and dirt.

In 1999 petitioner began working for respondent in Crown 2 and Crown 3. He was hired as a rod man and did that for 6.5 years. All this work was performed underground. Petitioner was also a crew leader. In that

position he was exposed to coal dust. He testified that while surveying on the returns a lot of miners, rock dust and diesels would pass by him and he was exposed to rock dust and diesel fumes. Petitioner mined the rooms off the main entry. He would set the site up in the returns, and at times he was overwhelmed by the fumes and dust.

Petitioner's last job while working for respondent was in the warehouse. Petitioner worked in this position for 2 year. He was moved to this position by Vice President Colwell because of his hearing problems. Once petitioner received his cochlear implant in 2006 he was unable to work in the mines because he was prohibited from working in areas where there may be methane gas present. The batteries in petitioner's cochlear implant are not MHSA approved. Petitioner was also unable to wear a hard hat because of the placement of his cochlear implant. In this position petitioner received and distributed supplies from the vendors. Petitioner would check parts in and out. These parts were used underground. In this position petitioner also cleaned the warehouse. He would sweep the floors every night. He cleaned the shelves in Crown 3. He testified that the shelves had thick layers of coal dust and other dusts. Petitioner testified that the warehouse door opened to the mine and the dust from the mine would enter the warehouse. Petitioner claims he got dirtier cleaning the shelves than he did working in the mine.

Petitioner testified that his breathing problems came on while he was working in the mines, but could not recall exactly when. He testified that he noticed it getting harder to do things. He noted that he would lose his breath easier, and it gradually worsened. Petitioner testified that in the past year his breathing has gotten worse. Before that he believed it was stable. Petitioner stated that he can only walk 2-3 blocks on level ground before he becomes short of breath. He can also walk a flight of stairs before becoming short of breath. Petitioner does not use any breathing medications.

Currently, petitioner states his breathing problems prevent him from fishing, hiking, walking, doing yard work and landscaping. Petitioner does not do any maintenance on his house. He also does not bike or exercise anymore because he gets short of breath too fast. Petitioner claims he has tightness in his chest all the time. Petitioner testified that his limits on walking is due not only to his breathing, but also bowel seepage. Petitioner also noted bowel seepage with activities that include squatting, bending and straining. Petitioner tries not to be too far from a rest room at any time. Petitioner experiences blockages in his colon every now and then based on his medicine and what he eats.

Petitioner never smoked, but he used Skoal. The last time he used it was in about 2004 or 2005. However, he does have other illnesses that include an autoimmune condition, ulcerative colitis, anxiety, and 75% loss of

hearing in the past two years as a result of his autoimmune condition. As a result of his ulcerative colitis, petitioner had his small intestine removed and resectioned.

On 2/25/09 petitioner filed his Application of Adjustment of Claim for this claim. He alleged an accident date of 8/31/07. He indicated that the accident occurred as a result of "inhalation of coal mine dust including but not limited to coal dust, rock dust, fumes & vapors for a period in excess of 33 years". He indicated that his lungs and/or heart were affected. He identified the nature of his injury as "shortness of breath & exercise intolerance".

On 2/4/09 Dr. Henry Smith, D.O., Board Certified Radiologist and NIOSH Certified B-Reader reviewed a radiograph taken 1/15/09. Dr. Smith has been a B Reader since 1987. Dr. Smith has continuously passed six out of the next eight re-exams without losing his certification status over the past 23 years. He rated the quality of the film as 1. His impression was "findings consistent with coal worker's pneumoconiosis with interstitial fibrosis of classification s/p, mid to lower zones involved, profusion 1/0; chronic scarring in the lung bases with associated diffuse pleural thickening/obscured lateral CP angle, left greater than right side.

On 3/18/12 Dr. Robert Cohen, M.D., Certified B-Reader since 5/1/98 reviewed a radiograph dated 1/15/09. He rated the film quality as 1. His impression was that the exam was positive for the opacities of pneumoconiosis q/p in shape, and 1/0 in profusion. He noted that the left CP angle was blunted and there was diffuse pleural thickening noted on the left of extent 3, width a. He opined that the cause of these findings was petitioner's 33 years of exposure to coal mine dust.

On 7/9/12 Dr. Smith reviewed a radiograph taken 7/31/1997. He rated the quality of the film as 1. His impression was simple coal worker's pneumoconiosis with small opacities, primary p, secondary s, upper, mid and lower zones involving bilaterally, profusion 1/1. Mild chronic pleural thickening of the left lateral CP angle was noted.

On 7/9/12 Dr. Smith also reviewed a radiograph taken 10/12/01. He rated the film quality as 1. His impression was simple coal worker's pneumoconiosis with small opacities, primary p, secondary s, upper, mid and lower zones involved bilaterally, profusion 1/1. He also noted diffuse pleural thickening in the lateral left lower lung with obscured lateral CP angle and ill-defined hemidiaphragms with associated plaque, suggestive of associated pneumoconiosis-related pleural disease. Dr. Smith could not exclude other possible infiltrate or mass pneumonitis versus occult neoplasm by his exam.

On 7/9/12 Dr. Smith also reviewed a radiograph taken 2/10/05. He rated the film quality as 1. His impression was simple coal worker's pneumoconiosis with small opacities, primary p, secondary s, upper, mid

and lower zones involved bilaterally, profusion 1/1. He also noted chronic pleural thickening along the lateral left lower lung with obscured lateral CP angle and diaphragmatic plaque, extent 3, findings consistent with pneumoconiosis-related pleural disease.

On 7/9/12 Dr. Smith also reviewed a radiograph taken 4/11/05. He rated the film quality as 1. His impression was simple coal worker's pneumoconiosis with small opacities, primary p, secondary s, upper, mid and lower zones involved bilaterally, profusion 1/1. He also noted associated pleural changes with diffuse pleural thickening along the lateral left lower lung with obscured lateral CP angle and diaphragmatic plaque extent 3, findings consistent with pneumoconiosis-related pleural disease.

On 7/9/12 Dr. Smith reread a chest CT scan of petitioner's dated 4/14/05. He was of the opinion that the films were of sufficient high quality technique in terms of slice thickness and intervals between the slices necessary of evaluation of coal worker's pneumoconiosis. His impression was findings consistent with changes associated with coal worker's pneumoconiosis with small opacities, primary p, secondary s, upper, mid and lower zones involved bilaterally, profusion 1/1, associated chronic pleural parenchymal scarring in the left lung base with associated left diaphragmatic plaque and mild diffuse pleural thickening and circumscribed plaque of the left lateral chest wall; there were no associated pleural changes in the right lung and consideration was given to the possibility of unilateral coal worker's pneumoconiosis-related pleural disease versus other associated chronic pleural parenchymal scarring process. He also noted that the lungs were mildly hyperinflated, related to early mild COPD changes.

On 7/9/12 Dr. Smith reviewed a radiograph dated 3/12/2008. He rated the film quality as 1. His impression was simple coal worker's pneumoconiosis with small opacities, primary p, secondary s, upper, mid and lower zones involved bilaterally, profusion 1/1. He also noted associated pleural thickening and chest wall plaques face-on left mid to lower lung, obscured lateral CP angle and left diaphragmatic plaque, findings consistent with pneumoconiosis-related pleural disease. He noted that the lungs were mildly hyperinflated, related to mild COPD changes.

On 10/1/12 Dr. Michael Alexander, Certified B-Reader since 1992, reviewed a radiograph dated 1/15/09. He rated the film quality as 1. His impression was coal worker's pneumoconiosis, category p/q, 1/0, id, ih.

Petitioner offered into evidence the records of Dr. Michael Brewer from Wabash Medical Center IL, from 6/24/97 through 11/17/11. On 2/21/11 he gave a history of spitting up some blood with a cough. His lungs and heart were normal. On 4/22/03, 2/16/10, 3/13/09, 7/1/08, 2/21/06 petitioner's lung and heart exams were normal. On 12/1/09 Dr. Brewer assessed possible persistent bronchitis. On 3/28/08 petitioner presented Dr. Brewer with

some disability papers to be filled out. He reported that he did not feel like he could work at all because of his hearing and his frequent diarrhea. On 3/12/08 Dr. Brewer assessed a history of some changes in his chest xray and a little dyspnea on exertion. On 5/13/05 Dr. Brewer noted a few scattered rhonchi, and chronic lung disease that he confirmed with a CT scan. He assessed possible acute bronchitis and underlying chronic disease. On 2/14/05 and 7/29/02 petitioner was diagnosed with pneumonia. On 9/11/01 petitioner was assessed with possible allergic rhinitis, maybe some aggravation from coal dust. He had a fairly persistent cough for 2-3 months. Petitioner gave a prior history of problems with his lungs in the past. On 2/18/01, 3/11/01, 3/16/01 petitioner was assessed with bronchitis. On 3/16/00 petitioner complained of a cough most of the winter, he was assessed with possible bronchitis. On 6/24/97 petitioner was assessed with probable pneumonia, in the left lower lobe.

While treating with Dr. Brewer petitioner underwent various diagnostic tests. X-rays taken 2/21/11 revealed lungs clear of alveolar infiltrate; and bibasilar scarring and chronic pleural scarring, left greater than right. Chest x-rays taken 3/12/08 showed evidence of chronic pleural and parencymal fibrotic changes in the left hemithorax unchanged; clear right lung; mild apical pleural thickening, unchanged. A Chest CT performed 4/14/05 showed chronic infiltrates in the right middle lobe and left lower lobe, suggesting bronchiectasis; fibrosis in the left chest and lingula; prominent epicardial fat; and no acute findings. Chest x-rays taken 4/11/05 showed stable and chronic pleural parenchymal changes in the left lung base with some stable fibrotic changes suggesting the lingula and perhaps the right middle lobe. There was an area of increased density either in the lingula or right middle lobe, suggesting an acute infiltrate superimposed upon chronic fibrotic changes with perhaps slight improvement since the examination performed 2/10. Underlying COPD was present and stable. Also noted were small nodular opacity in the right pulmonary apex unchanged from 2002. Chest x-rays taken 8/22/02 showed infiltrates in the left lower lung similar to those shown on films dated 10/12/01. The pleural density at the left lung base appeared less prominent. A small density projecting through the lateral aspect of the right lung apex appeared to be benign. Chest x-rays taken 10/12/01 showed infiltrate in the left lung base with associated pleural reaction of the left costophrenic angle. The degree of infiltrate was unchanged with a slight increase in pleural reaction. Chest x-rays performed 9/11/01 showed interval increase in the left basilar infilitrate and blunting of the left costophrenic angle. Chest x-rays performed 4/18/00 showed fibrosis in the middle lung base, and minimal left costophrenic angle blunting that may represent some pleural thickening. A chest CT scan taken 8/7/97 showed left lower lobe infiltrate and some infiltration of the right middle lobe and lingula that could be chronic. Small nodular infiltrative density along the left heart border of unknown chronicity. Chest x-rays performed 7/31/97 revealed persistent infiltrate in the left lung base and a possible superimposed mass, possibly chronic scarring.

Petitioner offered into evidence records from Springfield Clinic from 3/17/02 through 11/7/12. Records were reviewed for any lung or breathing problems. On 1/21/11 petitioner reported spitting up some blood with cough three weeks ago. His lungs were clear. On 12/1/09 petitioner reported that he had been coughing for 5-6 months. He reported that he was coughing up green and brown stuff. His lungs were clear. He was diagnosed with possible persistent bronchitis. On 10/8/07 petitioner reported coughing up some colored mucous. He was assessed with tracheobronchitis. On 5/14/06 petitioner reported sinus complaints with productive cough of a dark sputum. No chest pain or shortness of breath was noted. He was assessed with a sinus infection. On 5/13/05 petitioner reported "coughing up of green stuff". He was assessed with possible acute bronchitis and underlying chronic disease. On 2/14/05 and 4/11/05 he presented for follow-up of pneumonia. On 2/10/05 petitioner was assessed with probable early pneumonia.

Petitioner also offered into evidence records from Springfield Clinic from 11/1/12 to present. On 4/16/13 petitioner reported a productive cough every morning, and after he exerts himself. He was assessed with probable components of allergic rhinitis and COPD with frequent cough and changes of emphysema in last chest x-ray. Petitioner underwent pulmonary tests on 5/13/13 that revealed normal spirometry, diffusing capacity and methacholine challenge. His lung volume was restricted.

Petitioner offered into evidence records from Springfield Clinic from 6/3/13 to present. Chest xrays taken 8/26/13 revealed stable blunting of the left costophrenic angle likely related to scarring or pleural thickening; mild scarring in the right medial lower lung. No pleural effusion was noted.

Dr. Wiot reviewed the petitioner's chest x-rays of 7/31/97, 3/12/08, 10/12/01, 4/11/05, and 1/15/09. All films had a quality of 1. He opined that none of them showed any evidence of coal worker's pneumoconiosis. He was of the opinion that the 7/31/97 films showed changes within the left base which subsequently proved to represent an inflammation process, with minor changes in the lingular segment of the left upper lobe. The study of 10/12/01 showed similar changes at the left base, with a small left pleural effusion. The study of 4/11/05 showed similar changes. The study of 3/12/08 showed no change, and the study dated 1/15/09 showed extensive pleural thickening at the left base and changes in the left base which probably represented a manifestation of an old inflammatory disease. Dr. Wiot was of the opinion that the major problem is that petitioner develops chronic pleural disease due to repeated inflammatory processes at the left base, and not dust exposure. He opined that pneumonia and recurrent pneumonia are something that can result in the changes observed in the petitioner's lungs, and these were the cause of the changes he saw with respect to the pleural disease or related to the inflammatory process of the pneumonia.

On 9/8/10 the evidence of Dr. Wiot, a B reader and a board-certified diagnostic radiologist, was taken on behalf of respondent. Dr. Wiot testified that he's been board-certified in radiology since 1959. He testified that he has been a B reader since the first exam was given. He testified that he currently reads about 50 or 60 films a day. Dr. Wiot began in academia as an assistant professor of radiology in 1959, and eventually was elevated to a full professor in 1966. Dr. Wiot was director of the Department of Radiology at University Hospital from 1968 to 1992. He was also Chairman of the Department of Radiology at the University of Cincinnati Medical Center from 1973 to 1992. He testified that these two facilities were the same. Dr. Wiot is a past president of the American Board of Radiology. Dr. Wiot testified when he was a trustee of the board, he was part of a group that developed the first questions for the written portion of the board examination for the B reader. Dr. Wiot is also a past president of the American College of Radiology. Dr. Wiot would teach those enrolled in the B reader program how to read x-rays properly, and consistently.

Dr. Wiot testified that a 1/0 is the lowest level of positive film. He stated that 0/1, is a film that is normal, but you seriously considered that it may be positive because it has something such as couple of nodules that would suggest the presence of pneumoconiosis. Dr. Wiot was of the opinion that in coal worker's pneumoconiosis the vast majority of the nodules will be primarily Qs and Ts. Dr. Wiot opined that coal worker's pneumoconiosis invariably always begins in the upper lung fields, more often on the right, and then moves to the mid and lower zones. He further opined asbestos always begins in the bottom of the lungs. Dr. Wiot opined that coal worker's pneumoconiosis and silica don't cause pleural changes. Dr. Wiot opined that a CT scan is a standard tool that is used for the diagnosis of lung disease but are not classified by the ILO. Dr. Wiot testified that he saw no emphysema on the CT scan.

On cross examination Dr. Wiot testified that you cannot put up an x-ray and say it is unquestionably coal worker's pneumoconiosis if it is simple, because there are 30 possibilities of why a person may have nodules, with coal worker's pneumoconiosis and silicosis being just 2 of them. If it is complicated coal worker's pneumoconiosis, it is easier to say it is unquestionably coal worker's pneumoconiosis. Dr. Wiot agreed that when coal miners work in the coal mine environment for 10, 20, 30 or more years and leave, they are all going to come out with some coal dust deposit in their lungs, but they won't all have tissue reaction to the coal dust. He was of the opinion that those that do may have coal worker's pneumoconiosis, if there is enough reaction. By definition, he was of the opinion that a person with coal worker's pneumoconiosis will have an impairment in the function of their lungs at the site of the scar tissue and emphysema, even though the impairment may not be able to be measured by pulmonary function testing. Dr. Wiot opined that simple coal worker's

pneumoconiosis itself does not cause any pulmonary function abnormalities. Dr. Wiot agreed that you can have coal worker's pneumoconiosis and have a perfectly normal chest x-ray, but shows up pathologically.

On 1/23/14 the evidence deposition of Dr. Brewer, a family physician, was taken on behalf of the petitioner. Dr. Brewer opined that petitioner has chronic bronchitis, COPD, restrictive lung disease and coal worker's pneumoconiosis that were caused in part or aggravated and made worse by his occupational exposure as a coal miner and further exposure to a coal mine would present a risk to his health and possible progression of this disease. Dr. Brewer was of the opinion that coal worker's pneumoconiosis is a scarring process in the lungs.

On cross-examination Dr. Brewer testified that he met with petitioner's attorney, Bruce Wissore twice. He testified that they talked about the case and what Mr. Wissore needed to help petitioner prove his claim, and it was after that that he sent his letter with his opinions to Mr. Wissore. Dr. Brewer testified that before 10/10/07 he has no diagnosis of coal worker's pneumoconiosis in petitioner's records. Dr. Brewer testified that he never restricted petitioner because of his diagnosis of allergic rhinitis, and petitioner still has problems with it since he left the mine. He testified that it could be due to many allergens and never told a coal miner that he could not work because of it. Dr. Brewer opined that petitioner has restrictive disease, but not obstructive disease. He testified that he never interpreted a chest film of petitioner's as being positive for coal worker's pneumoconiosis. Dr. Brewer was of the opinion that fibrosis and pneumonia result from an inflammatory process. Dr. Brewer did not know what petitioner's last job was when he worked in the coal mine, and he had no documentation of shortness of breath with exertion in his records on 8/31/07, when petitioner left the mine.

On 1/12/10 Dr. Cohen examined petitioner at the request of the petitioner. He did not generate his report until 4/4/12. Dr. Cohen took a history, and performed a physical examination and pulmonary function tests. Petitioner gave a history of shortness of breath on exertion for the last two years, with more shortness of breath when pushing a mower or snow blower than he had in the past. He complained of DOE when climbing two flights of stairs, and stated that he gets shortness of breath walking 5 to 10 minutes on level ground. Petitioner complained of cough with 1/2 cup of sputum production which was brownish in the morning and then green to brown the rest of the day for 10 years, worse in the last 2 to 3 years and even worse over the last six months. He also complained of wheezing for one year with slight exertion, after showering. Dr. Cohen was of the opinion that the sum of the medical evidence in conjunction with petitioner's work history indicates that he had more than 33 years of coal mine dust exposure that significantly contributed to the development of his positive CXR for pneumoconiosis. He was further of the opinion that petitioner's exposure to coal mine dust significantly contributed to his restrictive lung disease, diffusion impairment, and altered gas exchange with exercise.

On 6/10/14 the evidence deposition of Dr. Robert Cohen, was taken on behalf of petitioner. Dr. Cohen is a professor of medicine and director of occupational lung diseases at Northwestern University Feinberg School of Medicine, and is a consultant for NIOSH. He also serves on a task force that was created by MSHA to study and look at health and injuries in the mining population in the US. Dr. Cohen is the medical director of the National Coalition of Black Lung Clinics, and course director for NIOSH spirometry courses. Dr. Cohen has been a B-Reader since 1998 continuously. Dr. Cohen testified that people with chronic bronchitis may have it for many years before they report it to their doctor and realize that the problem is chronic. Dr. Cohen believed that the coal mine dust exposure during petitioner's 33 years of coal mine employment was the main respiratory hazard that petitioner was exposed to. Dr. Cohen was of the opinion that gradual and slow developing processes can escape detection until they reach a certain critical point, despite the fact that the symptoms were there before. Dr. Cohen was of the opinion that petitioner had lung function testing that showed moderately impaired FEV1, along with moderate diffusion impairment, and significant resting and exercise gas exchange problems that were noted on his exercise test. He believes petitioner does not have the pulmonary capacity to perform heavy manual labor, specifically in the coal mine. Dr. Cohen believes petitioner's underlying lung disease is a significant contributor to petitioner's low oxygen level. Dr. Cohen opined that petitioner is only capable of working at the sedentary level due to his lung problems. Dr. Cohen does not believe petitioner could have any further exposure to the coal mines without endangering his health. Dr. Cohen opined that for a person to have pneumoconiosis they must have a tissue reaction to the coal dust that is trapped in the lungs. Dr. Cohen opined that that the scarring and emphysema of coal worker's pneumoconiosis cannot perform the function of a normal healthy lung tissue. He stated that if a person has minimal simple coal worker's pneumoconiosis they could present without measurable impairment and pulmonary function. He also stated that many patients with coal worker's pneumoconiosis complain of shortness of breath. Dr. Cohen recommended that petitioner no longer be exposed to the coal mine. He testified that CT scans are not recognized by NIOSH for purposes of making B-readings for pneumoconiosis. Dr. Cohen testified that x-ray reading is very subjective, and it's not uncommon to have readings that are positive by some readers and others negative.

On cross-examination Dr. Cohen testified that he has performed over 100 exams at the request of Culley & Wissore. Dr. Cohen testified that he did not report that petitioner took any medications for breathing. Dr. Cohen testified that the presence of a cough is not considered an objective determinant of pulmonary impairment as noted in the AMA guides, since it could be related to so many things including allergic rhinitis. Dr. Cohen testified that petitioner did not relate to him an inability to do his work in the mine due to respiratory problems. Dr. Cohen testified that petitioner's exercise testing was not stopped due to his breathing reserve, but rather due to generalized fatigue and leg fatigue.

On 8/8/14 the evidence deposition of Dr. James Castle, was taken on behalf of the respondent. Dr. Castle is a pulmonologist, board certified in internal medicine, and has a subspecialty of pulmonary disease. He is also a B-Reader since 1985. Dr. Castle testified that he did not have a lot of coal worker's pneumoconiosis patients in his practice. The biggest group of patients he saw were for asbestos exposure. Dr. Castle taught medical students and residents about lung disease. He gave up his active practice in Roanoke, VA in 2003. Dr. Castle did most of his pulmonary examinations for federal cases. He testified that forensic review of records and films he does is for the coal mine, or employer.

Dr. Castle reviewed records and films regarding petitioner, at the request of the respondent. These records included 1) the deposition of Dr. Brewer dated 1/23/14, 2) radiographic reports of Dr. Smith, 3) radiographic reports by Dr. Wiot, 4) medical records from SafeWorks that included a chest x-ray dated 6/21/01 with an impression of COPD with left lower lobe pneumonia; a chest x-ray dated 8/20/02 with an impression of chronic changes in the left lung based without acute pulmonary abnormality; a chest x-ray dated 9/21/04 indicating chronic, bilateral pulmonary changes unchanged from previous x-rays, chronic infiltrate in the left lung base and an overlying pleural reaction, chronic obstructive lung disease, and fibrotic changes in the right middle lobe that were chronic; a chest x-ray dated 10/10/05 indicating blunting of the left costophrenic angle without significant change, infiltrate in the lingula unchanged, bilateral apical pleural thickening, and interstitial lung markings mildly prominent in the lung bases, 5) radiographic report of Dr. Alexander; 6) medical records from Dr. Cohen with medical summary dated 4/4/12, 7) medical records pertinent to Social Security application, 9) and medical records from the Springfield Clinic.

Based on his review of these records and films regarding petitioner, Dr. Castle opined that petitioner does not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure. He agreed that petitioner worked in or around the underground mining industry for a sufficient enough time to develop coal worker's pneumoconiosis if he were susceptible hosts. Dr. Castle opined that a risk factor for the development of pulmonary symptoms and disease is that of inflammatory bowel disease or ulcerative colitis. He noted that pulmonary complications have been seen with increasing regularity with these conditions since the mid-1970s. He opined that pulmonary complications typically follow the onset of inflammatory bowel disease in up to 85% of patients. He identified the pulmonary complications as airway inflammation, parenchymal lung disease, thromboembolic disease, serositis, and drug induced lung toxicity. Dr. Castle was of the opinion that patients with IBD associated bronchitis/bronchiectasis typically present with a cough with variable amounts of purulent sputum production. He was also of the opinion that recurrent pneumonias are not uncommon, and drugs used to treat these diseases may contribute to the pulmonary problems. He opined that

pulmonary function studies may demonstrate a reduced or normal forced vital capacity with a low FEV1. He also believed that other manifestations of restriction may be seen as well, including a reduction in the total lung capacity. He noted that petitioner's chest x-rays were abnormal for many years and showed evidence of chronic changes due to pneumonia or scarring particularly in the right middle and lower lobe as well as the left lower lobe with associated left pleural thickening. Dr. Castle opined that bronchiectasis is a well-known complication of inflammatory bowel disease and was noted on the CT scan of 4/14/05 and 8/9/97. Therefore he opined that the chest x-rays and CT scans did not show evidence of coal worker's pneumoconiosis, but did demonstrate evidence of significant bilateral bronchiectasis due to his inflammatory bowel disease or ulcerative colitis. Dr. Castle further opined that the changes seen on the pulmonary function studies were entirely in keeping with bronchiectasis related to ulcerative colitis, and not due to coal mine dust induced lung disease or coal workers' exposure.

In summary, Dr. Castle opined that petitioner does not suffer from any pulmonary disease or impairment that has occurred as a result of his occupational exposure to coal mine dust. He opined that petitioner does have physical evidence, radiographic evidence and physiologic evidence due to bronchiectasis associated with ulcerative colitis or inflammatory bowel disease, and not related to call mine dust exposure or coal worker's pneumoconiosis. Dr. Castle opined that bronchiectasis is not caused by coal dust exposure. He opined that it is an autoimmune, inflammatory process in the lungs that may have specific causes, such as inflammatory bowel disease and other types of problems like that. Dr. Castle opined that petitioner has a terrible autoimmune disease of ulcerative colitis, and other complications or problems related to that, namely hearing loss and very significant bronchiectasis. He opined that the bronchiectasis is not going to go way, and will need to be treated aggressively with antibiotics. Dr. Castle testified that the methacoline challenge test is used to detect asthma, and petitioner's was entirely normal, which meant he didn't have any evidence of obstruction related to reactive airway disease, nor did he have any evidence of obstruction on pulmonary function studies. Dr. Castle stated that this is why he indicated, in his opinion, that petitioner doesn't have COPD or obstructive airway disease. Dr. Castle believed that any restriction petitioner has is due to his bronchiectasis. Dr. Castle believed that recurrent pneumonias, and methotrexate which petitioner was taking for his hearing and lung disease, will result in pulmonary fibrosis. He also believed that sulfasalazine, that petitioner takes for his ulcerative colitis, can cause interstitial fibrosis.

On cross-examination Dr. Castle opined that petitioner has restrictive ventilatory defect, and that it can be consistent with coal worker's pneumoconiosis. He agreed that a person could have significant bilateral bronchiectasis, chronic bronchitis, and inflammatory bowel disease or ulcerative colitis and coal worker's

pneumoconiosis at the same time. Dr. Castle also agreed that a person can have bronchiectasis and chronic bronchitis at the same time. Despite Dr. Smith, Dr. Brewer, Dr. Paranjpe, and Dr. Locke's finding that petitioner had COPD on his chest x-ray, Dr. Castle opined that petitioner does not have COPD, or obstruction per se. Dr. Castle admitted that it is true that you can have a disease and have a negative x-ray. Dr. Castle agreed that if a person has been diagnosed with pneumoconiosis, there is no safe level of exposure to coal mine dust. Dr. Castle agreed that a person could have a pulmonary impairment due to some specific disease, injury, condition or exposure and still be within the range of normal pulmonary function.

Dr. Castle reviewed petiitoner's chest x-ray dated 2/10/05. His impression was that there were no parenchymal abnormalities consistent with pneumoconiosis. He noted evidence of a left sided effusion versus scar, and a left mid zone and lower zone scar with left pleural and diaphragmatic pleural scars.

Dr. Castle reviewed petitioner's chest x-ray dated 1/15/09. He was of the opinion that there were no parenchymal abnormalities consistent with pneumoconiosis. He noted evidence of a right lower zone scar, left mid zone and left lower zone scars, with pleural scars and/or effusion.

Dr. Castle reviewed the CT scan of petitioner's chest dated 4/14/05. He noted no parenchymal abnormalities consistent with pneumoconiosis. He saw evidence of the right lateral pleural-based scar in the right mid lung zone, markedly dilated bronchi noted in the right middle zone, right lower zone, and extensively in the left lower zone. Also noted was extensive bronchial wall thickening in these areas, particularly involving both lower lung zones; pleural scars along the left lower lung zone laterally and anterior chest wall; and chronic scarring in the right lower zone anteriorly. Dr. Castle opined that these changes were consistent with extensive bronchiectasis involving the right mid lung zone, and more extensively in the right lower lung zone and left lower lung zone.

Respondent also offered into evidence petitioner's medical records from Springfield Clinic. Dr. Brewer began treating petitioner in May of 1997. Petitioner also treated with other doctors at this facility. On 6/24/97 he saw petitioner for probable pneumonia of the left lower lobe. A chest CT scan was performed and petitioner has some infiltrates in the lower lobes that appeared to chronic, scarring and emphysema in his lungs and some bronchitis changes. On 12/4/97 petitioner had a colonoscopy because of long standing history of ulcerative colitis and dysplasia. On 3/16/00 petitioner reported a cough for most of the winter. He was diagnosed with possible bronchitis. On 2/20/01 petitioner was diagnosed with an upper respiratory illness, that was probably viral. On 3/16/01 he was diagnosed with bronchitis. On 9/11/01 he was diagnosed with allergic rhinitis due to some allergen. On 10/12/01 petitioner had postnasal drip that was consistent with allergic rhinitis. On 7/29/02 petitioner had a recheck for pneumonia that was not totally resolved. On 2/25/03 petitioner had another

colonoscopy to the cecum with biopsies. On 3/25/03 petitioner was diagnosed with ulcerative colitis and a proctoscopy, that found a couple of polyps. On 4/22/03 petitioner was advised to have a total colectomy. On his preoperative examination his lungs were clear. The total colectomy was performed on 4/25/03. On 6/3/03 petitioner had a UTI. On 7/2/03 petitioner had a takedown of his ileostomy. On 8/2/04 petitioner had ear wax problems. On 9/3/04 petitioner had decreased hearing. On 11/8/04 petitioner had pouchitis. On 2/14/05 he was again diagnosed with pneumonia. On 4/11/05 petitioner has a persistent infiltrate associated with pneumonia. On 5/13/05 petitioner was diagnosed witch acute bronchitis, and bronchiecstatis, and underlying chronic lung disease. On 8/10/05, 9/12/05, and 12/12/05 petitioner had increasing anxiety. On 2/21/06 petitioner's lung were clear and he was doing okay. On 5/16/06 he was diagnosed with plantar fasciitis. On 9/25/06 petitioner was seen for partial deafness and rapid loss of hearing in the past couple years, that was related to his underlying ulcerative colitis. Petitioner had a cochlear implant. On 10/20/06 he was diagnosed with suberic keratosis.

After petitioner was laid off from the mine on 8/31/07, when it closed, he presented to Springfield Clinic and was fearful of securing employment due to his hearing loss, former colectomy, and J-pouch. He stated that he worked as long as he did for respondent due to accommodations made for these conditions, and assistance from co-workers. Petitioner then applied for Social Security Disability with letters from his gastroenterologists, ear, nose and throat specialist, and his rheumatologist. On 9/12/07 petitioner's chart included accommodations petitioner needed due to his ulcerative colitis. On 9/19/07 petitioner underwent a pouchoscopy. On 10/10/07 he had his disability paperwork completed. Up to this point Dr. Brewer never made an assessment of coal worker's pneumoconiosis and did not take petitioner off work for an occupational disease. On 5/12/08 Dr. Brewer's notes state that petitioner was on disability due to a total colectomy due to Crohn's or due to ulcerative colitis, and partial deafness. Petitioner began having hand/wrist pain at that time and was diagnosed with carpal tunnel syndrome. On 3/28/08 petitioner reported that he did not feel he could work because of his hearing and frequent diarrhea. Dr. Brewer noted that petitioner continued to have allergic rhinitis after he left the mine. On 7/1/08 petitioner's lungs were clear and he was doing well. On 10/1/08 petitioner reported that he was riding a bike for four miles a day. On 11/26/08 his lungs were clear, but he had urinary calculus and kidney stones. On 3/13/09 petitioner was diagnosed with nocturia. On 7/1/09 petitioner had another pouchoscopy. On 12/1/09 petitioner was diagnosed with possible persistent bronchitis. Petitioner reported that he had congestion for 5-6 months in the summer and fall. On 2/21/11 petitioner reported that he had an incident where he spit up some blood with a cough while out in the cold, but has had no problems since. He was assessed with hemoptysis. On 3/2/11 petitioner was seen for pouchitis, and then hospitalized for bowel obstruction. His lungs were clear. On 3/11/13 petitioner was doing well and his lungs were clear. After that he was hospitalized for dehydration and pouchitis on 3/18/13. On 4/16/13 petitioner presented because of breathing problems. He reported productive cough

every morning with drainage down the back of his throat. He stated that once he gets it out he is usually pretty good for the day. His O2 saturation was 98%, and his lungs were clear. Petitioner was scheduled for a pulmonary function test and methacholine. Petitioner reported that he has problems when he exerts himself and gets short of breath when walking, or with 2 flights of stairs. He was assessed with allergic rhinitis, COPD, frequent cough and changes of emphysema on last x-ray. The test results of 5/3/13 did not reveal any obstruction, but there was evidence of a restriction. His diffusion capacity was normal and the methacholine challenge test was normal. Petitioner did not have restrictive airway disease or obstruction. On 6/21/13 petitioner was again hospitalized for a bowel obstruction with his J-pouch. On 7/8/13 he was hospitalized for pouchitis. On 9/13/13 petitioner underwent a left cochlear implant. Dr. Brewer never restricted petitioner from work due to his allergic rhinitis.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?
O. SECTIONS 1(D)-(F) OF THE OCCUPATIONAL DISEASE ACT

Petitioner began his mining career with Peabody in Coal in 1973. He worked there for a few years before beginning work at the Will Scarlett Mine. He worked there for 7 years. He next transferred to Illinois Mine 10 where he worked for about 16 years. Most of petitioner's work was underground in the mines.

Petitioner did not begin working for respondent until 1999. His work for respondent included work as a rod man underground for 6.5 years. When petitioner could no longer work in the mines due to the batteries in his cochlear implant, he was transferred to the warehouse where he worked until the mine closed on 8/31/07. Petitioner testified that he was exposed to dust and fumes in this position.

Petitioner did not smoke. but used Skoal until 2004 or 2005. Petitioner was also diagnosed with ulcerative colitis in 1982, which got progressively worse to the point where he needed a total colectomy on 4/25/03. Thereafter petitioner had multiple problems with his colon. As a result of his ulcerative colitis petitioner eventually lost 75% of his hearing and had to get cochlear implants.

Petitioner had Dr. Smith, a B-Reader, review petitioner's chest x-rays from 7/31/97, 10/12/01, 2/10/05, 4/11/05, 3/21/08 and 1/15/09, and a CT scan of the chest taken 4/14/05. Dr. Smith found evidence of coal worker's pneumoconiosis with small opacities, p/s, upper, mid and lower zones bilaterally, profusion 1/1. He also noted chronic pleural thickening of the left lateral CP angle. However, when Dr. Smith read the x-ray dated 1/15/09 he found coal worker's pneumoconiosis with interstitial fibrosis of classification s/p, mid to lower zones involved, profusion of 1/0; and chronic scarring in the lung with associated diffuse pleural thickening/obscured lateral CP angle, left greater than right. Given the fact that all experts testified that once a coal miner has coal

worker's pneumoconiosis it does not get better or go away, the arbitrator questions how the findings on petitioner's x-rays dated 7/31/97, 10/12/01, 2/10/05, 4/11/05, and 3/12/08, and a CT scan of the chest taken 4/14/05 could have been worse than the findings on the x-ray dated 1/15/09 Dr. Smith interpreted this x-ray to have findings consistent with coal worker's pneumoconiosis with interstitial fibrosis of classification s/p, only in the mid to lower zones, with a profusion of 1/0, unlike all the earlier x-rays where he interpreted opacities in the upper lung zones. As a result, the arbitrator gives lesser weight to the findings of Dr. Smith.

Petitioner also had Dr. Cohen and Dr. Alexander interpret his chest x-rays dated 1/15/09. Dr. Cohen's impression was positive for opacities of pneumoconiosis q/p, and 1/0 profusion. Dr. Alexander's impression was coal worker's pneumoconiosis, category p/q, 1/0. Given the fact that the interpretations of the 1/15/09 chest x-ray by Dr. Cohen, Dr. Alexander and Dr. Smith are different, the arbitrator gives a lesser weight to their opinions. The arbitrator also notes that Dr. Alexander is not even a B-Reader.

Respondent had Dr. Wiot and Dr. Castle review petitioner's chest x-rays of 7/31/97, 3/12/08, 10/12/01, 4/11/05 and 1/15/09. They both found no evidence of coal worker's pneumoconiosis. Additionally, Dr. Wiot was of the opinion that petitioner developed chronic pleural disease due to repeated inflammatory processes at the left base, and not dust exposure. He also opined that pneumonia, and recurrent pneumonia, which petitioner was diagnosed with years before he began working for respondent, are something that can result in the changes observed in the petitioner's lungs, and these were the cause of the changes he saw with respect to the pleural disease, or related to the inflammatory process of pneumonia.

Dr. Castle opined that petitioner does not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure. He opined that petitioner's pulmonary symptoms and disease were related to his ulcerative disease. Petitioner has had ulcerative colitis since 1982 and pulmonary complications typically follow the onset of inflammatory bowel disease in up to 85% of patients. Dr. Castle opined that recurrent pneumonias are not uncommon with this disease, and petitioner has had several bouts of pneumonia. He further opined that the drugs used to treat ulcerative colitis, such as methotrexate, which petitioner took, can contribute to pulmonary problems, and be reflected on pulmonary studies that demonstrate a reduced or normal forced vital capacity with a low FEV1, which petitioner's was. Dr. Castle noted that petitioner's chest x-rays were abnormal for many years and showed evidence of chronic changes due to pneumonia or scarring particularly in the right middle and lower lobe, as well as the left lower lobe with associated left pleural thickening. Dr. Castle opined that bronchiecstatis is also a well known complication of ulcerative colitis and was noted on diagnostic tests as early as 8/9/97, before petitioner even worked for respondent. Therefore, Dr. Castle opined that changes seen on petitioner's pulmonary function studies were bronchiecstatis related to ulcerative colitis and not coal mine

dust induced lung disease or coal workers' exposure. Dr. Castle opined that petitioner does not have COPD or obstructive airway disease, and any restriction is due to his bronchiecstatis. He further opined that the sulfasalazine that petitioner takes for his ulcerative colitis, can cause interstitial fibrosis.

Dr. Brewer even testified that before 10/10/07 he never diagnosed petitioner with coal worker's pneumoconiosis, or interpreted a chest film of petitioner's as being positive for coal worker's pneumoconiosis. He agreed with Dr. Wiot and Dr. Castle that fibrosis and pneumonia result from an inflammatory process. He also testified that there was no evidence of shortness of breath with exertion in his records on 8/31/07, when petitioner left the mine.

Based on the above, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that he sustained an occupational disease that arose out of and in the course of his employment by respondent on 8/31/07. The arbitrator further notes that even if petitioner had proven by a preponderance of the credible evidence that he sustained an occupational disease that arose out of and in the course of his employment by respondent based on the radiographic findings of Dr. Smith, the arbitrator notes that such coal worker's pneumoconiosis would have been present at least 2 years prior to petitioner even starting work for respondent, based on Dr. Smith's interpretation dated 7/31/97.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?
L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

Having found petitioner has failed to prove by a preponderance of the credible evidence that he sustained an occupational disease that arose out of and in the course of his employment by respondent on 8/31/07, the arbitrator finds these remaining issues moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph Womack,
Petitioner,

vs.

NO: 09 WC 39411
12 WC 29600

City of Chicago,
Respondent.

16IWCC0219

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of nature and extent of Petitioner's permanent partial disability, casual connection and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 9, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

16IWCC0219

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 4 2016

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-03/23/16
jdl/wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WOMACK, JOSEPH
Employee/Petitioner

Case# **09WC039411**

12WC029600

CITY OF CHICAGO
Employer/Respondent

16IWCC0219

On 7/9/2015, 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 0.08% 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:

0154 KROL BONGIORNO & GIVEN LTD
RANDALL W SLADEK
120 N LASALLE ST SUITE 1150
CHICAGO, IL 60602

0113 CITY OF CHICAGO
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

JOSEPH WOMACK
Employee/Petitioner

Case #09 WC 39411
#12 WC 29600

v.

CITY OF CHICAGO
Employer/Respondent

16IWCC0219

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 Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on June 29, 2015. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

A. ☐ Was the 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 the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to the respondent?

F. ☒ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☐ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☐ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☐ What temporary benefits are due: ☐ TPD ☐ Maintenance ☐ TTD?

L. ☒ What is the nature and extent of injury?

M. ☐ Should penalties or fees be imposed upon the respondent?

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On August 6, 2009, and August 22, 2012, the respondent was operating under and subject to the provisions of the Act.

- On these dates, an employee-employer relationship existed between the petitioner and respondent.

- On these dates, the petitioner sustained injuries that arose out of and in the course of employment.

- Timely notice of the accidents was given to the respondent.

- In the year preceding the injuries, the petitioner earned $72,178.60 and $73,481.20, respectively; the average weekly wages were $1,388.05 and $1,413.10, respectively.

- At the time of injuries, the petitioner was 64 and 68 years of age, respectively, married with no children under 18.

- The parties agreed that the respondent paid the appropriate amount for all the related, reasonable and necessary medical services provided to the petitioner for each injury.

- The parties agreed that the petitioner is entitled to temporary total disability benefits for 87-4/7 weeks, from August 7, 2009, through April 11, 2011, and received $81,014.82 in temporary total disability benefits from the respondent and that the petitioner is entitled to temporary total disability benefits for 25 weeks, from August 23, 2012, through February 13, 2013, and received $23,551.75 in temporary total disability benefits from the respondent.

ORDER:

- The respondent shall pay the petitioner the sum of $664.72/week for a further period of 100 weeks, as provided in Section 8(d)2 of the Act, because the injury sustained on August 6, 2009, caused the permanent partial disability to petitioner to the extent of 20% loss use of the man as a whole. The respondent shall pay the petitioner the sum of $712.55/week for a further period of 15 weeks, as provided in Section 8(d)2 of the Act,

because the injury sustained on August 22, 2012, caused the permanent partial disability to petitioner to the extent of 3% loss use of the man as a whole.

- The respondent shall pay the petitioner compensation that has accrued from August 6, 2009, through June 29, 2015, and shall pay the remainder of the award, if any, in weekly payments.

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.

Robert E. Williams

Signature of Arbitrator

July 9, 2015

Date

JUL 9 - 2015

FINDINGS OF FACTS:

The petitioner, a laborer, sustained a low back injury on August 6, 2009, while lifting bags of cement. The incident is the subject matter of claim #09 WC 39411. He received immediate care with Dr. Diadula at MercyWorks and reported that his back gave out while lifting, causing him to fall to his knees. For the diagnosis of a low back strain, the petitioner was prescribed medication, ice packs, a home exercise program and no work. He saw Dr. Passovoy on August 12th, whose impression was that, in addition to a lumbar injury, the petitioner had a cerebrovascular incident that had not improved significantly since its onset on August 2nd. On September 14th, Dr. Passovoy opined that the petitioner had fully recovered from his mild, lucunar transient ischemic cerebral incident by the time of his lumbar inury on August 6th and that the CVA didn't play a role in that injury. On September 18th, Dr. Diadula noted 9/10 low back pain particularly in the petitioner's left paralumbar and left SI joint with left thigh tingling. Dr. Diadula reported on September 30th that a lumbar MRI showed diffuse enhancement of the surgical scar, no evidence of thecal sac compromise or spinal stenosis, a broad-based disc bulge and moderate ligamentous and facet hypertrophy at L4-5 and mild neural foramen compromise at L3 and L4.

Dr. Espinosa evaluated the petitioner on November 3rd and noted complaints of lumbar pain, cervical pain and stiffness and bilateral leg pain and heaviness. The petitioner denied upper extremity pain or weakness. Dr. Espinosa's diagnosis was cervical spondylosis with myelopathy and his opinion was significant disc desiccation, collapse and possible pseudoarthrosis at L5-S1. A cervical MRI on November 5th showed a disc osteophyte complex and a left paracentral protrusion causing compression on the

anterior spinal cord at C4-5 and a disc osteophyte complex at C3-4 causing moderate central canal narrowing. On December 31st, Dr. Espinosa performed an anterior cervical discectomy and fusion with instrumentation at C3-4 and C4-5. On January 15, 2010, the petitioner reported difficulty swallowing and neck discomfort. The petitioner started physical therapy for his neck on March 4, 2010.

The petitioner reported severe back pain to Dr. Espinosa on March 16th. On March 19th, Dr. Espinosa opined that an MRI on the 16th showed spinal stenosis and spondylolisthesis at L4-5 with a left foraminal herniated disc causing moderately severe foraminal stenosis, mild degree of spinal stenosis at L3-4 and moderate degree of facet arthrosis at multiple levels, including L3-4 and L4-5. The doctor recommended a far lateral left L4-5 microdiscectomy and nerve decompression. On April 16, 2010, Dr. Espinosa stated that the petitioner had fully recovered for his cervical spine condition as of April 5, 2010. On April 29, 2010, Dr. Espinosa removed the instrumentation from the previous L5-S1 fusion and performed a left facetectomy and a lateral laminectomy at L4-5 and a transforaminal lumbar interbody fusion. The petitioner started physical therapy in August 2010 and followed up with Dr. Espinosa for low back discomfort. A lumbar CT scan on December 1, 2010, showed no signs of instrumentation failure. Work conditioning was started in February 2011. On April 5, 2011, the petitioner reported mild low back discomfort, no leg pain or bladder or bowel symptoms and the use of only Tylenol occasionally. The petitioner was released to his regular job duties without any restrictions as of April 11, 2011.

On August 22, 2012, the petitioner received emergency care at Mercy Hospital for back pain and reported pushing a box of bolts and feeling a pull and tightening on the left

side of his back. The incident is the subject matter of claim #12 WC 29600. The diagnosis was low back pain and strain. He started care at MercyWorks with Dr. Diadula on August 30, 2012, for low back pain down his left leg to his foot with numbness and tingling. The petitioner was kept off of work and treated with medication. On September 13, 2012, Dr. Diadula reported that a lumbar MRI showed no evidence of recurrent post-operative disc extrusion or central canal stenosis. The petitioner sought treatment with Dr. Lorenz of Hinsdale Orthopedics on October 18, 2012, who noted that the MRI revealed canal stenosis at L3-4, postoperative changes of the previous fusion at L5-S1 and no recurrent herniation. Dr. Lorenz's diagnosis was left-sided radiculopathy. The petitioner was given a Medrol Dosepak and kept off of work. A lumbar CT scan on November 1st, showed findings compatible with moderate spinal stenosis at L3-4 with bilateral neuroforaminal encroachment and a mild broad-based posterior protrusion at L5-S1 asymmetrical to the left. The XR myelogram the same day had findings suspicious for spinal stenosis at L3-4. On November 7, 2012, the petitioner reported low back pain and bilateral radiculopathy. The diagnosis was L3-4 spinal stenosis. Dr. Bernstein evaluated petitioner at respondent's request on December 17, 2012, and opined that the petitioner had a degenerative, bulging disc at the adjacent level just proximal to his previous fusion.

Dr. Lorenz's opinion on December 19, 2012, was junctional stenosis at L3-4. On January 15, 2013, the petitioner had a transforaminal lumbar epidural steroid injection at the left and right L3 nerve roots. On January 21, 2013, the petitioner sought care with Dr. Passovoy and reported no back pain. On January 23, 2013, the petitioner reported a temporary relief of his symptoms with the injections. The petitioner declined a decompressive laminectomy at L3-4 recommended by Dr. Lorenz. On February 11, 2013,

Dr. Bernstein opined that he did not feel the petitioner was a surgical candidate. The petitioner returned to work in March 2013. On October 14, 2013, the petitioner sought care for a left knee abrasion with Dr. Passovoy and reported no back pain. On December 23, 2013, the petitioner sought care with Dr. Passovoy for a left knee injury three days earlier and reported no back pain. The petitioner worked until the end of 2013 and then retired. On June 3, 2014, the petitioner reported back pain to Dr. Passovoy and at his last visit on October 15, 2014, he reported no back pain.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that his current condition of ill-being with his lumbar spine is causally related to the work injuries. The petitioner failed to prove that his current condition of ill-being with his cervical spine is causally related to the work injuries.

The petitioner's work injury on August 6, 2009, was due to lifting. His complaints and treatment at MercyWorks was only for low back pain. The petitioner did not report or complain of cervical symptoms when he sought care with Dr. Passovoy on August 12, 2009, or at any of the seven follow-ups at MercyWorks through October 2009. Dr. Espinosa's opinions are not consistent with the evidence and have no probative value. The petitioner's request for benefits for his cervical condition of ill-being is denied.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The petitioner suffered a lumbar injury while lifting in 1999, which resulted in a lumbar fusion at L5-S1 in February 2000. He suffered low back strains in 2003 and 2005, for which he received medical care through April 2007. On March 9, 2009, the petitioner sustained a lumbar lifting injury with radiation to his left buttock. The petitioner reported

a week of low back pain due to lifting to Dr. Passovoy on July 31, 2009, with radiation to his left buttock.

There is no AMA impairment rating or evidence concerning the impact of the petitioner's August 22, 2012, injury in regard to his occupation, age or future earning capacity, as delineated in Section 8.1(b)(i) through (iv) of the Act, nor can any effect be reasonably inferred from the evidence. Regarding Section 8.1(b)(v), the petitioner complains of a little back pain. The respondent shall pay the petitioner the sum of $664.72/week for a further period of 100 weeks, as provided in Section 8(d)2 of the Act, because the injury sustained on August 6, 2009, caused the permanent partial disability to petitioner to the extent of 20% loss use of the man as a whole. The respondent shall pay the petitioner the sum of $712.55/week for a further period of 15 weeks, as provided in Section 8(d)2 of the Act, because the injury sustained on August 22, 2012, caused the permanent partial disability to petitioner to the extent of 3% loss use of the man as a whole.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☒ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JENNIFER JURCAK,

Petitioner,

vs. NO: 10 WC 43618

CITY OF CHICAGO,

Respondent.

16IWCC0211

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court of Cook County. Pursuant to the Opinion and Order dated July 2, 2015, the Circuit Court affirmed, in part, and reversed, in part, the Commission's October 9, 2014 Decision and Opinion on Review.

The Circuit Court affirmed the Commission's conclusion that Petitioner, Jennifer Jurcak, was exposed to a risk of injury greater than that which is faced by the general public. The Circuit Court noted that the Commission's finding was "wholly reasonable and supported by the evidence." The Court further noted that it would be "disingenuous" to argue otherwise.

The Circuit Court, however, reversed and remanded the matter to the Commission with instructions that the Commission "explain how it reached its conclusions and provide the bases for its decision consistent with this Order."

The Court found that the Commission failed to provide support for its decision on causal connection of the right knee injury noting that the Commission made the "conclusory statement that Plaintiff's pre-existing condition was aggravated by the work accident."

The Circuit Court noted that proof of prior good health and change immediately following and continuing after an injury may establish that an impaired condition was due to the

injury. *Spector Freight System, Inc. v. Indus. Comm'n,* 93 Ill. 2d 507 (1983), *Darling v. Indus. Comm'n*, 176 Ill. App. 3d 186, 193 (1st Dist. 1988) ("A causal connection between work duties and a condition may be established by a chain of events including petitioner's ability to perform duties before the date of the accident and inability to perform the same duties following that date.")

The Circuit Court noted that the Commission did not mention this theory of law and, if it had, it would follow that the Commission's decision on causal connection of the low back condition would be approached in a similar manner. However, the Commission did not do so. The Court reversed and remanded the matter with specific instructions to the Commission to articulate a basis for its decision on casual connection. The Commission was ordered to "connect the dots" and explain why it reached the conclusion it did. The Commission was ordered to state if it relied upon a chain of events analysis.

Regarding the low back, the Circuit Court noted that the Commission adopted the opinions of Dr. Ghanayem in finding that the accident was not the cause of petitioner's back condition. The Court further noted that if the Commission found causal connection for the right knee injury based upon the chain of events analysis, which the Court could only infer it did based on the Commissions' writing, it should have used a similar analysis for the low back condition. The Court noted that both Dr. Ghanayem and Dr. Newman opined that Plaintiff may have sustained a low back strain as a result of the incident. The Court further noted that the City even conceded in its brief that: "if it is found Plaintiff sustained an accident arising out of and in the course of her employment, it would follow that it should be found she also sustained a low back sprain, at worst, as a result." The medical records following the accident support this conclusion that plaintiff suffered a lumbar strain.

The Court reversed and remanded the matter back to the Commission for a determination as to the causal connection between the alleged accident and petitioner's current state of ill-being regarding her low back. The Court further required that the Commission enunciate whether or not it relied upon the chain of events theory relative to the injury to petitioner's knee.

The Commission adopts and incorporates by reference herein its Findings of Fact from its October 9, 2014 Decision and Opinion on Review.

The Court has asked the Commission to "connect the dots" and "explain why it reached the conclusion it did," and to state if it relied upon the chain of events analysis. The Commission is somewhat bewildered by the Court's inference that the Commission relied upon the "chain of events" theory. As the Court is well aware, the chain of events theory is one of many theories by which causal connection can be established. Simply, the Commission did not rely upon the chain of events theory of law.

As stated in its Decision, the Commission noted:

> Employers take their employees as they find them. *O'Fallen School District No. 90 v. Industrial Comm'n*, 313 Ill. App. 3d 413, 417, 729 N.E.2d 523, 246 Ill. Dec. 150 (2000). To result in compensation under the Act, a claimant's employment need only be a causative factor in his condition of ill-being; it need not be the sole cause or even the primary cause. *Sisbro Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003). "[A] preexisting condition does not prevent recovery under the Act if that condition was aggravated or accelerated by the claimant's employment." *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d 30, 36, 440 N.E.2d 861, 65 Ill. Dec. 6 (1982).

The evidence clearly established that Petitioner had a significant pre-existing right knee condition. Petitioner underwent three prior right knee surgeries due to a prior work-related injury in 2002. (The Commission notes that the prior work-related injury, 02 WC 12686, is currently pending before the Commission pursuant to Section 19(h)/8(a) of the Act.) As a result of the multiple surgeries--stemming from the earlier accident, petitioner's right knee lacked 20 degrees of full extension, which resulted in permanent restrictions. Because of her right knee condition, Petitioner testified that she could not ride her bike and could not jog. T.16. She had to learn how to live with her condition. *Id.* Further, petitioner testified that her right knee condition stayed pretty much the same between April 2007, the date which she last received medical treatment, and September 21, 2010, the date of the second work-related accident. T.17. The Commission notes that the medical record from April 27, 2007, revealed a mild limp secondary to pain, mild swelling, and no joint effusion or instability.

Consequently, while petitioner may have been able to perform her job duties prior to the second accident, the record does not demonstrate a prior condition of good health. Rather, the record is replete with evidence that her prior right knee condition resulted in permanent restrictions and had a significant impact on her daily lifestyle.

The Commission notes that *Spector Freight System, Inc.* and *Darling,* as cited by the Circuit Court, are factually distinguishable from the case at bar. In both of those cases, there is no indication that either of the petitioners had permanent restrictions, that their knee lacked full extension, or that they had to alter their lifestyle due to a prior injury. Further, in *Spector,* the petitioner testified that he was feeling well prior to the accident. In the present case, there is no testimony as to Petitioner's condition prior to the accident. In *Darling*, the Court noted that there was no evidence that petitioner's condition pre-dated the alleged accident. Whereas, in this case, the record clearly demonstrates that petitioner had a pre-existing condition.

The Commission was, therefore, of the opinion that petitioner failed to establish a condition of good health prior to the accident. Thus, the Commission acknowledged her pre-existing condition and determined that her pre-existing condition was aggravated by the work accident. It did not rely upon the chain of events theory of law relative to her leg.

Contrary to petitioner's wishes, the Commission was unable to connect petitioner's alleged low back injury and the work accident. While petitioner sought medical treatment following the accident and was diagnosed with a low back strain, the Commission was not persuaded that her low back condition was a result of the accident.

It is well established that "a chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability *may be sufficient* circumstantial evidence to prove a causal nexus between the accident and the employee's injury." *International Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63-64, 442 N.E.2d 908, 66 Ill. Dec. 347 (1982). However, such testimony is not always dispositive, particularly where there is persuasive medical opinion testimony or other evidence suggesting that the claimant's injury is not related to the accident. See, *e.g., Sorenson v. Industrial Comm'n*, 281 Ill. App. 3d 373, 382, 666 N.E.2d 713, 217 Ill. Dec. 44 (1996) (affirming Commission's finding that a work-related accident did not cause or aggravate claimant's bone spur based upon medical testimony despite undisputed evidence that claimant's back symptoms began after the accident); *Williams v. Industrial Comm'n*, 216 Ill. App. 3d 536, 539, 576 N.E.2d 383, 159 Ill. Dec. 714 (1991) (affirming Commission's finding that claimant's injury was unrelated to the alleged accident notwithstanding claimant's testimony that he had no symptoms before the accident where other evidence suggested that the accident would not have caused the injury).

Even had the Commission applied the chain of events theory, the Commission is not automatically bound to find that Petitioner's low back condition is the result of the accident. The Commission is tasked with reviewing all the evidence.

As stated in the Commission's Decision:

> It is the province of the Commission to weigh the evidence and draw reasonable inferences therefrom. *Niles Police Department v. Industrial Comm'n*, 83 Ill. 2d 528, 533-34, 416 N.E.2d 243, 245, 48 Ill. Dec. 212 (1981). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Industrial Comm'n*, 51 Ill. 2d 533, 536-37, 283 N.E.2d 875, 877 (1972). The resolving of conflicting medical views, including those relating to causation of a physical condition, is peculiarly within the province

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of the Industrial Commission. *Ford Motor Co. v. Industrial Com.*, 55 Ill.2d 549, 554.

The Commission notes that the low back strain diagnosis was rendered following the accident. However, the Commission found the opinion of Dr. Ghanayem persuasive. Dr. Ghanayem was of the opinion that the incident would not be sufficient to cause a back injury of any significance. He noted that the findings on the MRI likely pre-dated her September 2010 accident. Her condition was not at risk for an aggravation given the mechanism of injury. He further noted that she had non-compressive disc pathology which did not correlate with her low back symptoms. After reviewing the record in its entirety, the Commission was of the opinion that petitioner failed to prove that her low back condition arose out of and in the course of her employment.

On review, a court "must not disregard or reject permissible inferences drawn by the Commission merely because other inferences might be drawn, nor should a court substitute its judgment for that of the Commission unless the Commission's findings are against the manifest weight of the evidence." *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 206, 797 N.E.2d 665, 673, 278 Ill. Dec. 70 (2003). In order for a finding to be contrary to the manifest weight of the evidence, an opposite conclusion must be clearly apparent. *Mendota Township High School*, 243 Ill. App. 3d at 837.

Having answered the questions posed in the Circuit Court's Opinion and Order, the Commission affirms its previous decision dated October 9, 2014.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $598.15 per week for a period of 25-2/7 weeks, from September 22, 2010 through October 21, 2010 and from June 24, 2011 through November 17, 2011 that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses related to the right knee only under §8(a) of the Act and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired

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without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 4 2016

Michael J. Brennan

MJB/tdm
D: 3-8-16
052

Thomas J. Tyrrell

Dissent

I respectfully maintain my ongoing dissent from the decision of the majority. I would affirm Arbitrator Carlson's thorough and well reasoned decision in its entirety and without modification.

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cassandra Fillers,
Petitioner,

vs. No: 11 WC 00694

16IWCC0222

State of Illinois – NIU
Dept.of Public Safety,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accidental injury, notice, causal connection, permanent disability and medical expenses, and being advised of the facts and law, reverses the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Arbitrator found that Petitioner sustained accidental injury -- specifically, post-traumatic stress disorder (PTSD) -- arising out of and in the course of her employment with Respondent on February 14, 2008. The Arbitrator awarded medical expenses and permanent partial disability benefits reflecting loss of 5% of the person as a whole. The Commission, after reviewing the entire record, finds that Petitioner failed to prove that her current ill-being is causally connected to any alleged accident of February 14, 2008. The Commission also finds that she did not provide timely notice of the alleged accident. Based upon Petitioner's failure to prove a compensable accident, the Commission finds all other issues moot.

16IWCC0222

FACTUAL BACKGROUND

A. February 14, 2008 Mass Shooting, Prior and Subsequent Alcohol Abuse, and Alleged PTSD

Petitioner, 27 years old at the time, was employed as a police officer for Northern Illinois University (NIU) Department of Public Safety. She had been at this job for four years. On February 14, 2008, Petitioner was at the police station when dispatch announced that there was an active shooter situation at Cole Hall. Petitioner was dispatched to Holmes Student Center, located adjacent to Cole Hall, where she was to provide first aid to injured students who had taken shelter there. While assisting at the student center, Petitioner was dispatched to Cole Hall because she was one of the only officers on duty with paramedic training. (Tr. 6-9).[1]

At Cole Hall, she attended to two victims, including one with gunshot wounds to his back. She testified about assisting a victim who was in shock; she was trying to get him to lie down, but he was scared and mumbling that he was "going to die." Petitioner testified that she saw three people lying on the ground and at least one individual who was "not viable." Once the shooter was confirmed deceased, paramedics were allowed into the building. Petitioner assisted and facilitated the treatment of the wounded and their transport to the hospital. (Tr. 9-12).

Petitioner testified that she felt fine in the days after the shooting. But about three months later she began to feel "lonely." She testified that she lost interest in hobbies and socializing. After a meeting arranged by NIU for the family members of the victims to meet the first responders, she had feelings of guilt that she "didn't do more." She testified that she began drinking more in May or June 2008. (Tr. 14-16).

On September 30, 2009, she tested positive for alcohol at work; her blood alcohol level was measured at .102. This was not the first time she had shown up at work with alcohol in her system. Around December 2007 – two months prior to the shooting – she was reprimanded for smelling of alcohol while on the job. (Tr. 20-21, PX 2).

After the September 30, 2009 incident, NIU suspended her and ordered her to undergo a fitness for duty evaluation. Two weeks later, on October 14, 2009, she initiated treatment on her own for self-endorsed PTSD at Ben Gordon Center in Dekalb. She attended two counseling sessions centered on exposure therapy, and then abandoned this treatment. (PX 2; RX 4). Her last counseling session for PTSD occurred near the time that she was arrested for DUI, in February 2010. At that point, Respondent asked her to resign or be fired. She resigned. (Tr. 27). Her treatment from September 30, 2009 through some months after her February 2010 DUI are discussed in greater detail below.

At hearing, she testified that she currently works as a clinical registrar at a hospital. She states that she is "trying to cope with things in a better manner" and tries to stay occupied so she does not "drink to get rid of everything." She states that she "hasn't changed psychologically"

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[1] All references to pages from the hearing transcript will take the form "Tr. --." References to Petitioner's Exhibits and Respondent's Exhibits will take the form "PX –" and "RX –", respectively.

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since her last visit to Ben Gordon Center in 2010 and she still feels "impassive" and "emotionless." She has not worked in public safety since leaving employment with NIU. (Tr. 17-18).

B. Treatment Records for Alcohol Abuse and PTSD Reveal Noncompliance and Inconsistencies, and Indicate that PTSD is "In Remission"

As mentioned above, on September 30, 2009, Petitioner tested positive for alcohol at work for a second time. Respondent suspended her and required her to get a substance abuse evaluation at Ben Gordon Center (BGC) [2]. BGC eventually recommended that that she undergo 10 sessions of Risk Education. (PX 2; RX 4). Petitioner testified that she attended four sessions. (Tr. 23).

On October 14, 2009, before any substance abuse treatment was started, Petitioner initiated treatment for PTSD symptoms at Ben Gordon Center on her own. Notably, her assessment interview report of that day stated she "denied symptoms of alcohol abuse" (even while she disclosed getting in trouble on two occasions for having alcohol in her system at work). She agreed to a treatment plan with a projected completion date of May 2, 2010. The plan included weekly hour-long therapy sessions centered on exposure therapy. However, this file was soon closed due to her not following through with the treatment plan. According to the discharge summary, she attended only the assessment interview, treatment planning session, and two follow-up therapy appointments (on January 18, 2010 and February 3, 2010). Her case manager noted that she made no observable gains and missed several appointments, and officially closed the file on April 16, 2010. (PX 2; RX 4).

On January 25, 2010, Petitioner completed a "CMS Workers' Compensation Employee's Notice of Injury" form, alleging psychological injury arising from the February 2008 shooting. As to the explanation for not reporting the injury on the date of incident, she wrote, "diagnosis was not made until Dec. 2009." (RX 1).

Soon thereafter, sometime in February 2010, she was arrested for DUI. Her blood alcohol level was measured at .22. She was convicted of misdemeanor DUI and ordered to undergo substance abuse counseling by the court. On July 28, 2010, she reported to Ben Gordon Center again for an assessment interview. The assessment report of that date stated:

> Cassie's BAC was .22 at the time of the arrest. Cassie reported that she drank 2 shots and 3 beers over the course of 4 hours. Cassie reported that she had been feeling a great deal of anxiety in the days before the DUI related to her finances, housing and hours being cut at work. Cassie reported a history of post traumatic stress disorder that developed after she was a first responder at the NIU shooting in 2008. Cassie reported a significant increase in her drinking as a method of coping with her anxiety. Cassie reported being suspended from work after

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[2] The interview at BGC for the substance abuse evaluation in connection with the fitness for duty evaluation arising from the September 30, 2009 incident was not done until January 28, 2010. Three days earlier, Petitioner had completed her CMS Workers' Compensation Employee Notice Of Injury.

showing up with alcohol in her system at work... ***Cassie denied having any of the re-experiencing thoughts in the past four months.***

(PX 2; RX 4). This document noted that she had "difficulty with staying asleep due to nightmares up until several months ago." It indicated DSM-IV diagnoses of "Post traumatic stress disorder, ***in remission"*** and alcohol abuse. On the last page, it stated, "Cassie endorsed symptoms meeting criteria for alcohol abuse including recurrent failure to fulfill role obligations due to her alcohol use. Cassie has been diagnosed with post traumatic stress disorder (see report dated 10/14/09) which ***Cassie reported being in remission for the past four months, reporting no re-experiencing of the trauma in that time.***" (PX 2; RX 4) (emphases added).

On August 11, 2010, she returned to BGC for the treatment planning session and indicated consent to a treatment plan for alcohol abuse with a projected completion date in February 2011. (RX 4). However, this August 11, 2010 visit would be her last one to BGC. On November 23, 2010, according to a discharge summary, this file too was closed for treatment noncompliance. After the treatment planning session, Petitioner failed to return for any further services. The case manager further noted that "Cassandra's BAC at the time of her arrest was significantly larger than her reported use, and she was not able to reconcile the inconsistency. Cassandra did not respond to a letter sent and her case will be closed due to treatment noncompliance." (PX 2; RX 4).

At hearing, Petitioner testified that, although she underwent the assessment at BGC, she completed her court-ordered counseling at a different facility, Braden Counseling. (Tr. 24-25). She did not submit any records from Braden Counseling at trial.

II. DISCUSSION

The Commission finds that Petitioner's case is fatally flawed as to the issues of notice and causation. Furthermore, any purported PTSD is now "in remission" and thus the Arbitrator's permanency award is unwarranted.

A. Untimely Notice

As an initial matter, Petitioner did not provide timely notice. She submitted her Notice of Injury on January 25, 2010 – almost two years after the date of alleged accident, and more than three months after she was formally diagnosed with PTSD on October 14, 2009 (not December 2009, which was what she indicated on the Notice of Injury). Petitioner offered no evidence or testimony that she communicated any information about her injury to her employer prior to submitting this Notice of Injury.

In the Request for Hearing, Petitioner asserted that notice was provided on February 14, 2008, the date of the shooting itself. She proffers a constructive notice argument, contending that Respondent received notice that day inasmuch as news of the mass shooting was widely televised. This argument is misbegotten. While it cannot be doubted that NIU had notice of this horrific event on the day of its occurrence, the Act's notice requirement goes to when an employer gains knowledge of the fact of injury to the employee, not knowledge of an event that

could have caused injury (whether foreseeable or not). To hold otherwise would be to completely relieve the employee of her duty of notification under the Act on the grounds that the employer "should have known" that an injury occurred or could have occurred.

B. Lack of Causation

Furthermore, the timing of Petitioner's seeking of treatment for PTSD on October 14, 2009 casts doubt as to causation and/or accident occurrence. While it is true that psychological injury may manifest some time after the triggering event, her first appointment – made specifically for PTSD symptoms, not alcohol abuse, which Petitioner denied at the time – was secured more than a year and a half after the alleged triggering event, and only after Petitioner's job was jeopardized by her second incident of on-the-job intoxication. The legitimacy of her claimed PTSD is further called into question by her abandonment of the PTSD treatment she sought after only two therapy sessions.

Insofar as the evidence shows that Petitioner suffered and/or continues to suffer from psychological ill-being, it is more likely than not that this ill-being was due to an alcohol abuse problem, a problem that pre-existed the accident and culminated in her DUI of February 2010. The Ben Gordon Center records indicate that she had a problematic relationship with alcohol that began long before the shooting. Those records indicate that she first began drinking at the age of 15 and divorced a husband in 2005 or 2006 due in part to his own alcohol abuse. (PX2). At hearing, she suggested that instances of her excessive alcohol consumption – which would include the September 30, 2009 incident and her February 2010 DUI -- were a manifestation of her PTSD. However, obviously this explanation does not apply to the first incident of on-the-job intoxication in December 2007.

C. No Permanent Disability

The Commission's conclusions regarding causation and notice, as discussed above, render moot all other issues, including the issue of permanency of disability. However, the Arbitrator's award of permanency reflecting 5% loss of the person as a whole warrant the following observations.

The Ben Gordon Center records of July 28, 2010 indicated that her PTSD was "in remission," and that she had not had the "re-experiencing thoughts of trauma" that are a hallmark of PTSD for four months (i.e., since March 2010). The Arbitrator noted that her PTSD was in remission, and also that Petitioner continued to have alcohol abuse issues. (Arbitrator's Decision p. 5). The Arbitrator stated that "while the February 14, 2008 shooting may have been a primary trigger for the ... alcohol abuse," she (the Arbitrator) "cannot conclude that [Petitioner's] alcohol abuse was definitely related to this event," given the prior incident of discipline for having alcohol in her system at work in December 2007. The Arbitrator went on therefore to "clari[fy] that Petitioner's PTSD and its treatment are causally related to the incident but that her alcohol abuse and related treatment after April 16, 2010 are not." (Id.)

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However, after stating that her medical expenses determinations were based on a separation of Petitioner's PTSD from her ongoing alcohol abuse, the Arbitrator proceeded to make a permanency award of 5% loss of the person as a whole. (Arbitrator's Decision p. 5). This is puzzling. The events witnessed by Petitioner on February 14, 2008 certainly were "traumatic in nature," in the Arbitrator's words. But the Arbitrator's citation to "the lasting and damaging effects of the incident on Petitioner's mental health and her career path" as grounds for a permanency award are unsupported in the record -- and are indeed contradicted by the Arbitrator's own observation that Petitioner's PTSD has been in remission for the past five years.

Accordingly, the Commission finds that compensation in this matter is unwarranted. All other issues are moot.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 27, 2015 is hereby reversed. Benefits denied.

DATED: MAR 2 4 2016

Joshua D. Luskin

Charles J. DeVriendt

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Ruth W. White

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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FILLERS, CASSANDRA
Employee/Petitioner

Case# **11WC000694**

16IWCC0222

SOI/NIU DEPT OF PUBLIC SAFETY
Employer/Respondent

On 3/27/2015, 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 0.10% 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:

0190 LAW OFFICES PETER F FERRACUTI
JENNIFER L KIESEWETTER
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OTTAWA, IL 61350

0061 ASSISTANT ATTORNEY GENERAL
ERIN DOUGHTY
100 W RANDOLPH ST 13TH FL
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0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

MAR 27 2015

RONALD A.RASSIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF Kane)

☐ 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

Cassandra Fillers
Employee/Petitioner

v.

State of Illinois/NIU Department of Public Safety
Employer/Respondent

Case # 11 WC 00694

Consolidated cases: _____

16IWCC0222

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 **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Geneva**, on **2/10/2015**. 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 **2/14/2008**, 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 $**64,385.60**; the average weekly wage was $**1,238.18**.

On the date of accident, Petitioner was **27** years of age, ***single*** with **0** 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 $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

Respondent is entitled to a credit of $**350.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in the treatment of her causally related injuries pursuant to Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for amounts paid.

Respondent shall pay Petitioner permanent partial disability benefits of $636.15/week for 25 weeks, because the injuries sustained caused the 5% loss of the person as a whole, as provided in Section 8(d)2 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.

Carolyn Doherty
Signature of Arbitrator

3/23/15
Date

MAR 27 2015

FINDINGS OF FACT

Petitioner testified that on 2/14/08 she worked for Respondent Northern Illinois University in the Department of Public Safety as a public safety officer. As of 2/14/08, Petitioner had worked in that capacity for 4 years. Petitioner further testified prior to 2/14/08 she had no treatment for mental health or alcohol abuse problems.

Petitioner testified that on 2/14/08 she had just returned home from work when she heard a call for a "shooter" over the dispatch radio. Petitioner returned immediately to her squad car to return to campus. Petitioner testified that the radio traffic was "confusing." Petitioner arrived at the campus building and immediately saw several gunshot victims in the student center. Petitioner had paramedic training so she immediately began to assist the gunshot victims which were severely injured students. Many students had sustained multiple gun shots.

Petitioner testified that she grabbed an EMT bag from the center and began assisting victims without any additional assistance as Petitioner was one of the first responders to the scene. Petitioner testified that one of the students she was assisting was talking about how he was going to die. Petitioner testified that she continued to assist the victims until a replacement medic arrived. Petitioner then went to Cole Hall where other victims were found.

Petitioner testified that when she arrived at Cole Hall she saw three bodies on the ground. Petitioner testified that she tried to assist these victims but they were already deceased from gunshot wounds to the head. Petitioner was a direct witness to the aftermath of those shootings. At this point in the trial, the Arbitrator observed Petitioner break down and cry during her testimony.

Petitioner eventually testified that other EMTs arrived on the scene and joined Petitioner in rendering treatment to the victims. Petitioner testified that the victim's bodies were found in between chairs in the lecture hall and that she had to move the bodies into a hallway for treatment.

Petitioner testified that on the same night of 2/14/08, Respondent offered assistance to the responders including Petitioner at the end of the shift. She further testified that the next morning "a lady" came in to offer counseling. Petitioner testified that in the days following the incident she felt "fine" or didn't feel "anything." She testified that 2 to 3 months later she started to feel lonely and sad. She testified that during this period of time Respondent required the responders including Petitioner to meet with victims' families to receive thanks for their help. However, Petitioner testified that the meetings made her feel worse and "guilty" because she was unable to do more to save the victims due to a lack of help and equipment.

Petitioner testified that she continued to work for Respondent. Petitioner testified that she now felt "different" than before the incident and that she felt no feelings of happiness. She felt only sadness. Petitioner testified that she no longer engaged in her hobbies of cooking, baking or gardening and that her family relationships deteriorated. She stayed at home alone with her dog.

On cross-exam, Petitioner testified that she was divorced in 2006 before this incident. In December 2007 or January 2008, prior to the February 2008 incident, Petitioner is documented as having reported to work with alcohol in her system. Petitioner testified that she sought alcohol abuse treatment on her own at the

Ben Gordon Center where she told the therapist that her ex-husband had problems with alcohol. No Ben Gordon Center treatment records pre-dating the February 2008 incident were submitted at trial. PX 2, RX 4.

Petitioner testified that after the February 2008 incident, around June 2008, she started to drink alcohol more than usual. Petitioner testified that she lived alone and was depressed. She testified that she would drink at night so she could "forget" and try to sleep. She testified that drinking wine relaxed her, gave her a feeling of happiness, and allowed her to think less about the incident.

In September 2009, a year and a half after the incident, Petitioner reported to work again with alcohol in her system. According to Petitioner, this was her second violation. Petitioner testified that she again sought treatment on her own at the Ben Gordon Center as a result of this second alcohol related violation. The Ben Gordon record dated 10/14/09 documents that Petitioner reported "problems related to PTSD symptoms stemming from the NIU shooting on February 14, 2008... she reported significant emotional reactions and attempts at avoidance of these issues, which are complicated by her continuing to work as an NIU officer with the Cole Hall area being her assignment. Cassandra reported that prior to the shooting in January 2008 she drank mixed drinks that were prepared by her then boyfriend and when she later presented to work was reprimanded for having alcohol in her system. Late September 2009 she was again determined to have alcohol in her system at work reportedly due to changing shifts and not planning out how long until her next shift. She was sent for a fitness for duty assessment elsewhere and she scheduled this appointment for herself due to her own concerns." PX 2.

The October 2009 record indicates that Petitioner had been directed to speak with a therapist on the evening of the shooting and again at the one year anniversary but did not feel either was beneficial. When asked at trial why she did not seek psychological help at any point after the shooting Petitioner testified that she did not want the treatment to go on her permanent record.

On October 14, 2009, Petitioner was diagnosed with PTSD at Ben Gordon based on her symptoms as well as alcohol abuse. It was noted she was "not interested in psychiatry at this time." Petitioner was recommended to "individual therapy and to investigate services for first responders through NIU." The Ben Gordon records indicate that Petitioner attended follow up individual therapy sessions on three occasions, 11/2/09, 1/18/10 and 1/28/10. PX 2. Petitioner reported a strong desire to work through her fears and "decreasing her emotional reaction to past trauma and agreed to use an exposure therapy approach." PX 2. The therapy records also relate Petitioner's PTSD as one of the triggers of her abuse of alcohol along with other life stressors. PX 2. Continued mental health treatment was recommended to address her triggers. Individual exposure therapy continued on 2/3/10 where at Petitioner agreed to address her emotional experiences during the event of February 2008. PX 2.

The Ben Gordon records indicate that Petitioner was discharged on April 16, 2010 after attending the assessment, treatment planning session and two follow-up therapy appointments centered on using exposure therapy to treat symptoms of PTSD. She made no observable gains and missed several appointments. She is closed due to not following through with therapy." PX 2.

At trial, Petitioner testified that in February 2010, she was received a DUI.

Petitioner testified that she had one additional visit at Ben Gordon and then received additional treatment at Braden Counseling in DeKalb, Illinois. Petitioner testified that she treated at Braden once per week for 2 months for a total of 8 visits. No records from Braden were admitted at trial.

Ben Gordon records from July and August 2010 reference that Petitioner returned to Ben Gordon with the referral source listed as "Court ordered DUI." The records further indicate that Petitioner had been treated at Ben Gordon in October 2009 for PTSD "which Cassie reported being in remission for the past four months reporting no re-experiencing of the trauma in that time." PX 2. More individual and group therapy was recommended. On 8/11/10, Petitioner attended at treatment planning session focused on the elimination of alcohol use. Petitioner was discharged on 11/23/10 when it was noted that she did not attend any follow up after the treatment planning session. Her case was closed due to treatment non-compliance. PX 2.

Petitioner testified that she left Respondent's employ after returning from medical leave in February 2010. She testified that she was told to leave or she would be fired. Petitioner was paid while on medical leave. TTD was not placed at issue at trial.. ARB EX 1. Currently, Petitioner works as a clinical registrar at a hospital.

Petitioner testified that she has moved from DeKalb and that the moved has helped her. She testified that she tries to cope by working out her problems. She does not drink to dull her pain and communicates more with her family. However, Petitioner testified that she is "emotionless" all of the time.

RX 1 contains Respondent's Workers' Comp file on Petitioner. The file contains a notice of injury form completed by Petitioner with regard to the 2/14/08 shooting. The notice of injury report is dated 1/25/10. The report documents Petitioner's claim as testified to at trial. The report asks "if not reported on date of incident, explain" and Petitioner wrote "diagnosis was not made until December 2009."

CONCLUSIONS OF LAW

In support of the Arbitrator's Decision as to C. WHETHER PETITIONER SUFFERED ACCIDENTAL INJURIES WHICH AROSE OUT OF AND IN THE COURSE OF HER EMPLOYMENT WITH RESPONDENT, the Arbitrator finds the following:

Petitioner testified as to the events of February 14, 2008 and her role as a first responder to the shootings that occurred on the NIU campus. She testified as to the necessity to care for victims with gunshot wounds as well as the experience of seeing no signs of life in some of the victims. Further, she testified and the medical records document that during some of this time period she had no assistance or adequate medical equipment and the shooter was still not yet accounted for on campus. The Arbitrator notes that Petitioner was clearly within the course of her employment at the time of the incident, responding to dispatch and an emergency on campus as a campus police officer.

This type of event was a both "exceptionally distressing" and "uncommon" work related experience. As such, the Arbitrator finds that the incident qualifies as a shocking, traumatic event which would satisfy the "arising out of" requirement of the Act. See Pathfinder v. Industrial Commission, 62 Ill.2d 556 (1976); see also, Chicago Transit Authority v. IWCC, 2013 IL.App.1st 120253WC. Based upon the greater weight

of the evidence, the Arbitrator finds that Petitioner suffered accidental injuries on February 14, 2008 which arose out of and in the course of her employment with Respondent.

In support of the Arbitrator's Decision as to E. WHETHER RESPONDENT WAS GIVEN TIMELY NOTICE OF THE ACCIDENT, the Arbitrator finds the following:

The Respondent was obviously aware of this nationally broadcast event regarding the campus shootings of February 14, 2008. Further, the Arbitrator notes that Respondent would have been aware that Petitioner was on duty at the time of the event. Respondent did not call any witnesses or present any evidence to suggest that Petitioner was not at the scene in the capacity that she described as a first responding police officer and acting paramedic.

The Arbitrator further notes that Respondent immediately offered counseling and mental health assistance to Petitioner and other first responders on the night of the event and the morning after the event. As such, the Arbitrator notes that Respondent was vividly aware of the catastrophic incident and the potential effect on its first responder employees including Petitioner. The Arbitrator notes that notice of Petitioner's claim was defective in that it was provided beyond the 45 day period under the Act. However, the Arbitrator finds that given the magnitude of this event, Respondent's awareness of Petitioner's status as a first responder and Respondent's offers of immediate and on-site mental health assistance to those Responders, the Arbitrator finds that Respondent has not shown any undue prejudice as a result of the defective notice sufficient to negate Petitioner's claim under the Act.

In support of the Arbitrator's Decision as to F. WHETHER PETITIONER'S CURRENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE ACCIDENT, the Arbitrator finds the following:

The Act allows for recovery of a mental condition which is the result of a severe sudden emotional shock traceable to a definite time and place which caused psychological injury or harm. See Pathfinder v. Industrial Commission, 62 Ill.2d 556 (1976) Petitioner's response in this case to the shooting victims while the shooter was at large on campus is no less compensable merely because she was a police officer and trained paramedic. See Diaz v. IWCC, 2013 ILApp.2d 120294WC. In addition to the shock and trauma of trying to assist the shooting victims, the Petitioner also experienced the trauma of fear for her safety and the safety of others since part of her time at the scene was before the shooter himself was identified and accounted for. The medical treatment records substantiate her fear with the shooter at large. Being placed in personal danger is a factor that has been found to support an award for a psychological injury. See Matlock v. Industrial Commission, 321 Ill.App.3d 167 (2001).

Petitioner testified that following the shootings she at first felt fine but lacked emotion and ultimately noticed that following an NIU event to meet the families of the shooting victims her feelings of solitude and depression increased. She was unable to sleep and increased her alcohol intake to cope. She withdrew from socializing with family and friends. She was concerned initially about seeking professional help as she knew it would appear on her permanent record if she did. She eventually sought professional help on her own through Ben Gordon Center after she was disciplined in September 2009 for appearing at work with alcohol in her system. Her initial diagnosis was PTSD following the NIU shootings and ruling out alcohol abuse. The treatment records continue to document PTSD related to her role at the scene of the NIU shootings during her few follow up visits. The Ben Gordon records clearly

support a finding of causal connection between Petitioner's diagnosed PTSD and the incident of February 14, 2008. The Arbitrator further finds that Petitioner's failure to seek psychological treatment for her symptoms prior to October 2009 does not mandate a finding of no causal connection for her condition as Petitioner continued to work and testified that she tried to work through her problems, albeit unsuccessfully, on her own.

As of April 2010, the medical records documented that her PTSD was in remission. However, Petitioner continued to have alcohol abuse issues.

Based on a preponderance of the credible evidence, the Arbitrator finds that the Petitioner has met her burden of proving that her PTSD condition is causally related to the accident of February 14, 2008. While the shooting event of February 14, 2008 may have been a primary trigger for her alcohol abuse as indicated in the records, the Arbitrator cannot conclude that her alcohol abuse was definitively related to this event given that she had a prior incident of discipline for alcohol in her system at work in 2007 and also continued to potentially abuse alcohol even when the records support that her PTSD was in remission. Thus, the Arbitrator clarifies that Petitioner's PTSD and its treatment are causally related to this incident but that her alcohol abuse and related treatment after April 16, 2010 are not.

In support of the Arbitrator's Decision as to J. WHAT AMOUNT OF MEDICAL EXPENSES SHOULD BE AWARDED, the Arbitrator finds the following:

Petitioner's Exhibit #1 contains the medical expenses related to Petitioner's medical treatment at Ben Gordon Center. Based upon the finding of liability, the Arbitrator finds that the Respondent shall pay Petitioner the causally related medical expenses through April 16, 2010 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid including credit pursuant to Section 8(j) of the Act. ARB EX 1.

In support of the Arbitrator's Decision as to K. THE NATURE AND EXTENT OF THE INJURY, the Arbitrator finds the following:

The date of accident is February 14, 2008. No AMA evidence was presented or required at trial. The Arbitrator notes the traumatic nature of the events witnessed by Petitioner. The Arbitrator further notes the lasting and damaging effects of the incident on Petitioner's mental health and her career path. Petitioner underwent a few visits to Ben Gordon Center and as of April 2010 was discharged for non-compliance. Later in July/August 2010, Ben Gordon records note Petitioner's report that her PTSD was in remission for approximately 4 months. Petitioner reported that her nightmares noted in the treatment records had subsided. At trial, Petitioner testified that she has learned other ways to cope with her memories of the events and has tried to steer away from alcohol. She has moved away from DeKalb and spends more time with her family. She testified that she still finds that she has a lack of emotion. Petitioner no longer works as a safety officer.

Accordingly, the Arbitrator finds that Petitioner has sustained a 5% loss of use of the person as a whole under Section 8(d)(2) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Johnsy Anderson,

Petitioner,

vs. NO: 11 WC 17775

Dr. Kim Livtezy,

16IWCC0209

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the sole issue of temporary total disability benefits and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

In *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission*, 236 Ill.2d 132, 142 (2010), the Court explained that:

> "[i]t is a well-settled principle that when a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's condition has stabilized, *i.e.*, whether the claimant has reached maximum medical improvement."

The Court further explained:

> "The fundamental purpose of the Act is to provide injured workers with financial protection until they can return to the work force. *Flynn, 211 Ill. 2d at 556*. Therefore, when determining whether an employee is entitled to TTD benefits, the test is whether the employee remains temporarily totally disabled as a result of a work-related injury **and** whether the employee is capable of returning to the work force." *Interstate Scaffolding*, 236 Ill.2d at

16IWCC0209

146. (emphasis added)

The Commission notes that on December 2, 2013, Dr. Baker released Petitioner to return to work with the following restrictions: no use of vibratory tools, no repetitive motion activity and no scissoring activity. (PX2) In January of 2014, Petitioner was fired from Respondent's employ. (T.13,43) During this time, Petitioner had been attending Parkland College on a full-time basis. (T.44) On July 16, 2014, Dr. Baker issued a letter explaining that "taking into account [Petitioner's] current symptoms and after reviewing the IME report done by Dr. Brown and taking in to account his impression/recommendations I am recommending NO WORK at this time." (PX3-EPX4) However, the Commission notes that Dr. Brown had released Petitioner to return to work finding "no functional reason why she could not return to work." (RX1-ERX2)

In August of 2014, Petitioner was offered work through Parkland College and FAFSA (work study), but turned the offer down. (T.48) At hearing, Petitioner testified that she did not know what the job would entail and that she told financial aid that she could not take a position because she had not been released from her doctor's care yet. (T.48-49)

It is clear to the Commission that Dr. Baker considered Petitioner's ongoing symptoms and need for treatment, as recommended by Dr. Brown, and found that Petitioner could not return to work. It is also clear to the Commission, based on the findings and opinions of Dr. Baker and Dr. Brown, that Petitioner has not reached maximum medical improvement regarding her left thumb condition. Therefore, the Commission finds that the record establishes that Petitioner remains temporarily totally disabled as a result of her work-related injury and is not capable to returning to the work force because of it. As such, the Commission finds that Petitioner has proven entitlement to temporary total disability benefits through the date of hearing, March 13, 2015 and modifies the Arbitrator's Decision to reflect as such.

So that the record is clear, and there is no mistake as to the intentions or actions of this Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical / legal perspective. Furthermore, we have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent. Finally, one should not and cannot presume that we have failed to review any of the record made below. Though our view of the record may or may not be different than the arbitrator's, it should not be presumed that we have failed to consider any evidence taken below. Our review of this material is statutorily mandated and we assert that this has been completed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on May 7, 2015 is modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $275.99 per week for a period of 38 weeks, from June 21, 2014 through March 13, 2015, that being the period of temporary total incapacity for work under Section 8(b), and that as provided in Section 19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

16IWCC0209

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under Section 19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $9,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 4 2016
MJB/ell
o-02/08/16
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

ANDERSON, JOHNSY
Employee/Petitioner

Case# **11WC017775**

16IWCC0209

DR KIM LIVTEZY
Employer/Respondent

On 5/5/2015, 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 0.07% 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:

0293 KATZ FRIEDMAN EAGLE ET AL
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1010 MARKET ST SUITE 1510
ST LOUIS, MO 63101

8905300181

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

☐ 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
19(b)

Johnsy Anderson
Employee/Petitioner

Case # 11 WC 17775

v.

Consolidated cases: n/a

Dr. Kim Livtezy
Employer/Respondent

16IWCC0209

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 William R. Gallagher, Arbitrator of the Commission, in the city of Urbana, on March 13, 2015. 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. ☐ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

16IWCC0209

On the date of accident, April 15, 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 $14,351.48; the average weekly wage was $275.99.

On the date of accident, Petitioner was 48 years of age, single with 1 dependent child(ren).

Respondent has paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $31,909.43 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $31,909.43. At trial, the parties stipulated that TTD benefits were paid in full through June 20, 2014, and that Respondent was entitled to a credit for any benefits awarded of $1,116.82.

Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $275.99 per week for 10 2/7 weeks commencing June 21, 2014, through August 31, 2014, as provided in Section 8(b) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

William R. Gallagher, Arbitrator
ICArbDec19(b)

April 29, 2015
Date

MAY 5 - 2015

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained a repetitive trauma injury arising out of and in the course of her employment for Respondent. The Application alleged a date of accident (manifestation) of April 15, 2011, and that Petitioner sustained repetitive trauma to the left elbow and wrist (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of temporary total disability benefits of 38 weeks, from June 21, 2014, through March 13, 2015 (the date of trial). Respondent's position was that Petitioner was not entitled to any further payment of temporary total disability benefits.

At trial, Petitioner and Respondent stipulated that Petitioner sustained a repetitive trauma injury and that her current condition of ill-being was causally related to same. Petitioner and Respondent further stipulated that Petitioner had been paid temporary total disability benefits for various time periods and that all temporary total disability had been paid in full through June 20, 2014. They also agreed that Petitioner was paid temporary total disability benefits of $286.00 per week, but that the correct rate was $275.99 per week. They further agreed that, because of Petitioner having been paid at a higher rate than what she was entitled to, that Respondent was entitled to a credit of $1,116.82.

Petitioner worked for Respondent as a dog groomer and her job duties required her to cut hair with a clippers, trim nails, shave hair between paws, clean ears, bathe and dry the dogs, etc. Petitioner testified that performing all of the preceding tasks required the active and repetitive use of both of her hands. The amount of force Petitioner had to use in performing these tasks varied considerably depending on the size and temperament of the dog. Petitioner stated that she would generally groom five dogs per day.

Even though Petitioner is right hand dominant, she began to develop symptoms of pain, numbness and tingling in the left hand/wrist sometime in October, 2010. Petitioner initially sought medical treatment from Dr. Clifford Johnson, an orthopedic surgeon, who initially saw Petitioner on March 4, 2011. At that time, Petitioner informed Dr. Johnson of her work duties. Dr. Johnson opined Petitioner had left carpal tunnel and cubital tunnel syndrome. He ordered nerve conduction studies (Petitioner's Exhibit 1).

Petitioner underwent nerve conduction studies which were apparently positive for moderate left carpal tunnel syndrome (the report of the nerve conduction studies was not tendered into evidence). Dr. Johnson saw Petitioner on April 15, 2011 (the date of manifestation alleged in the Application) and he discussed the findings of the nerve conduction studies with Petitioner (Petitioner's Exhibit 1).

Dr. Johnson again saw Petitioner on December 9, 2011, and reviewed a report of Dr. Mark Greatting (who had examined Petitioner at Respondent's request) and noted that Dr. Greatting diagnosed Petitioner with left carpal tunnel syndrome determined both by symptoms and the positive nerve conduction studies, but that left cubital tunnel syndrome was not identified in the nerve conduction studies. Dr. Greatting opined Petitioner should have left carpal tunnel surgery but not left elbow transposition surgery. Dr. Johnson performed a left carpal tunnel surgical

release on January 16, 2012, and, during the course of that procedure, he injected the STT joint of the left wrist (Petitioner's Exhibit 1).

In May and June, 2012, Petitioner sought further treatment from Dr. Johnson, primarily for left thumb symptoms. Because of Petitioner's ongoing symptoms, on July 2, 2012, Dr. Johnson recommended Petitioner obtained a second opinion.

Petitioner was evaluated by Dr. Stuart Baker, a plastic/hand surgeon, on August 6, 2012. At that time, Petitioner had complaints of pain in the left wrist and tingling in the fourth and fifth fingers of the left hand. Dr. Baker examined Petitioner and directed her to obtain her prior treatment records (Petitioner's Exhibit 2).

On August 9, 2012, Petitioner was again examined by Dr. Greatting who diagnosed cubital tunnel syndrome and CMC osteoarthritis and mild arthritis of the scaphotrapezoid joint. He recommended Petitioner have another nerve conduction study performed to evaluate the cubital tunnel syndrome. He also noted that a left thumb arthroplasty might be indicated (Petitioner's Exhibit 2).

Petitioner continued to be treated by Dr. Baker. Ultimately, Dr. Baker performed surgery on the CMC joint on December 3, 2012. The surgical procedure consisted of removal of the trapezium and replacement of it with the flexor carpi radialis tendon that he took from the left wrist (Petitioner's Exhibit 2).

Petitioner continued to be treated by Dr. Baker following surgery. Because Petitioner continued to have symptoms in the base of the thumb and wrist, Dr. Baker ordered a CT scan which was performed on June 19, 2013. The CT scan revealed extensive osteoarthritic degenerative changes. On July 1, 2013, Dr. Baker gave Petitioner an injection in the base of the left thumb (Petitioner's Exhibit 1).

When Dr. Baker saw Petitioner on August 27, 2013, he noted that she had another IME performed and that an EMG was recommended. He referred Petitioner to Dr. Douglas Dove, a neurologist, who performed an EMG/nerve conduction study on September 26, 2013, which was normal (Petitioner's Exhibit 1).

When Dr. Baker saw Petitioner on December 2, 2013, he released her to return to work but with restrictions of no vibratory tools, no repetitive motion and no scissoring activity. Petitioner was again seen by Dr. Baker on January 20, 2014, and had complaints of significant pain in the STT joint. Dr. Baker continued to treat Petitioner conservatively with medication and the use of splints at nighttime (Petitioner's Exhibit 1).

At the direction of Respondent, Petitioner was examined by Dr. David Brown, a plastic/hand surgeon, on June 3, 2014. In connection with his examination of Petitioner, Dr. Brown reviewed medical reports provided to him by Respondent. At that time, Petitioner had ongoing complaints of numbness/tingling in the left thumb, index and middle fingers, aching at the base of the thumb and tingling at the base of the thumb when she placed pressure on the surgical scar (Respondent's Exhibit 1; Deposition Exhibit 2).

In regard to Petitioner's carpal tunnel syndrome, Dr. Brown's findings on examination were normal. He also noted that the EMG/nerve conduction study that was recently performed was normal as well. He opined that Petitioner was at MMI in respect to that condition. In regard to Petitioner's left thumb condition, he opined that Petitioner had findings indicative of neuropathy at the base of the thumb. He recommended further diagnostic procedures and possible surgery. He further opined that Petitioner was not at MMI in respect to that condition. Dr. Brown also stated that Petitioner could return to work (Respondent's Exhibit 1; Deposition Exhibit 2). Based on the opinion of Dr. Brown that Petitioner could return to work, Respondent terminated payment of temporary total disability benefits as of June 20, 2014.

Petitioner continued to be treated by Dr. Baker. On July 21, 2014, Dr. Baker gave her an injection in the left wrist which produced temporary relief (Petitioner's Exhibit 2).

Dr. Baker was deposed on January 28, 2015, and his deposition testimony was received into evidence at trial. Dr. Baker's testimony was consistent with his medical records which only went through August 18, 2014, so a considerable amount of his deposition testimony was for treatment subsequent to that date. Dr. Baker testified that he saw Petitioner on September 15 and December 1, 2014. When Dr. Baker was deposed, he testified that further surgery might be indicated, specifically a decompression of the palmar cutaneous nerve (Petitioner's Exhibit 1; pp 40-41).

In regard to Petitioner's ability to work, Dr. Baker testified that as of December 1, 2014, Petitioner was not able to work. However, when cross-examined, Dr. Baker agreed that Petitioner was able to use her right hand but would have to keep her left hand in a splint, in a neutral position and in an even tempered environment. He further stated that Petitioner could work so long as she was not doing heavy lifting or grasping, exposed to cold, using vibratory tools and any activity that required constant movement of the carpal metacarpal joint or STT joint of the left hand (Petitioner's Exhibit 1; pp 49-52).

Shortly after he was deposed, Dr. Baker saw Petitioner on February 2, 2015, and gave the left wrist an injection. On March 12, 2015, he sent Petitioner's counsel a statement of Petitioner's work restrictions which consisted of no use of vibratory tools and no carrying of her back pack with her left arm (Petitioner's Exhibits 3 and 4).

Dr. Brown was deposed on March 2, 2015, and his deposition testimony was received into evidence at trial. Dr. Brown's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. He opined that Petitioner could return to work without restrictions because his findings on examination were essentially normal. He did not agree that Petitioner should be restricted from performing her dog grooming job even if it caused pain when she gripped because he did not believe that Petitioner's complaints of pain were consistent with his findings on examination (Petitioner's Exhibit 1; pp 15-16, 24-25).

At trial, Petitioner testified that her left hand is painful and sensitive virtually all of the time and that her range of motion is restricted. Petitioner stated that she is unable to carry a bag of groceries, do dishes, hold a coffee cup, open a jar, etc. with her left hand.

Petitioner's employment was terminated by Respondent in January, 2014. Petitioner became a full-time student at Parkland College in August, 2013, and anticipates finishing school in December, 2015. Petitioner was able to obtain financial aid for her higher education and she testified that sometime in either August or September, 2014, she was offered a job at the college as a student worker. Petitioner did not make a determination as to the nature of the job, what the duties consisted of, how much it paid, etc. Petitioner simply declined to accept or even consider the job offer. Petitioner stated that she relies on her right hand to perform her schoolwork, pull her rolling book bag, etc.

Conclusions of Law

In regard to disputed issue (L) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner is entitled to further temporary total disability benefits of 10 2/7 weeks commencing June 21, 2014, through August 31, 2014.

In support of this conclusion the Arbitrator notes the following:

Petitioner has continued treatment with Dr. Baker primarily for the left thumb, CMC and STT joint conditions. Dr. Baker has opined that additional surgery may be indicated.

When he was deposed, Dr. Baker opined that as of December 1, 2014, Petitioner was able to work but with significant restrictions; however, subsequent to his deposition, in his note of March 12, 2015, the work restrictions were limited to no use of vibratory tools and not carrying her back pack with her left arm.

The Arbitrator is not persuaded by Dr. Brown's opinion that Petitioner can work without restrictions given his opinion that Petitioner was not at MMI in regard to the left thumb condition and that further diagnostic procedures and treatment might be indicated.

Petitioner testified that sometime in either August or September, 2014, she was offered a job at the college as a student worker which she refused without making any determination as to information regarding the job. This job may or may not have been within her work restrictions, but there is no way for the Arbitrator to make a determination of this under these circumstances.

Petitioner's refusal to even consider a job effectively removed her from the job market.

Because Petitioner testified that the job was to begin sometime in either August or September, 2014, the Arbitrator finds Petitioner is entitled to temporary total disability benefits from June 21, 2014, through August 31, 2014.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Manuel Badillo,
Petitioner,

vs. No: 11 WC 31354

Rollprint Packaging,
Respondent.

16IWCC0223

DECISION AND OPINION ON REMAND FROM THE APPELLATE COURT

This matter returns to the Commission pursuant to the June 26, 2015 Order of the Workers' Compensation Commission Division of the Appellate Court for the First District of Illinois under its case number 1-14-0564WC.

In the Rule 23 Order, the Appellate Court affirmed in part and reversed in part the February 25, 2014 judgment of the Circuit Court of Cook County, which judgment had confirmed the April 16, 2013 decision of the Commission. Specifically, the Appellate Court reversed the portions of the Circuit Court's judgment that had affirmed the Commission's: (1) finding that claimant's lumbar spine injury was limited to a contusion or sprain that had resolved by October 17, 2011; (2) denial of benefits associated with claimant's lumbar spine injury after October 17, 2011; and (3) denial of penalties under Section 19(l) of the Workers' Compensation Act. All other aspects of the Commission's decision were affirmed. The Appellate Court remanded the cause to the Commission so that it may award claimant benefits under the Act consistent with the Appellate Court's decision; the Appellate Court instructed that such award include prospective medical expenses for the treatment recommended by Dr. Robert Erickson and Section 19(l) penalties.

In accordance with the Appellate Court's Order, the Commission makes an award of medical benefits to Petitioner in connection with his lower back condition to include medical expenses incurred after October 17, 2011. The Commission also awards prospective medical expenses in the form of the work conditioning program recommended by Dr. Erickson. The Commission further awards penalties under Section 19(l).

With regard to Section 19(l) penalties, these penalties are set by the Act at $30 per day for each day an employer, without good and just cause, neglects, refuses or unreasonably delays the payment of benefits owed to an injured employee. The Appellate Court found that Respondent violated Section 19(l) by its delay in paying certain causally-related medical expenses without adequate reason for its delay. Therefore, these mandatory penalties must be imposed. As the Commission had noted in its June 14, 2013 decision, the Respondent stated on the record that all reasonable and necessary medical expenses through October 20, 2011 were paid. However, the Commission found that some of Petitioner's outstanding charges were for reasonable and related services incurred prior to October 17, 2011, the earliest being a bill for x-rays from Marque Medicos on August 12, 2011. The Commission awarded claimant $3,974.45 in medical expenses incurred from August 12, 2011 to October 13, 2011 and which remained unpaid through the date of the arbitration hearing on February 27, 2012. The employer did not seek review of the Commission's decision on this point. The Section 19(l) penalties found to be warranted by the Appellate Court are calculated to be $5,970.00 ($30 per day covering the period of August 12, 2011 through the arbitration date of February 27, 2012, or 199 days).

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of **$ 495.73 per week** for the following periods, representing **27 and 4/7** weeks, pursuant to Section 8(b): July 13, 2011 through July 17, 2011; July 21, 2011; July 27, 2011; August 12, 2011 through February 13, 2012.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner medical expenses related to the lumbar spine injury incurred from October 18, 2011 to February 27, 2012 pursuant to Sections 8(a) and 8.2. Pursuant to the Appellate Court's Order affirming the Commission's decision as it regarded expenses related to Petitioner's shoulders and cervical spine as well as transportation, this award excludes those expenses.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize the work conditioning program as recommended by Dr. Erickson.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay additional compensation in the amount of **$5,970.00** as provided by Section 19(l).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of the subject accidental injury.

16IWCC0223

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of the expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 24 2016

Joshua D. Luskin

r-03/23/16
jdl/ac
68

Charles J. DeVriendt

Ruth W. White

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mark Schrubbe,

Petitioner,

vs. NO: 11 WC 48384

16IWCC0206

Southern Wine & Spirits,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of permanent partial disability, wages, rate, penalties, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 11, 2014, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

16IWCC0206

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $15,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 3 2016
TJT:yl
o 3/8/15
51

Thomas J. Tyrrell

Kevin W. Lamboin

Michael J. Brennan

REDACTED

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

SCHRUBBE, MARK
Employee/Petitioner

Case# **11WC048384**

SOUTHERN WINE & SPIRITS
Employer/Respondent

16IWCC0206

On 12/11/2014, 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 0.09% 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:

0206 GAINES & GAINES
GEORGE L GAINES
PO BOX 6345
EVANSTON, IL 60202

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT E MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 2290
CHICAGO, IL 60606

16IWCC0206

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ 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
CORRECTED ARBITRATION DECISION

Mark Schrubbe
Employee/Petitioner
v.
Southern Wine & Spirits
Employer/Respondent

Case # 11 WC 48384

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 Deborah Simpson, Arbitrator of the Commission, in the city of Chicago, on August 26, 2014. 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 October 6, 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 $43,815.80; the average weekly wage was $842.61.

On the date of accident, Petitioner was 51 years of age, single with one dependent child.

Petitioner has received all reasonable and necessary medical services.

Respondent has paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $ -0- for TTD, $255.99 for TPD, $ -0- for maintenance, and $ -0- for other benefits, for a total credit of $255.99.

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

ORDER

Petitioner is found to have suffered a permanent injury pursuant to Section 8(e) of the Act. Respondent shall pay Petitioner permanent partial disability benefits of $505.37/week for 30.75 weeks, because the injuries sustained caused the 15% loss of the right hand, as provided in Section 8(e) of the Act.

The Petitioner is entitled to $690.51 in temporary partial disability benefits. The Respondent has paid $255.99 leaving an unpaid balance of $434.52.

The Petitioner's request for Penalties and Attorney's Fees is denied

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.

Deborah L. Simpson
Signature of Arbitrator

12/11/14
Date

DEC 11 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mark Schrubbe,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No.11 WC 48384**
	)	
Southern Wine and Spirits,	)	
	)	
Respondent.	)	
	)	

CORRECTED
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on October 6, 2011, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. On that date the Petitioner sustained an accidental injury or was last exposed to an occupational disease that arose out of and in the course of the employment. They further agree that the Petitioner gave the Respondent notice of the accident within the time limits stated in the Act and that his current condition of ill-being is causally connected to this injury.

At issue in this hearing is as follows: (1) What were the Petitioner's earnings during the year preceding the injury and what was his average weekly wage, calculated pursuant to Section 10 of the Act; (2) Is the Petitioner entitled to TPD from October 7, 2011 through December 1, 2011; (3) What is the nature and extent of the injury; and (4) Is the Petitioner entitled to penalties/attorney's fees under § 19(k), § 19(l) and §(16).

The Respondent stipulated that the medical bills listed in Paragraph 7 of Arbitrator's Exhibit number 1, for Physician's Immediate, Hand Surgery Assoc. and Chicago Metro, would be paid by Respondent pursuant to the fee schedule.

STATEMENT OF FACTS

The Petitioner testified that he was employed by the Respondent on October 6, 2011 as a delivery driver. He delivers wine and spirits. He testified that basically he gets orders from the sales department and delivers them to the customers. The Petitioner takes the orders off of the truck and places them on a hand truck. He then wheels the hand truck with beer, wine and or liquor into the customers stores/shops and puts the orders where the customer wants them. On

come accounts he also collects for the deliveries, on others he does not. The Petitioner is right hand dominant.

On October 6, 2011, when making a delivery he had to move a dumpster to get into the alley in order to make his delivery. While rolling the dumpster back his hand got trapped between two dumpsters. Prior to this incident he did not have any injuries to this hand. His hand was caught between the handle bar where the dump truck picks up the dumpster and his hand was crushed.

Petitioner reported the injury to his employer and they sent him to Immediate Care that same day. Dan, the night supervisor, referred Petitioner to the employer's clinic, Physician's Immediate Care. Petitioner treated there on the date of accident and four occasions thereafter.

Petitioner was diagnosed with a fracture of the right fifth metacarpal,(PX1), and was treated conservatively. Petitioner was restricted to left hand work only. Angulation of the distal fragment was noted the following day. A lidocaine injection was administered at the fracture site in an attempt to better reduce the fracture. (PX 1). Petitioner's hand was quite swollen and caused Petitioner to have difficulty sleeping. (PX 1) Swelling, ecchymosis and discoloration of the hand at the proximal fourth phalanx was also noted. Petitioner rated his pain at a level of 8/10. Anterior angulation was noted. (PX 1).

Two weeks after the injury, the clinic deemed the condition to be worsening, noting more angulation of the fracture fragment to the radial side. "Skin changes," were also noted and the clinic referred Petitioner to a hand surgeon, Scott Sagerman. (PX 1).

Petitioner underwent about seventeen physical therapy sessions at the direction of Dr. Sagerman from late October 2011 through December of 2011at Chicago Metro Hand Therapy. They had a satellite office in Alsip, which Petitioner attended because it was closer to his home. (PX3). Two months post-injury, the fracture line continued to be visible. (PX 2).

Three months after the injury, he was discharge to activities "as tolerated." (PX 2 . According to the Petitioner he was released to return to work by Dr. Sagerman on January 12, 2012 with respect to his hand injury. He testified that due to the unrelated health issues he was not able to return at that time. Eventually he did return to his regular duties.

The Petitioner testified that currently he is working full duty with no restrictions imposed by his treating doctors. He currently experiences stiffness in his hand. When it is cold the hand aches and when it is warm or hot he gets cramps. Petitioner feels that his right hand is not as strong as it used to be, therefore he takes lighter loads in when making deliveries which sometimes results in more trips from the truck to the store. He testified that at night he ices his hand when he has pain and he still works with a squeeze ball.

The Petitioner testified that his regular work week consisted of four ten hour days. He stated that he did not lose any time from work, as they found light duty work for him to do within his work restrictions however he worked five eight hour days when he was working light duty. According to the Petitioner, he worked light duty from the day after the accident until the first or second week of December when he got sick and could not work. The illness that prevented him from working was not related to the injury he suffered on October 6, 2011.

The Petitioner testified on cross examination that as a delivery driver he was a member of the teamsters union local 710 and as such was paid union wages. He testified that in 2010, he was making $17.50 per hour and that he would have gotten a raise on his anniversary date. He was not sure of the date however his pay did increase to $22.83 per hour. According to the Petitioner he began working for the Respondent on August 10, 2009, so he should / would have received his raise on or about August 10, 2011.

The Petitioner also testified on cross examination that during the light duty work was part of their contract and it was union approved. According to the Petitioner he was paid $19.41 per hour when he worked light duty and this was an underpayment based upon what he would have received for TTD payments if no light duty work was available.

Petitioner claims that he worked 190 days from 10-7-2010 through 9-23-2011, earning a gross amount of $40,450.30. Petitioner alleges that his calculation reflects, among other things, that Petitioner lost eight days of work in total during the weeks of 10-29-2010, 12-3-2010, 1-28-2011, 2-11-2011 and the end of May 2011. RX2. In reviewing Respondent's exhibit number 2 the Petitioner did not miss a day during the week of 10/29/2010 he had 10 hours PTO (line 13) plus 20 hours at the rate of $17.50 (line 18) and 10 hours at the rate of $17.70 (line 19) per hour. Petitioner does appear to have missed 8 hours of work during the week of 12/3/10 (line 25) and 10 hours of pay on 1/28/11 (line 35) and 10 hours of pay the week of 2/11/11 (line 37). Petitioner is also claiming to have lost time at the end of May, does not cite a specific number of days however lines 50, 51and 70 reflect that Petitioner was paid for three weeks at 40 hours per week and one week at 50 hours which is designated as "RVAC." Petitioner did not prove that he lost 5 or more calendar days during the year preceding the injury. (RX 2)

According to the Petitioner's testimony and Petitioner's exhibit numbers 4 and 5 during light duty from 10/21/2011 through 12/9/2011 the Petitioner was paid $19.41 per hour, which amounted to $776.40 per week. At the time Petitioner's actual rate of pay was $22.83 per hour which totaled $913.20 per week. (RX2, PX 4,5)

The Petitioner submitted to an AMA evaluation performed by Dr. David Fletcher on September 7, 2012. The Petitioner's complaints at this time were of mild hand stiffness and discomfort. The doctor's physical examination revealed that range of motion was within normal limits. There was no swelling. The Petitioner demonstrated a normal grip. The diagnosis was "fracture, fifth metacarpal, (not metacarpal head), healed-excellent results." The AMA evaluation resulted in an impairment rating of 4% of the right little finger, zero percent of the hand. Dr. Fletcher also commented that the injury in question was minor with excellent outcome with a quick-dash score less than 5. Dr. Fletcher opined that considering the Petitioner's age, this injury does not in any way affect his ability to continue in his current occupation, and does not, in any way, affect his future earning capacity. (RX 3)

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial*

Comm'n, 115 Ill.2d 524, 505 N.E.2d 1026 (1987). This includes the nature and extent of the petitioner's injury.

In determining the level of permanent partial disability, for injuries that occur on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (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; (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. (820 ILCS 305/8.1b)

What were Petitioner's earnings?

The Arbitrator finds the following facts:

The Petitioner, for the year preceding, received two different hourly wages, one being $17.50 an hour and the other being $22.83 an hour.

The Petitioner worked for 20-1/2 weeks earning an hourly rate of $17.50/ hour which totaled $700.00/a week. $700/ week for 20 1/2 weeks equals $15,050.00.

The Petitioner worked for 31-1/2 weeks earning an hourly rate of $22.83/ hour or $913.00 a week. $913.20/week times 31 1/2 weeks equals $28,765.80. The sum of both parts of the year, totals $43,815.80 for the year resulting in an average weekly wage of $842.61.

The Arbitrator finds the Petitioner's average weekly wage to be $842.61.

What amount is due for temporary total disability?

The Arbitrator notes that the Petitioner worked modified duty for 7-4/7ths weeks. The Petitioner, during the period of time that he worked modified duty, received $776.40 a week. The Petitioner at the time, was earning $22.83 an hour, or $913.20 a week.

Under Section 305/8(a), the Petitioner was entitled to two-thirds of the difference between what he would have earned in his full employment at the time of modified duty and the gross of his modified duty wages or in this case, $3.42 ÷ 3 x 2 = $2.28 an hour x 40 hours = $91.20 x 7-4/7ths weeks = $690.51. The Arbitrator finds that the Petitioner is entitled to $690.51 in temporary partial disability benefits. The Respondent has paid $255.99 leaving an unpaid balance of $434.52.

What is the nature and extent of the injury?

The Arbitrator adopts by reference all prior findings and conclusions into this Section without restating them herein. This claim arose after September 1, 2011, therefore the 5 factors for determining Permanent Partial Disability shall be applied here. The Arbitrator notes the five factors to determine Permanent Partial Disability are: 1) AMA Impairment Rating; 2)

Occupation of the injured employee; 3) Age of the employee at the time of the injury; 4) Employee's future earning capacity; and 5) Evidence of disability corroborated by the treating medical records. No one factor shall be controlling but a written explanation is required if an award is greater than the AMA Impairment Rating. 820 ILCS 305/8.1b(b).

It is the claimant's burden to prove all aspects of his claim for benefits. This includes entitlement to Permanent Partial Disability.

1. ***AMA Impairment Rating***: The Respondent presented an AMA Impairment Rating prepared by Dr. David Fletcher. The AMA evaluation performed by Dr. David Fletcher found a 4% impairment of the right little finger.

The treatment for Petitioner's injury was for his hand. The Petitioner testified to lingering effects of the injury involving pain, weakness and swelling. The Arbitrator gives little weight to this factor.

2. ***Occupation of the injured employee***: Petitioner was employed by Respondent as a delivery driver, delivering beer, wine and liquor. He is responsible for unloading the orders onto a hand truck, wheeling them into the places of business and unloading the product from the hand truck where ever the customer directs him to stack the deliveries.

Petitioner testified that he continues to work for the Respondent in this capacity and that due to the weakness, cramping and swelling he experiences based upon the weather and over use of his hand he is able to do his job, however he does make the loads lighter when he is transporting product with the hand truck. This results in more trips from the truck into the stores. The Arbitrator gives some weight to this factor.

3. ***Age of the employee at the time of the injury***: Petitioner was 51 at the time of his accident. There is no evidence that Petitioner's age impacted his injury or created any permanent disability. No weight is given to this factor.

4. ***Employee's future earning capacity***: Petitioner testified that he continues to work at his previous job with no permanent restrictions. There was no evidence in the records or testimony by the Petitioner that the job required overtime. His pay checks were consistently for 40 hours per week.

Petitioner did not testify to any diminution of his earnings since this accident. Petitioner's exhibit number 5 indicates that he has received at least one raise since he returned to work after the injury. Petitioner continues to work forty hours per week. There is no evidence of disability due to this factor, the Arbitrator gives some weight to this factor.

5. ***Evidence of disability corroborated by the treating medical records***: The Petitioner sustained a crush injury to his right hand, resulting in a fracture of the 5th metacarpal with some anterior angulation, on October 6, 2011. The Petitioner underwent conservative treatment including splinting and physical therapy and was released from care by his treating doctor on January 12, 2012, with no work restrictions. The Petitioner testified that currently he experiences stiffness in his hand, when it is cold the hand aches and when it is warm or hot he gets cramps. Petitioner feels that his right hand is not as strong as it used to be, therefore he

takes lighter loads in when making deliveries. He testified that at night he ices his hand when he has pain and he still works with a squeeze ball. At the time of the AMA evaluation by Dr. Fletcher, he noted that the Petitioner was still taking over the counter anti-inflammatory medications for the condition. The Arbitrator places some weight on this factor.

Given the nature of the injury the Petitioner suffered to his right hand following the October 6, 2011, incident, he is entitled to have and receive from the Respondent compensation for 15% loss of use of the right hand, or 30.75 weeks at a weekly PPD rate of $505.37 / per week.

Should penalties and attorney's fees be imposed upon Respondent?

The Arbitrator finds the following:

The Petitioner did not miss any time from work, but was placed on modified duty for a period of 7-4/7ths weeks. The Petitioner's average weekly wage for purposes of TTD and permanency was $842.61, but for purposes of temporary partial disability, $913.20. The Petitioner, during the period of his temporary partial disability, received an amount in excess of his temporary total disability rate ($776.40 versus the TTD rate of $561.74), but less than what he was entitled to under Section 8(a) for temporary partial disability which was $913.20 minus $776.40 = $136.80 ÷ 3 x 2 or an additional $91.20 a week more than he received.

The Petitioner's attorney filed a Petition For Assessment of Penalties under Section 19(k) on October 30, 2013, claiming that the Respondent failed to pay temporary partial disability benefits, but did not indicate in that penalty petition what he was claiming was due and owing.

The Respondent responded to the 19(k) penalty petition on November 5, 2013, indicating that it was the Respondent's understanding that the Petitioner was paid, indicating that the Petitioner's attorney did not identify what the alleged underpayment was.

The Respondent, thereafter, continued to inquire of Petitioner's counsel as to what the underpayment was.

The Petitioner's attorney did have in his possession the Petitioner's pay checks and he did have from Respondent the payment history for the period of time in question. In this matter, there was no evidence that the Petitioner made a demand for payment of benefits until the filing of his penalty petition under Section 19(k) on October 30, 2013. The Respondent did reply to the 19(k) penalty petition on November 5, 2013 asking for the Petitioner to identify what the alleged underpayment was. The Respondent did continue to send correspondence to Petitioner's counsel after the 19(k) petition was received, asking him to advise as to what was due and owing.

The Respondent calculated what it believed to be the temporary partial disability difference to be, $255.99, and forwarded same to Petitioner or Petitioner's counsel on or about the date of check, March 28, 2014.

The Petitioner's attorney and the Respondent's attorney were unable to find an agreement as to what the actual wages were that the Petitioner should have been making. There were

conflicts with respect to rates that Petitioner was paid due to a raise in pay during the year previous to the injury, there were questions regarding the method of calculating the average weekly wage, the time worked and time off. Sections 19(k), 19(l) and 16 penalties lie in situations where there has been an unreasonable or vexatious delay of payment or intentional underpayment of compensation. In terms of Section 19(l) penalties lie only after the employee has made a written demand for payment of benefits under Section 8(a) or Section 8(b).

It is obvious from the penalty petition on file with the Commission for penalties under Section 19(k), the Respondent's response to the penalty under Section 19(k) and the subsequent correspondence, that the Respondent did make an effort to reach out to the Petitioner's counsel asking for the amount that was due and owing. Although the temporary partial disability was not paid at the time of the modified duty, and then was subsequently paid at a later date at an incorrect amount, and given the opposing views of how to calculate the AWW, both by method and appropriate hours, the Arbitrator cannot find the Respondent's conduct was vexatious or unreasonable in terms of 19(k) penalties.

The petition for penalties filed by the Petitioner's counsel on October 30, 2013, was for 19(k) penalties with no mention of 8(a) or penalties under Section 16 or 19(l), with no evidence that the Respondent was unreasonable or vexatious in their conduct.

For the reasons stated, the Arbitrator denies the Petitioner's request for 19(l) penalties.

The Arbitrator denies the Petitioner's Section 16 penalty request as well for the above stated reasons.

ORDER OF THE ARBITRATOR

Petitioner is found to have suffered a permanent injury pursuant to Section 8(e) of the Act. Respondent shall pay Petitioner permanent partial disability benefits of $505.37/week for **30.75** weeks, because the injuries sustained caused the 15% loss of the right hand, as provided in Section 8(e) of the Act.

The Petitioner is entitled to $690.51 in temporary partial disability benefits. The Respondent has paid $255.99 leaving an unpaid balance of $434.52.

The Petitioner's request for Penalties and Attorney's Fees is denied.

Deborah L. Simpson
Signature of Arbitrator

Dec. 11, 2014
Date

STATE OF ILLINOIS)	☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF SANGAMON)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOE FICKAS,

Petitioner,

16IWCC0218

vs.

NO: 11 WC 48606

CHRISTY-FOLTZ, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability, and nature and extent of disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

On page 4, paragraph 7, the Commission strikes the entire paragraph: "In addition to his current workers' compensation claim, Petitioner also has a common law action pending against Caterpillar arising out of the same accident." On page 6, paragraph 3, sentence 2, the Commission strikes the entire sentence: "Further, the fact that Petitioner has a common law case pending against Caterpillar is also an incentive for him to remain off work." The Commission finds the existence of a common law action is of no relevance to the hearing on Petitioner's workers' compensation claim.

With regard to the issue of nature and extent, the Commission modifies the Arbitrator's permanent partial disability award from 15% loss of use of the man as a whole to 30% loss of use of the man as a whole, under §8(d)2 of the Act. The Commission bases the increased permanent partial disability award upon Petitioner's loss of trade. Here, the undisputed evidence showed that the claimant's right shoulder injury, requiring rotator cuff and supraspinatus tendon repair, was serious and permanent and left him unable to perform the duties of his usual and

customary line of employment as an ironworker. On July 31, 2012, Petitioner's treating physician, Dr. Watson, provided him with permanent work restrictions of no pushing or pulling with his right arm, a restriction which clearly prohibits Petitioner from returning to his prior employment as an ironworker.

With regard to the issue of vocational rehabilitation, the Commission affirms and adopts the Arbitrator's denial of an award of same. The Commission finds Petitioner's purported job searches in 2013 and 2014 were not valid efforts to attempt to obtain employment, with Petitioner failing to produce any job search logs, and Petitioner unable to recall the dates or exact names of any of the prospective employers he contacted. The Commission also finds Petitioner's request for an award of vocational rehabilitation suspect, given that Petitioner misrepresented his prior condition of ill-being and his prior work restrictions at the time of his vocational assessment with Bob Hammond, Respondent's vocational consultant. The December 21, 2012 vocational report of Mr. Hammond reflects that Petitioner denied any prior right arm or right shoulder injury, denied ever having any permanent work restrictions, and reported he had been released to full duty after all his past treatment (bilateral carpal tunnel surgeries, cervical fusion, left knee injury, and low back injury) with no limits and no restrictions. Petitioner further reported to Mr. Hammond that he himself was of the opinion he could not return to any form of employment. (RX4). Despite Petitioner's testimony otherwise, it is well documented in the record that Petitioner has a significant past medical history of two shoulder surgeries, one in 1998, and the other one a rotator cuff surgery in 2002, and after his 2002 surgery he was released with permanent work restrictions of no lifting or pushing with his right arm as of October 3, 2002. (RX2). Furthermore, Dr. Watson testified those 2002 restrictions would have prevented Petitioner from returning to work as a union ironworker, and that after he imposed those restrictions Petitioner did not return to him to have those permanent restrictions lifted or modified. (PX1, T48-52).

While the Commission had considered the fact that the claimant had not yet been successful in obtaining employment, based upon Petitioner's own lack of motivation and attempt to misdirect the initial vocational assessment, it nevertheless concludes that the claimant has only lost the ability to work in his usual and customary ironworker trade, but he is still employable in other areas.

Petitioner's date of accident falls before September 1, 2011, and therefore § 8.1b of the Act, Determination of Permanent Partial Disability, need not be discussed concerning the permanent partial disability award being issued herein.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's April 14, 2015 Decision is modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $777.33 per week for a period of 44-4/7 weeks, from September 22, 2011 through July 31, 2012, that being the period of temporary total incapacity for work under §8(b) of the Act.

RECEIVED

16IWCC0218

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $699.60 per week for a period of 150 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent partial disability to the extent of 30% man as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the medical expenses identified in Petitioner's Exhibit 7 and 10 as provided in Sections §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit of $119,500.24 for temporary total disability benefits previously paid under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 4 2016
KWL/kmt
02/08/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

Document

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0218

FICKAS, JOE
Employee/Petitioner

Case# 11WC048606

CHRISTY-FOLTZ INC
Employer/Respondent

On 4/14/2015, 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 0.10% 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:

1727 LEE, MARK N LAW OFFICE
ALLEN C MUELLER
1101 S SECOND ST
SPRINGFIELD, IL 62704

0771 FEATHERSTUN GAUMER POSTLEWAIT
DAN GAUMER
PO BOX 1760
DECATUR, IL 62525

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

☐ 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 **16 IWCC0218**

Joe Fickas
Employee/Petitioner

v.

Christy-Foltz, Inc.
Employer/Respondent

Case # 11 WC 48606

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 William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on February 20, 2015. 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 Vocational Rehabilitation

FINDINGS

On August 18, 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, in part, causally related to the accident.

In the year preceding the injury, Petitioner earned $60,632.00; the average weekly wage was $1,166.00.

On the date of accident, Petitioner was 45 years of age, single with 0 dependent child(ren).

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 $119,500.24 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $119,500.24.

Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical bills as identified in Petitioner's Exhibit 12, excluding Dr. Bova's medical bills and prescriptions as identified in Petitioner's Exhibits 7 and 10 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall pay Petitioner temporary total disability benefits of $777.33 per week for 44 4/7 weeks commencing September 22, 2011, through July 31, 2012, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $699.60 per week for 75 weeks because the injury sustained caused the 15% loss of use of the body as a whole as provided in Section 8(d)2 of the Act.

Petitioner's Petition for penalties and attorneys' fees is denied.

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.

William R. Gallagher, Arbitrator

March 31, 2015
Date

APR 14 2015

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on August 18, 2011. The Application alleged that Petitioner injured his right shoulder while "Welding on a project" (Arbitrator's Exhibit 2). Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner's counsel tried the case for a final award; however, he stated that an award under Section 19(b) might also have been appropriate. At trial, Petitioner and Respondent stipulated that Respondent had paid all of the medical bills incurred by Petitioner with the exception of medical bills of Dr. Michael Bova. Petitioner also claimed to be entitled to Sections 19(k) and (l) penalties and Section 16 Attorneys' Fees; however, Petitioner did not file a petition for same (Petitioner's Exhibit 1).

Petitioner was 45 years old at the time of the accident and was employed as an ironworker for his entire working career. Petitioner testified that on August 18, 2011, he was working for Respondent at a work site at the Caterpillar plant in Decatur, Illinois. While welding on some roof trusses, Petitioner was standing with one foot on the top of a lift bucket and the other foot on a portion of the structure. Petitioner was not certain as to exactly what happened, but he testified that the bottom fell out from under him which caused him to fall. Petitioner was secured by safety line; however, he reached out to catch himself from falling with his right arm. He was able to grab something, but, when he did so, he sustained an extremely painful "pop" in his right shoulder. This accident was not witnessed but it was reported to Respondent that same day.

Prior to the accident of August 18, 2011, Petitioner had seven workers' compensation claims for which Petitioner received settlements which totaled over $335,000.00. Two of the prior workers' compensation claims also involved right shoulder injuries. Case number 97 WC 32597 involved an accident that occurred on July 2, 1996, for which Petitioner was paid temporary total disability benefits for almost one year. That case was settled for $19,814.73 representing 20% loss of use of the right arm. Case number 02 WC 48051 involved an accident that occurred on February 22, 2002, for which Petitioner was paid temporary total disability benefits for approximately 35 weeks. That case was settled for $165,000.00 (Respondent's Exhibit 3). Petitioner testified that he was able to return to work as an ironworker subsequent to settling both of these cases and that he worked up until the accident of August 18, 2011, without experiencing any difficulties using his right shoulder.

Following the accident of July 2, 1996, Petitioner was treated by Dr. Michael Watson, an orthopedic surgeon. Dr. Watson initially evaluated Petitioner on July 30, 1996, and Petitioner informed him that he hurt his right shoulder when he fell and grabbed a scaffold with his right hand. Dr. Watson performed arthroscopic surgery on March 31, 1997, which consisted of a subacromial decompression. There was not a rotator cuff tear diagnosed. Petitioner received work hardening and was last seen by Dr. Watson in regard to that injury on August 12, 1997. Dr. Watson did not state whether Petitioner had any permanent work/activity restrictions (Petitioner's Exhibit 1; Deposition Exhibit 2).

Subsequent to the accident of February 22, 2002, Petitioner was again treated by Dr. Watson who initially saw him on February 26, 2002. Dr. Watson ordered an MRI scan which revealed a full thickness tear of the supraspinatus tendon. Dr. Watson performed rotator cuff surgery on May 3, 2002. When Dr. Watson saw Petitioner on August 7, 2002, he opined that Petitioner would never be able to work above his head with his right arm. On October 3, 2002, he further opined that Petitioner would not be able to do any work which required lifting or pushing with his right arm (Petitioner's Exhibit 2).

In spite of the significant permanent restrictions imposed by Dr. Watson, Petitioner testified that he had no right shoulder symptoms and was able to work as an ironworker. When questioned about the restrictions Dr. Watson had previously imposed on him, Petitioner testified that he did not recall any specifics only that he was told that his arm would get better.

Subsequent to the accident of August 18, 2011, Petitioner was again treated by Dr. Watson who saw him that same day. Dr. Watson ordered an MRI scan which revealed a full thickness tear of the right distal supraspinatus tendon. On September 22, 2011, Dr. Watson performed rotator cuff surgery and the procedure consisted of repair of the supraspinatus tendon that was reinforced with two suture anchors (Petitioner's Exhibit 2).

When Dr. Watson evaluated Petitioner on December 21, 2011, he noted that Petitioner had no active elevation or abduction, had retained full passive motion but was in considerable pain. He opined Petitioner remained unable to work and referred him to Dr. Mark Greatting, an orthopedic surgeon, for consideration of a possible tendon transfer procedure (Petitioner's Exhibit 2).

Dr. Greatting saw Petitioner on February 21, 2012, and opined that Petitioner had marked arthritic changes in his right shoulder and suspected that the rotator cuff repair had not fully healed. Dr. Greatting opined that further rotator cuff surgery was not indicated but that Petitioner could potentially be considered for a reverse arthroplasty but that Petitioner was far too young to consider it at that time (Petitioner's Exhibit 2).

Petitioner continued to be treated by Dr. Watson. When Dr. Watson saw Petitioner on January 25, 2012, he noted that Petitioner had persistent pain and loss of function of his right shoulder, essentially no elevation and grade 2 strength. When Dr. Watson last saw Petitioner on August 1, 2012, he opined that Petitioner was at MMI and imposed a permanent work restrictions of no lifting, pushing or pulling with his right arm (Petitioner's Exhibit 2).

Following his release by Dr. Watson, Petitioner sought pain management treatment from Dr. Michael Bova, an internist, who previously treated Petitioner from 2002 to 2009. Dr. Bova prescribed a number of narcotic analgesics, muscle relaxers, sleep aids and anti-depressants (Petitioner's Exhibit 3; Deposition Exhibit 2). Petitioner testified that he has continued to seek pain management treatment from Dr. Bova.

At the direction of Respondent, Petitioner was evaluated by Bob Hammond, a vocational rehabilitation expert, on December 21, 2012. When Petitioner met with Hammond, he informed him that, prior to August 18, 2011, that he had never had a right arm or right shoulder injury, and that he never had any permanent work restrictions. Petitioner did inform Hammond of having

prior carpal tunnel surgeries, a low back injury, a left knee injury and a cervical fusion. Hammond reviewed Dr. Watson's medical records as well as a Social Security assessment also prepared by Dr. Watson which indicated various work restrictions that permitted some use of the right upper extremity. Hammond was uncertain as to Petitioner's exact work restrictions and stated that he needed a clarification prior to making any vocational recommendations (Respondent's Exhibit 4).

At the direction of his attorney, Petitioner was evaluated by David Patsavas, a vocational expert, on August 30, 2014. Patsavas reviewed medical records including those of Dr. Watson and noted the restrictions imposed by Dr. Watson in August, 2012. He opined that Petitioner's ability to return to work was limited and that he could probably not earn more than $10.00 an hour. He also opined that Petitioner was a candidate for vocational rehabilitation services (Petitioner's Exhibit 8).

At the direction of Respondent, Petitioner was examined by Dr. Frank Petkovich, an orthopedic surgeon, on November 10, 2014. In connection with his examination, Dr. Petkovich reviewed medical records provided to him by Respondent and he noted that following the May, 2002, right shoulder surgery, Dr. Watson imposed permanent restrictions but that Petitioner returned to work as an ironworker without restrictions. Dr. Petkovich opined that Petitioner had degenerative arthritis and a chronic rotator cuff tear of the right shoulder, both of which were not related or aggravated by the accident of August 18, 2011. Dr. Petrovich opined that Petitioner sustained a right shoulder strain which should have resolved within six weeks of the time of the injury. He further opined that Petitioner was at MMI and could return to work without restrictions (Respondent's Exhibit 1; Deposition Exhibit 2). Based on Dr. Petkovich's opinions, Respondent terminated payment of temporary total disability benefits to Petitioner at that time.

Dr. Watson was deposed on July 30, 2014, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Watson's testimony was consistent with his medical records regarding the treatment he provided to Petitioner. In regard to causality, Dr. Watson acknowledged that Petitioner had a pre-existing right shoulder condition but that the accident of August 18, 2011, aggravated it to where Petitioner eventually required surgery. He also opined that Petitioner's right shoulder function was worse than it was when he discharged Petitioner in 2002 and that he was presently disabled from returning to work as an ironworker (Petitioner's Exhibit 1; pp 38-42).

On cross-examination, Dr. Watson agreed that he imposed the same work restrictions on Petitioner subsequent to the right shoulder surgery in 2011 that he previously imposed following the right shoulder surgery in 2002. Dr. Watson further agreed that Petitioner did not return to him following his release in 2002 to have the work restrictions removed and that he (the Petitioner) apparently determined that he was not disabled. Dr. Watson also agreed that if Petitioner was not honest about his right shoulder being asymptomatic prior to the August, 2011, accident that the treatment provided to him may or may not have been related to the accident (Petitioner's Exhibit 1; pp 51-57; 60-62).

Dr. Bova was deposed on October 15, 2014, and his deposition testimony was received into evidence at trial. Dr. Bova testified that since May, 2012, Petitioner was released by Dr. Watson

and that he assumed responsibility for pain management treatment for Petitioner's shoulder condition. He opined that his treatment was reasonable and necessary for Petitioner's right shoulder condition (Petitioner's Exhibit 3; pp 13, 29).

Dr. Petkovich was deposed on December 18, 2014, and his deposition testimony was received into evidence at trial. Dr. Petkovich's testimony was consistent with his medical report and he reaffirmed the opinions contained therein, specifically that Petitioner's right shoulder arthritis and rotator cuff conditions were not related to the accident of August 18, 2011; that Petitioner sustained a right shoulder strain which would have resolved than six weeks time; and that Petitioner could return to work without restrictions (Respondent's Exhibit 1; pp 20-26).

Patsavas testified when this case was tried. His testimony was consistent with his report and he opined that, even with vocational assistance, Petitioner would probably still not be able to make more than $10.00 per hour. On cross-examination, Patsavas conceded that he was not aware of the restrictions that had been imposed by Dr. Watson subsequent to the 2002 accident. He also agreed that Petitioner would not have been able to return to work as an ironworker if he had followed those prior restrictions.

At trial, Petitioner testified that he had little or no strength or function of his right arm. Petitioner lifted his right arm to just below shoulder level but then dropped it back into his lap after just a few seconds. Petitioner stated that his activities are extremely limited although he still rides a motorcycle and hauls a fishing boat.

Petitioner stated that in 2013 and 2014, he conducted a job search but he did not maintain any job search logs. He recalled applying for jobs at Jiffy Lube and Walgreens but had received no job offers. Petitioner was awarded Social Security Disability and presently draws $1,733.00 a month in Social Security Disability benefits. Further, Petitioner testified that he is drawing a disability pension from the Ironworkers Union of approximately $1,900.00 per month. Petitioner acknowledged that if he were to return to work, his ironworkers' pension would be reduced by approximately $900 a month and his entitlement to Social Security Disability benefits could be completely terminated.

Petitioner acknowledged that following the $165,000.00 settlement he received for his 2002 right shoulder injury, he returned to the Union Hall and advised that he was ready to return to work. He did not recall if Dr. Watson imposed any permanent work restrictions on him in 2002.

In addition to his current workers' compensation claim, Petitioner also has a common law action pending against Caterpillar arising out of the same accident.

Conclusions of Law

In regard to disputed issue (C) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner sustained an accidental injury arising out of and in the course of his employment for Respondent on August 18, 2011.

In support of this conclusion the Arbitrator notes the following:

In spite of the fact that the accident was not witnessed and, as stated herein, the Arbitrator found Petitioner's credibility to be lacking, the accident was reported to Respondent in a timely manner and Petitioner sought medical treatment immediately afterward. Further, the history of the accident was reported to Petitioner's medical providers.

In regard to disputed issue (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner's current condition of ill-being in regard to the right shoulder is causally related to the accident of August 18, 2011.

In support of this conclusion the Arbitrator notes the following:

Dr. Watson treated Petitioner and performed all three right shoulder surgeries. Specifically, he personally observed the rotator cuff pathology following both the 2002 and 2011 accidents. As such, the Arbitrator finds his opinion as to the issue of causality to be persuasive.

In regard to disputed issue (J) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary, with the exception of bills related to medical services provided by Dr. Michael Bova, and that Respondent is liable for payment of the medical bills incurred therein.

Respondent shall pay reasonable and necessary medical bills as identified in Petitioner's Exhibit 12, excluding Dr. Bova's medical bills and prescriptions as identified in Petitioner's Exhibits 7 and 10, as provided in Section 8(a) and 8.2 of the Act, subject to the fee schedule.

In support of this conclusion the Arbitrator notes the following:

As noted herein, the Arbitrator found Petitioner's credibility to be lacking and that the pain management treatment provided by Dr. Bova is primarily limited to prescribing narcotics and other medications. The Arbitrator finds that Petitioner's motivation for obtaining this treatment may be to enhance his recovery in both this case and the common law action against Caterpillar.

In regard to disputed issue (K) the Arbitrator makes the following conclusions of law:

The Arbitrator concludes that Petitioner is entitled to temporary total disability benefits of 44 4/7 weeks commencing September 22, 2011, through July 31, 2012.

The Arbitrator further concludes that Petitioner is not entitled to any maintenance benefits.

In support of these conclusions the Arbitrator notes the following:

Petitioner was treated by Dr. Watson who authorized him to be off work until Dr. Watson opined that Petitioner was at MMI on August 1, 2012.

While Dr. Watson imposed permanent work restrictions when he evaluated Petitioner on August 1, 2012, the Arbitrator finds the validity of these restrictions to be suspect. Dr. Watson previously imposed virtually identical work restrictions upon Petitioner following the 2002 surgery; however, Petitioner apparently determined that he was not disabled and was able to return to work as an ironworker sometime after his workers' compensation case was settled for $165,000.00.

Petitioner's testimony that he had no knowledge of the restrictions imposed by Dr. Watson 2002 is totally unbelievable. Further, Petitioner could not give any explanation as to how his right shoulder condition improved to such a dramatic extent after he settled his 2002 workers' compensation claim to where he was able to return to work without restriction as an ironworker.

The Arbitrator finds that Petitioner's purported job searches in 2013 and 2014 were not actually aimed at finding employment but may have been to enhance the value of his workers' compensation case. Further, the fact that Petitioner has a common law case pending against Caterpillar is also an incentive for him to remain off work.

When Petitioner was evaluated by Bob Hammond, he was able to specifically recall other injuries that he had previously sustained, but denied any prior right arm/shoulder injuries or that he had any restrictions prior to the accident of August 18, 2011.

Based on the preceding, the Arbitrator finds Petitioner is not credible.

In regard to disputed issue (L) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 15% loss of use of the body as a whole.

In support of this conclusion the Arbitrator notes the following:

While the Arbitrator found Petitioner not to be credible, Petitioner sustained a right shoulder injury which required rotator cuff surgery.

In regard to disputed issue (M) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner is not entitled to Sections 19(k) or (l) penalties or Section 16 Attorneys' Fees.

In support of this conclusion the Arbitrator notes the following:

The Arbitrator finds Respondent's conduct in this case to be more than reasonable. Respondent has paid most of the medical bills and, based on the Arbitrator's conclusions of law in disputed issue (K), has overpaid temporary total disability benefits.

In regard to disputed issue (O) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner is not entitled to vocational rehabilitation services.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michelle I. Schleyhahn,
Petitioner,

16IWCC0214

vs.

NO: 12 WC 4669

SOI/Dept. of Commerce & Economic Opportunity,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary total disability, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 6, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

DATED: MAR 24 2016
KWL/vf
O-3/21/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

Appendix

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0214

SCHLEYHAHN, MICHELLE I
Employee/Petitioner

Case# 12WC004669

SOI/DEPT OF COMMERCE & ECONOMIC OPPORTUNITY
Employer/Respondent

On 7/6/2015, 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 0.11% 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 BRESNEY
CHARLES N EDMISTON
129 S CONGRESS
RUSHVILLE, IL 62681

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

5002 ASSISTANT ATTORNEY GENERAL
JOSEPH BLEWITT
500 S SECOND ST
SPRINGFIELD, IL 62706

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

CERTIFIED as a true and correct copy pursuant to 820 ILCS 305/14

JUL 6 - 2015

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

- ☐ 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

16IWCC0214

Michelle I. Schleyhahn
Employee/Petitioner

Case # 12 WC 04669

v.

Consolidated cases: n/a

Sate of Illinois/Dept. of Commerce & Economic Opportunity
Employer/Respondent

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 William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on May 27, 2015. 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 February 11, 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 not 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 not causally related to the accident.

In the year preceding the injury, Petitioner earned $66,756.04; the average weekly wage was $1,283.77.

On the date of accident, Petitioner was 56 years of age, married with 0 dependent child(ren).

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 $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00.

Respondent is entitled to a credit of amounts paid under Section 8(j) of the Act.

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

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.

William R. Gallagher, Arbitrator

June 29, 2015
Date

JUL 6 - 2015

16IWCC0214 Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained a repetitive trauma injury arising out of and in the course of her employment for Respondent. The Application alleged a date of accident (manifestation) of February 11, 2011, and that Petitioner sustained repetitive trauma to the bilateral upper extremities (Arbitrator's Exhibit 2). Respondent disputed liability on the basis of accident and causal relationship.

Petitioner testified that she worked for various state agencies for over 37 years. From 1974 to 1995, Petitioner worked for Public Aid. From 1995 to 1996, Petitioner worked for the Department of Energy & Natural Resources. In 1996, Petitioner began working for the Department of Commerce & Economic Opportunity. Petitioner stated that for approximately the last 30 years, her jobs for Respondent all required her to perform an extensive amount of keyboarding.

Petitioner estimated that she spent 90% of her time at work keyboarding. Petitioner would typically use eight or nine different computer programs during the course of a day and would switch back and forth between them. Petitioner would also answer 30 to 40 telephone calls per day and spent approximately 10% of her time handling files. Petitioner stated that when she was keyboarding, she would rest her wrist on the edge of the desk. Respondent provided Petitioner with wrist pads sometime in 2010.

Petitioner testified that sometime in the late summer of 2010, she began to experience numbness in her fingers, initially in the right hand and then in the left hand. She also had difficulties grasping and noted a lack of strength in both hands.

Petitioner initially sought medical treatment from Dr. Koteswara Narla on February 11, 2011 (the date of manifestation alleged in the Application). At that time, Petitioner complained of numbness/tingling in both arms from the shoulders into the hands and it that had been present for approximately one month. She reported that the symptoms occurred primarily at night and caused some sleep disruption. On clinical examination, Dr. Narla noted some muscular wasting of the thenar eminence, more so on the right than left. He opined that Petitioner had bilateral carpal tunnel syndrome and recommended nerve conduction studies (Petitioner's Exhibit 1; pp 26-27).

On February 15, 2011, Dr. Narla performed nerve conduction studies which confirmed the diagnosis of moderate to severe bilateral carpal tunnel syndrome, more so on the right than left (Petitioner's Exhibit 1; pp 65-66). Dr. Narla subsequently referred Petitioner to Dr. Richard Brown, a plastic surgeon.

Dr. Brown saw Petitioner on March 22, 2011, and he confirmed the diagnosis of bilateral carpal tunnel syndrome. At that time, Petitioner informed Dr. Brown that she had symptoms in both hands for over a year which had gotten progressively worse. Petitioner also informed Dr. Brown that she had worked for the State for 37 years and basically did computer work. Dr. Brown

recommended Petitioner undergo bilateral carpal tunnel surgery (Petitioner's Exhibit 1; pp 50-51).

Dr. Brown performed right and left carpal tunnel release endoscopic surgeries on May 9, 2011. When Dr. Brown saw Petitioner on May 17, 2011, the numbness and tingling had resolved and he released her to return to work on May 23, 2011, but with a restriction of limiting computer work to one to two hours for a four hour period of time for two weeks and then to full unrestricted duty. When Petitioner was subsequently seen by Dr. Brown on June 17, 2011, she again had no complaints of numbness and tingling and was back to actively using both of her hands (Petitioner's Exhibit 1; pp 43-46, 106).

At the direction of Respondent, Petitioner was examined by Dr. James Williams, an orthopedic surgeon, on December 17, 2014. In connection with his examination of Petitioner, Dr. Williams reviewed medical records provided to him by Respondent. When Dr. Williams obtained a history from Petitioner, she informed him of her various job duties for the State from the time she began working for the State in 1974 up to and including the time of her retirement.

Dr. Williams opined that Petitioner had bilateral carpal tunnel syndrome and right and left thumb CMC joint arthritis. In regard to causality, Dr. Williams opined that Petitioner's job duties of typing and answering the telephone did not aggravate or contribute to the development of the bilateral carpal tunnel syndrome. He referenced Petitioner's post-menopausal status and CMC joint arthritis as being more related to the bilateral carpal tunnel syndrome than Petitioner's work activities. He also noted that while Petitioner informed him that she rested her wrist on the edges of tables when she was typing until pads were provided, that this was not a history stated in any of the treatment records that he reviewed (Respondent's Exhibit 1).

Dr. Brown was deposed on January 5, 2015, and his deposition testimony was received into evidence at trial. When questioned about the etiology of the bilateral carpal tunnel syndrome, Dr. Brown testified that he could not say that the work caused the condition but that it could be an aggravating factor. He also noted that Petitioner had other contributing causes which included the CMC arthritis and the fact that Petitioner was a smoker (Petitioner's Exhibit 2; pp 12-13).

On cross-examination, Dr. Brown agreed that he had very limited information regarding the details of Petitioner's work duties. Dr. Brown did not know how many minutes per day Petitioner typed on a keyboard, he did not know which hand Petitioner used to manipulate the mouse, Petitioner did not inform him whether she had a computer at home, Petitioner did not describe the layout of her desk at work to him, and Petitioner did not demonstrate to him how she held her hands and arms when at work. In addition to the other risk factors of CMC arthritis and smoking, Dr. Brown also agreed that Petitioner's post-menopausal status and mild obesity were risk factors as well (Petitioner's Exhibit 3; pp 14-18).

Dr. Williams was deposed on April 16, 2015, and his deposition testimony was received into evidence at trial. Dr. Williams' testimony was consistent with his medical report and he reaffirmed the opinions contained therein. In regard to causality, Dr. Williams testified that Petitioner's job duties did not involve significant repetitive forceful gripping and/or pinching or

vibration. He further opined that Petitioner's condition was either idiopathic or related to the bilateral CMC arthritis (Respondent's Exhibit 2; pp 5-6).

At trial, Petitioner testified that she does not have the strength in either of her hands that she had previously; however, she agreed that her complaints of numbness and tingling had completely resolved. Petitioner was able to return to work to her regular job for Respondent but subsequently retired.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner did not sustain a repetitive trauma injury arising out of and in the course of her employment for Respondent and that her current condition of ill-being is not related to her work activities.

In support of this conclusion the Arbitrator notes the following:

While Petitioner testified that she typed and 90% of every work day, Petitioner also performed other various tasks including telephone calls and filing. There was no data regarding either the intensity or frequency of Petitioner's typing other than her statement that it was 90% of every work day.

Dr. Brown's, Petitioner's treating physician, testimony clearly indicated that he only had a very limited amount of knowledge in regard to Petitioner's work duties. Further, Dr. Brown agreed that there were other contributing factors to the development of bilateral carpal tunnel syndrome.

Dr. Williams opined that Petitioner's bilateral carpal tunnel syndrome was either idiopathic or related to various other contributing factors.

The Arbitrator finds the opinion of Respondent's Section 12 examiner, Dr. Williams, to be more persuasive than that of Dr. Brown. While Dr. Brown is certainly a well-qualified expert, he lacked sufficient details of Petitioner's work duties to give a definitive opinion as to whether there was a causal relationship between Petitioner's work duties and the bilateral carpal tunnel syndrome.

In regard to disputed issues (J), (K) and (L) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issues (C) and (F).

William R. Gallagher, Arbitrator

12 WC 21209
13 WC 23631
Page1

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ronald Broughton,
Petitioner,

vs.

NO: 12 WC 21209
13 WC 23631

City Of Chicago,
Respondent,

16IWCC0207

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, causal connection, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 26, 2016, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 3 2016
o022516
DLG/mw
045

David L. Gore

Stephen Mathis

Mario Basurto

NOTICE OF ARBITRATOR DECISION

BROUGHTON, RONALD
Employee/Petitioner

Case# 12WC021209

13WC023631

16IWCC0207

CITY OF CHICAGO
Employer/Respondent

On 5/26/2015, 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 0.08% 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:

2356 FOHRMAN, DONALD W & ASSOCS
ADAM J SCHOLL
101 W GRAND AVE SUITE 500
CHICAGO, IL 60610

0010 CITY OF CHICAGO
MICHELLE BRYANT
30 N LASALLE ST 8TH FL
CHICAGO, IL 60602

16IWCC0207

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

☐ 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

Ronald Broughton
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # 12 WC 21209

Consolidated cases: 13 WC 23631

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 **Maria S. Bocanegra**, Arbitrator of the Commission, in the city of **Chicago**, on **3/23/15**. 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 _____

16IWCC0207

FINDINGS

On **6/13/12 and 7/12/13**, 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 **$66,853.25**; the average weekly wage was **$1,285.64**.

On the date of accident, Petitioner was **39** years of age, ***single*** with **0** dependent children.

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$50,810.84** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$50,810.84**.

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 **$857.09** per week for **70-3/7**th weeks 6/14/12 through 11/5/12 and 7/12/13 through 6/24/14. Respondent shall be given a credit of **$50,810.84** for TTD paid.

Respondent shall pay Petitioner permanent partial disability benefits of **$695.78**/week for **30** weeks, because the injuries sustained caused the **3%** man as a whole for the left shoulder and **3%** man as a whole for the low back pursuant to Section 8(d)(2) 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.

Signature of Arbitrator

5/22/15
Date

MAY 26 2015

BACKGROUND

Ronald Broughton ("Petitioner") filed two applications for adjustment of claim alleging injuries occurring while under the employ of City of Chicago ("Respondent"). The parties completed a request for hearing form and proceeded to trial on all issues on 3/23/15 in Chicago, Illinois. At trial, the parties stipulated that on both 6/13/12 and 7/12/13 both Petitioner and Respondent were operating under the Illinois Workers' Compensation Act and their relationship was one of employee and employer and that on those dates, Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent, proper notice having been given. Further, the parties agreed that Petitioner's earnings in the year preceding the injuries were $66,853.25 and that his average weekly wage was $1,285.64. The disputed issues at trial were causal connection, entitlement to temporary total disability (TTD) and the nature and extent of the injury.

FINDINGS OF FACT

Petitioner testified he has been employed by Respondent since 2000 as a laborer. Duties included loading garbage trucks, cleaning lots, walk ways and alleys. His job required him to b able to lift anyhere from 1 to 100 pounds. In cleaning alleys, he would pick up garbage and throw it into the garbage truck.

On 6/13/12, Petitioner testified he worked for Respondent and was riding the side of his garbage truck when a dip in the road caused the truck to dip, breaking the step and causing Petitioner to be "sling shotted" off the back. He landed on the ground injuring his left shoulder and back. He hit his head and lost consciousness. He described pain in the head, neck, back, left shoulder and left knee. Emergency services were called and he was transported via ambulance to Christ Hospital. Petitioner recalled they performed a CAT scan, treated his left shoulder and back. He was released that same date.

On 6/14/12 Petitioner presented to MercyWorks. Doctors noted Petitioner's work injury causing him to fall and strike his head, lower back, neck, left shoulder and left knee. Petitioner complained of 5-8 out of 10 pains in the back of the head, neck, lower back and left shoulder. Petitioner told them he had a prior history of right and left shoulder rotator cuff repair. He was prescribed medications and was taken off of work.

On 6/19/12, Petitioner treated with Dr. Michael Foreman and complained of intermittent headaches 7 out of 10 pain, described as throbbing around the back of the head accompanied by mild dizziness, neck pain of seven described as achy and throbbing, left shoulder 6 out of 10 pain, described as tender and achy and low back pain 8 out of 10 described as tender and achy. Past medical history noted prior bilateral shoulder surgeries with no active complaints prior to the incident on 6/13/12. Exam of the left shoulder showed tenderness around the AC joint with increased tone in the deltoid muscle, in all rotator cuff muscles specifically the supraspinatus muscle. Motion was limited by pain in forward flexion and pain was also noted to the left knee. Impression was posttraumatic headaches, cervical spine strain, left shoulder sprain, lumbar radiculopathy and left knee sprain. X-rays, medications, therapy and off work was ordered. Dr. Foreman opined that Petitioner's diagnoses as indicated were causally related to the incident of 6/13/12.

On 6/12/12, x-rays of the spine showed anterolisthesis of L5 on S1. On 6/21/12, Mercy Works noted normal gait without limp. Exam of the spine and left shoulder had no point of tenderness. The doctor noted full range of motion with complaints of pain. Diagnosis was cervical and left shoulder strain. Petitioner remained off work. On 7/5/12, doctors noted Petitioner's neck was improved but left shoulder pain remained 3 out of 10 pain and low back pain 5 out of 10. Diagnosis was left shoulder and lumbar spine muscle strain.

On 8/3/12, MRI of the left shoulder showed evidence of prior surgery, partial tear of the distal tendon of the supraspinatus, mild glenohumeral joint effusion, mild degenerative changes at the AC joint with a small spur formation and mild subcoracoid bursitis. On 8/7/12, MercyWorks reviewed MRI of the left shoulder and noted partial tear of the distal tendon of the supraspinatus. Left shoulder and low back pain was 4 out of 10, non-radiating. Diagnosis was left rotator cuff tear and low back strain.

On 8/10/12, Petitioner saw Dr. Heller of Midland Orthopedic. Petitioner hand wrote that he believed his injuries to be work-related after falling off the back of a work garbage truck. He indicated he injured his head, neck, back, left shoulder and left knee. The doctor noted a prior history of left shoulder surgery. Dr. Heller noted a new injury occurring on 6/13/12 when Petitioner suffered a fall off of the back of a truck injuring his back, left shoulder and left knee. Physical exam showed intact motion with active forward flexion and abduction beyond 155, internal to T12 and external to 80 degrees. The doctor noted intact overhead strength to abduction and external rotation as well as forward flexion to 150 with internal or external rotation. The doctor was unable to produce any evidence of instability, gross crepitus or rotator cuff deficiency. He reviewed the left shoulder MRI and noted intact rotator cuff repair, mild thickening of the tendon typical of postoperative change, suspected partial thickness tearing but concluded that it was really a reflection of previous surgical treatment. The doctor concluded that he saw no significant evidence of full thickness tearing nor significant tendinopathy or partial thickness tearing. With no new significant pathology to the left shoulder, the doctor ordered therapy and Petitioner off of work.

On 8/14/12, Petitioner continued to complain of left shoulder pain 3 to 4 out of 10, lower back pain 4 out of 10 with occasional radiation to the right hamstring without numbness or tingling in the legs. On 8/31/12, MRI of the lumbar spine showed mild grade one anterolisthesis of L5 relative to S1 with probable bilateral spondylolysis defects involving the posterior elements of L5, multilevel degenerative disc disease, facet arthropathy and epidural lipomatosis.

On 9/10/12, Petitioner followed up with Dr. Heller who noted no improvement in left shoulder symptoms. The doctor ordered additional therapy and light duty. On 9/25/12, Petitioner presented to MercyWorks with 4 out of 10 left shoulder pains, 3 out of 10 low back pains with occasional radiation to the right hamstring. Exam of the left shoulder showed full abduction and forward elevation and internal rotation to L2. Exam of the lumbar spine showed forward flexion to 75 degrees, extension to 25 degrees, bilateral side bending to 40 degrees and negative bilateral straight leg raise.

On 10/12/12, physical therapists noted Petitioner achieved functional strength and range of motion of the left shoulder with decreasing pain. Therapists recommended discharge from therapy. On 10/15/12, Dr. Heller reviewed therapist notes documenting excellent motion and diminishing pain at 2 out of 10. Physical exam confirmed full active range of motion, minimal

pain complaints and minimal weakness. Negative drop arm testing, negative crepitus and no instability were noted. The doctor noted resolving left shoulder strain and recommended follow-up at the completion of work conditioning at which time he expected that Petitioner would be fully discharged.

On 11/2/12, therapists noted Petitioner had progressed the heavy physical demand level meaning that he demonstrated the ability to lift 105 pounds from the floor for six repetitions. On 11/5/12, Dr. Heller noted Petitioner met all necessary lifting tolerances of his job and was functioning at a heavy physical demand level with capabilities of lifting over 100 pounds. Petitioner was discharged and placed at maximum medical improvement.

On 7/12/13, Petitioner testified he re-injured himself at work after pulling a garbage can and slipping on a can or piece of metal, falling backwards to the ground. Chicago Fire Department noted that Petitioner complained of left arm and back pain. They noted pain radiated down his back, pain level was 9 out of 10 and that the onset was sudden. Petitioner was transported to Trinity. Advocate Trinity Hospital noted shoulder pain following a fall at work after pulling a garbage can, tripping and falling. Petitioner indicated he felt a pop in the shoulder but denied any direct hit to the shoulder or to the back. Petitioner related he was unable to move due to pain and swelling. He complained of left sided lower lumbar tenderness with movement, non-radiating in nature. Exam of the back showed normal range of motion, normal alignment, no step offs, mild left-sided paraspinal lumbar tenderness. Exam of the left shoulder showed mild tenderness to anterior aspect of the shoulder with full range of motion, positive impingement and 2+ radial pulses. There was no glenohumeral or AC joint osteoarthritis, no fracture and no dislocation. Impression was post op status without acute findings. Diagnosis was left shoulder pain.

On 8/9/13, Petitioner saw Dr. Heller, who noted Petitioner's work fall occurring 7/12/13. Petitioner related pain with sleeping and difficulty elevating his arm. On exam, Dr. Heller did not detect acute swelling, erythema or ecchymosis. Neurologically, the left shoulder was intact. No instability was noted and Dr. Heller could not palpate any type of significant subacromial crepitus or intra-articular locking. Assessment was recurrent injury to the left shoulder status post previous rotator cuff repair. Petitioner remained off of work and was referred to Dr. Strugala for the back. New MRI of the left shoulder did not demonstrate any new rotator cuff tearing. Dr. Heller noted small fluid collection some irregularities along the tendon insertion typical of post operative findings.

On 9/11/13, Dr. Heller completed disability insurance forms indicating that Petitioner's left shoulder injury began on 7/12/13. During therapy, Petitioner reported 3.5 out of 10 shoulder pain, that that he was able to sleep six hours without waking with shoulder pain but still unable to lift without increased pain. Left shoulder was tender over the anterior region. On 9/30/13, Dr. Heller noted full active range of motion with slight anterior pain in the left shoulder. Pain was rated 3 out of 10. Physical exam showed intact active motion, no crepitus, no instability and neurologically intact.

On 10/1/13, Petitioner was evaluated by Dr. Daniel Troy at the request of Respondent. The doctor noted that Petitioner had complaints of pain to the left shoulder and low back. Dr. Troy noted that Petitioner subjectively complained of mainly low back pain without radiation and that he rated his pain 4 out of 10. He noted Petitioner, at the time of his exam, felt that his

left shoulder was improved. Physical exam of Petitioner showed no antalgic gait, no appreciable complaints of pain in the neck with full flexion extension lateral rotation and lateral bending. Similarly, exam of both shoulders demonstrated full abduction and full flexion. The doctor did note that Petitioner complained of slight pain to the left shoulder at the extremes of flexion and abduction and internal rotation was limited to L2 and L3 secondary to pain. Otherwise, bilateral shoulders were diffusely nontender to palpation, no pain with palpation of the AC joint and no pain with palpation of the anterior, posterior or lateral aspect of the shoulder. Exam of the low spine showed pain in the lumbosacral junction both to the right and left but no pain to the lower extremities. Petitioner had negative straight leg raise bilaterally and limited flexion secondary to low back discomfort. According to the doctor, radiographs of the lumbar spine showed significant pre-existing pathology. The doctor noted that following the first injury, Petitioner as released in October 2012 and was "doing well until he suffered an additional injury which took place in July 2013." Dr. Troy indicated that Petitioner's current treatment was based subjective complaints of pain. The doctor recommended an additional physical therapy followed by a return to full duty work. In the interim, Dr. Troy recommended light-duty work causally related to the injury.

On 10/8/13, Dr. Heller recommended work hardening and diagnosed rotator cuff tendinitis of the left shoulder. Exam of the left shoulder showed intact motion and pain with heavier work conditioning activities. On 11/5/13, Petitioner was examined by Dr. Robert Strugala who noted Petitioner's July 2013 injury at work and back symptoms of intermittent paresthesias extending to the posterior aspect of the right leg. The doctor noted Petitioner had not yet had any physical therapy for the low back. Petitioner described back pain increased with lumbar flexion and with lying down. The doctor ordered an MRI of the lumbar spine.

On 11/11/13, Petitioner advanced to the medium physical demand level and additional work conditioning was recommended to meet the job demands with respect to the left shoulder. On 11/13/13, MRI of the lumbar spine showed minimal grade 1 anterolisthesis of L5 relative to S1 with probable bilateral spondylolysis defects involving the posterior elements of L5 along with degenerative disc disease, facet arthropathy and epidural lipomatosis.

On 11/25/13, ATI discharged Petitioner from work conditioning with respect to the left shoulder based upon the nurse case manager's indication that no additional therapy would be authorized. On 12/6/13, Dr. Heller noted Petitioner's inability to complete work conditioning due to insurance authorization issues, describing the delay as a holding pattern based upon utilization review. The doctor continued Petitioner off work until such time as authorization issues were resolved. On 12/17/13, Dr. Troy issued an addendum report stating that recent lumbar MRIs supported his original conclusions previously dictated in his 10/1/13 report and that there had been no objective traumatic changes to the lumbar spine. The doctor classified Petitioner's lumbar condition as long-term degenerative process at the L5-S1 level secondary to a lytic L5-S 1 spondylolisthesis.

On 1/10/14, with therapy still not yet approved, Dr. Heller ordered Petitioner off of work. On 1/14/14, Dr. Heller completed and attending physician certificate and noted Petitioner's inability to use the left upper extremity. In January and February 2014, Drs. Heller and Strugala noted therapy had not yet been approved. Dr. Heller continued Petitioner off of work.

On 3/10/14, Dr. Heller issued a narrative report at the request of Petitioner. In it, Dr. Heller noted that he had previously performed a both right and left shoulder arthroscopic surgery in 2006 and 2008, respectively. Dr. Heller noted Petitioner's 2012 injury for which he was released in October 2012. The doctor then noted Petitioner's second work injury in July 2013 injuring his left shoulder and low back. Dr. Heller acknowledged that Petitioner did not demonstrate any new left shoulder tears based upon imaging studies. Therefore, a conservative course of physical therapy and work conditioning was recommended. As of October 2013, Dr. Heller noted that Petitioner had normal range of motion of the left shoulder but that he had a desire to perform the work conditioning previously recommended. With regards to causality, Dr. Heller did not dispute that the June 2012 incident could have caused left shoulder symptoms requiring treatment. He concluded that all treatment provided was reasonable and necessary in addressing Petitioner's complaints. With respect to work restrictions, Dr. Heller noted that he was unaware whether Petitioner was on any work restrictions but that he believed Petitioner remained off of work.

On 3/14/14, Dr. Strugala issued his narrative report at the request of Petitioner. He noted his initial evaluation of Petitioner, Petitioner's recent work injury and Petitioner's present complaints of pain across the low back, intermittent paresthesias extending to the posterior aspect of the right leg without any physical therapy to the low back. He noted that at initial visit, Petitioner was able to ambulate without assistance and that there was no point tenderness over the lumbar spine. Range of motion was less than normal demonstrating active lumbar flexion and experiencing pain across the lower back with lumbar flexion. Straight leg raise testing was "equivocal" on the right and negative on the left. The doctor noted that MRI of the lumbar spine findings were primarily "chronic appearing and degenerative in nature." The doctor opined Petitioner suffered an aggravation of his underlying back condition more likely than not related to the event in July 2013. The doctor opined treatment recommendations and light duty were reasonable and necessary.

On 3/17/14, Dr. Heller noted Petitioner's last active treatment for the left shoulder was November 2013 at which time he was functioning at the medium physical demand level. Petitioner stated his left shoulder was basically unchanged. Shoulder exam showed intact active motion with forward flexion and abduction beyond 150, external rotation beyond 70, internal to the lumbar spine.

On 3/19/14, Midland Orthopedic completed insurance disability forms indicating Petitioner was unable to use the left upper extremity and that he was unable to perform all work duties while awaiting approval of work conditioning. On 4/10/14, Petitioner underwent an outpatient physical therapy initial evaluation. Chief complaint was pain and difficulty with standing, prolonged sitting, lifting and carrying. Low back pain was 5 out of 10. Palpation noted tenderness was reported right lumbar paraspinal lumbar spine tenderness was reported at L5-S1. Exam showed decreased core strength, postural derangement, limited muscle strength of the lower extremities, limited lumbar active range of motion and pain with testing lumbar joint mobility. On 4/11/14, Dr. Strugala noted Petitioner ambulated without difficulty and had a normal gait. Petitioner demonstrated active lumbar flexion to about 45 degrees limited by pain. Active lumbar extension was to 20 degrees.

By 5/8/14, Dr. Strugala's physical exam of Petitioner showed lumbar flexion to at least 90 degrees, which was considered a marked improvement from last evaluation. Petitioner had no

pain with trunk rotation. The doctor recommended a brief course of work conditioning. On 5/9/14, Dr. Heller noted work conditioning was under the supervision Dr. Strugala. Dr. Heller indicated that left shoulder would not limit his ability to perform regular work duties at that time but that Petitioner was to remain off of work during work conditioning. On 5/19/14, physical therapists indicated that Petitioner continued to function safely at the light to medium physical demand level and would benefit from an additional therapy given the fact that his job was considered very heavy.

On 6/3/14, therapists recommended additional work conditioning in order transition Petitioner from the medium to very heavy physical demand level. On 6/18/14, Petitioner demonstrated the ability to lift at very heavy physical demand level and was discharged from therapy for reaching his goals and reporting no low back discomfort. On 6/24/14, Dr. Strugala noted low back pain but ambulation without difficulty, normal gait, good active lumbar flexion and extension without pain, no pain with trunk rotation, no pain with lateral flexion to the right or left and that Petitioner was able to perform deep squat with good lifting technique without pain. The doctor indicated that Petitioner could return to work without restriction.

Petitioner's relevant prior medical history showed that in September 2006, Petitioner underwent right shoulder arthroscopic repair of the rotator cuff. Petitioner was eventually released back to work full duties without any restrictions with respect to the right shoulder. The next record appears 4/25/08 at which time Petitioner presented to Mercy following a left shoulder injury. Dr. Heller subsequently confirmed that a left shoulder MRI showed evidence of full thickness rotator cuff tearing along the anterior aspect and far posterior aspect of the supraspinatus into the infraspinatus tendon. The doctor noted that they were "small tears" but full thickness. On 5/21/08, Dr. Heller performed a left shoulder rotator cuff arthroscopic repair, left shoulder arthroscopic subacromial decompression and left shoulder glenohumeral joint arthroscopy with extensive debridement. In March 2009, Dr. Heller noted that Petitioner was functioning appropriately at the medium demand level however that there were certain job activities including pushing and pulling and lifting materials outside of a garbage container into a truck that he would still have difficulty with. In April 2009, Dr. Heller noted Petitioner had completed and met all necessary lifting capabilities and tolerances for his regular job duties with respect to the left shoulder and released Petitioner for the left shoulder to full duty without restrictions. The next record appears 3/25/11, at which time Dr. Heller noted Petitioner injured his left shoulder on 2/22/11 after lifting a heavy dresser in an alleyway in order to put it into a garbage truck. In April 2011, Dr. Heller released Petitioner back to full duty.

At trial Petitioner testified he has not received any treatment for his left shoulder or low back since being discharged in June 2014. Petitioner has since returned to his same job with Respondent and has had the same responsibilities. He testified he continued to experience pain in the low back and left shoulder when sleeping and soaks regularly. At work, he testified he works takes longer and his partner helps him if he has to lift too high. He acknowledged he always works with a partner and that they help each other with heavy lifting. Petitioner testified he currently does not take any prescription or over the counter medications and does not see any doctor for his continued complaints of pain.

CONCLUSIONS OF LAW

ISSUE (F) Is Petitioner's Current Condition Of Ill-Being Causally Related To The Injury?

The Arbitrator has considered Petitioner's testimony as well as all available medical evidence and concludes that the injuries sustained by Petitioner to both his left shoulder and low back are causally related to his undisputed work accidents occurring in June 2012 and July 2013. The Arbitrator finds Petitioner's testimony to be credible, forthright and honest. Petitioner testified that prior to his two undisputed work accidents of June 2012 and July 2013, Petitioner had undergone extensive medical treatment to the left shoulder as well as lower back. The prior medical history demonstrates that Petitioner was otherwise pain-free and symptom-free with respect to the left shoulder and the low back prior to his June 2012 undisputed work accident. Similarly, following his full duty release back to full duty work in October 2012, Petitioner remained pain-free and symptom-free. Then, in July 2013, Petitioner's pain and symptoms returned once again following his work accident.

Petitioner was diagnosed with left shoulder sprain/strain as well as a low back strain for both incidents occurring in June 2012 and July 2013. Based on the medical records, the Arbitrator finds Petitioner sustained aggravations of his pre-existing conditions to the left shoulder and low back. This conclusion is supported by the medical opinions of Drs. Heller and Strugala, both of whom opined Petitioner's conditions were likely related to his injuries in question.

The Arbitrator has considered the medical opinions of Dr. Troy on the issue of causal connection and does not find those persuasive in that regard. Specifically, Dr. Troy indicated that there were no objective findings or changes to the low back and that Petitioner's limitations were subjective in nature. Dr. Troy, however, acknoweledged in his initial evaluation report that Petitioner was doing fine up until his first work accident. Although Petitioner's symptoms may be subjective to some degree, the Arbitrator notes that Petitioner was otherwise pain and symptom free as indicated by Drs. Troy and Strugala. The Arbitrator adopts the opinions of Dr. Strugala over those of Dr. Troy as it relates to causation for the low back.

ISSUE (K) What Temporary Benefits Are In Dispute?

Petitioner claims to be entitled to temporary total disability (TTD) from 6/14/12-11/5/12 and from 7/12/13-6/24/14, representing 70-3/7th weeks. Ax1. Respondent disputes this time frame and claims Petitioner is entitled to TTD from 6/14/12-11/5/12 and from 7/12/13-1/16/14 and from 4/10/14-6/24/14. Thus, the relevant time period in dispute is 1/17/14 through 4/9/14, representing 83 days or 11-6/7th weeks.

The relevant medical record demonstrates that between December 2013 and Petitioner's full duty release in June 2014, Dr. Heller repeatedly noted Petitioner's inability to use the left extremity, to return to work at the very heavy demand level and continued to note approval issues delaying recovery. During this time, Dr. Strugala recommended light duty work restrictions for the low back. Thus, the record demonstrates Petitioner was unable to return to his prior full duty employment with Respondent based on doctor limitations and functional level during the disputed time in question. The record is not contradicted that Petitioners full-time job required him to be able to function at the very heavy physical demand level and does not indicate that Respondent offered any light duty.

The Arbitrator does not find the opinions of Dr. Daniel Troy persuasive on the issue of temporary total disability benefits. Specifically, Dr. Troy found that Petitioner only needed two more weeks of physical therapy. However, the record shows that Petitioner was not approved for some time for medical treatment and needed additional weeks of therapy to return him to pre-injury status. These conclusions are supported by Dr. Heller's opinions and his completion of insurance claim forms indicating Petitioner was unable to use the affected extremity. The Arbitrator declines to adopt the medical opinions of Dr. Troy on this issue.

Therefore, the Arbitrator concludes that Petitioner is entitled to temporary total disability benefits from 6/14/12 through 11/5/12 and 7/12/13 through 6/24/14, representing 70-3/7th weeks. Respondent shall pay Petitioner temporary total disability benefits of $857.09 per week for 70-3/7th weeks 6/14/12 through 11/5/12 and 7/12/13 through 6/24/14. Respondent shall be given a credit of $50,810.84 for TTD paid.

ISSUE (L) What Is The Nature And Extent Of The Injury?

The medical record shows that Petitioner was released to return to work full duty in June 2014. Petitioner's testimony corroborates this and Petitioner indicated he is working full time without restriction. Therefore, Petitioner's claims are ripe for consideration of the nature and extent of his left shoulder and low back injuries. Pursuant to *Will County Forest Preserve*, any award of benefits for Petitioner's shoulder injury is to be awarded under 8(d)(2) or person as a whole award. 970 N.E.2d 16, 19, 361 Ill.Dec. 16 (3d Dist. 2012).

In determining permanent partial disability, Section 8.1(b) provides that permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a); (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. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor. With regard to subsection (ii), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a construction/garbage laborer at the time of his accidents, that he is able to return to work in his prior capacity as a result of said injury. The Arbitrator notes that Petitioner testified that although he asks for help lifting and uses a partner, he acknowledged that he has always used a partner for lifting. Petitioner requires to other type of work accommodation. The Arbitrator therefore gives *greater* weight to this factor. With regard to subsection (iii), the Arbitrator notes that Petitioner was 39 years old at the time of the accident. His younger age indicates to the Arbitrator that the effects of his injuries may bear less due to his age and ability to convalesce. On the other hand, Petitioner's age also indicates that Petitioner has additional years of work ahead and therefore must work within the disabilities of his left shoulder and low back. Thus, the Arbitrator gives a degree of significant weight to this factor, acknowledging it can bear either way for Petitioner. With regard to subsection (iv), Petitioner's future earnings capacity, the Arbitrator notes

Petitioner's earning were not affected by his accidents or injuries. Therefore, the Arbitrator gives no weight to this factor.

With regard to subsection (v), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner's ultimate diagnoses for both accidents was left shoulder sprain/strain and low back sprain/strain. Treatment record for the first accident show Petitioner's left shoulder strain was nearly fully resolved as early as 10/12/12, when therapists noted full range of motion, no instability and minimal pain complaints. Regarding the low back, Petitioner reported low back pain with occasional radiation to the right hamstring. He was eventually released without restriction. Following the second work accident, Petitioner's initial treatment records show Petitioner's left shoulder with full range of motion and positive impingement. Low back exam show normal range of motion, normal alignment and mild left sided paraspinal tenderness. Dr. Heller was unable to appreciate any new tears, no swelling, instability or crepitus. MRI of the left shoulder showed only small fluid collection. Petitioner primarily reported difficulty with sleep and lifting. Dr. Troy's exam of Petitioner documented only slight pain to the left shoulder with full abduction and flexion. Low back exam showed pain with flexion, negative straight leg and no radiation. Exam was otherwise normal. Petitioner's subsequent therapy notes for the left shoulder after November 2013 fail to shed much light on specific capabilities or deficits to the left shoulder other than to state Petitioner's level of functioning. Petitioner eventually demonstrated that ability to lift a very heavy physical demand level. Prior to Petitioner advancing to the very heavy physical demand level, Dr. Strugala noted no pain with trunk rotation, ambulation without difficulty, normal gait, flexion limited by some pain. The Arbitrator takes note of Petitioner's prior medical history in noting to new significant pathology as a result of the two work accidents. In light of the foregoing, the Arbitrator therefore gives the greatest weight to this factor.

Considering all of the factors pursuant to Section 8.1(b) in conjunction with Section 8(d)(2), the Arbitrator concludes that the work accident of 6/13/12 in case number 12 WC 21209 and the work accident of 7/12/13 in case number 13 WC 23631 the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 3% man as a whole for the left shoulder and 3% man as a whole for the low back pursuant to Section 8(d)(2) of the Act.

MARIA S. BOCANEGRA, ARBITRATOR

5/22/15
DATE

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Marvet Washington,
Petitioner,
vs.

16IWCC0213
NO: 13 WC 24896

State of IL - Secretary of State,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary total disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 28, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

DATED: MAR 2 4 2016
Kwl/vf
O-3/21/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

16IWCC0213

WASHINGTON, MARVET
Employee/Petitioner

Case# 13WC024896

STATE OF IL-SECRETARY OF STATE
Employer/Respondent

On 7/28/2015, 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 0.14% 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:

1727 LEE, MARK N LAW OFFICE
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0514 ASSISTANT ATTORNEY GENERAL
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0502 STATE EMPLOYEES RETIREMENT
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0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

JUL 28 2015

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

☐ 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
19(b)

Marvet Washington
Employee/Petitioner

Case # 13 WC 24896

v.

Consolidated cases: n/a

State of IL - Secretary of State
Employer/Respondent

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 William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on May 28, 2015. 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

16IWCC0213

FINDINGS

On the date of accident (manifestation), July 3, 2013, 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 not sustain an accident that arose out of and in the course of employment.

Petitioner's current condition of ill-being is not causally related to the accident.

In the year preceding the injury, Petitioner earned $25,842.39; the average weekly wage was $496.97.

On the date of accident, Petitioner was 50 years of age, married with 0 dependent child(ren).

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

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00.

Respondent is entitled to a credit of amounts paid under Section 8(j) of the Act.

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

William R. Gallagher, Arbitrator
ICArbDec19(b)

July 24, 2015
Date

JUL 28 2015

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained a repetitive trauma injury arising out of and in the course of her employment for Respondent. The Application alleged a date of accident (manifestation) of July 3, 2013, and that Petitioner sustained injuries to "Bilateral Hands" as a result of repetitive duties (Arbitrator's Exhibit 2). Respondent disputed liability on the basis of accident and causal relationship. This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills as well as prospective medical treatment (Arbitrator's Exhibit 1).

Petitioner has been employed by Respondent since August, 2000. She initially worked as an Operations Assistant and, approximately one year later, Petitioner was promoted to Operations Associate. Petitioner testified that her job required her to use both of her hands to type, input data, wrap license plates, use a hole puncher, remove staples, answer telephone calls, use a scissors, handwrite envelopes, etc. Petitioner also stated that she spent 95% of her work day typing.

In 2013, Petitioner began doing which she described as "table work." When Petitioner performed table work duties, she would work on license plate renewals, cut sheets with a scissors, remove staples, etc. Petitioner testified that she had pain in both of her thumbs after using the scissors.

Petitioner testified that the hand numbness and pain began prior to 2013, but the symptoms worsened when she began doing the table work. Petitioner stated that when she did not have to do the table work, the symptoms were not as intense; however, they were still worse than what they were prior to doing the table work.

Petitioner has an Associate degree and is an RN; however, Petitioner stated that she was not able to work as an RN because of an infection she contracted while working in that capacity. Petitioner's inability to work as RN is not relevant to her workers' compensation claim.

Petitioner had a significant number of other health issues, including uncontrolled diabetes. Petitioner testified that she had to administer up to nine shots of insulin per day. She has had extensive foot surgeries and has been diagnosed with diabetic neuropathy. Petitioner also has high blood pressure and is obese as she is 5'2" tall and weighs almost 292 pounds. Further, Petitioner had a long history of cigarette smoking which she began when she was nine years old. For 30 to 40 years, Petitioner smoked one pack per day. She presently smokes approximately one half pack per day.

Petitioner initially sought medical treatment on July 3, 2013 (the manifestation date alleged in the Application), when she was seen by Dr. M. L. Mehra, a neurologist. Dr. Mehra's record noted that Petitioner was a type 2 insulin-dependent diabetic and that she took Cymbalta for neuropathy. He noted that Petitioner was a nurse. In regard to her symptoms, Petitioner complained of both hands getting numb and tingling and that she was losing grip strength in her right hand. Petitioner advised that her symptoms were worse at night, when she drove and when she held a newspaper. There were no references to Petitioner's job for Respondent (Petitioner's Exhibit 6).

Dr. Mehra examined Petitioner and performed nerve conduction studies which were positive for severe carpal tunnel syndrome, worse on the right than left. His diagnosis was "...type 2 diabetes with severe, bilateral, right worse than the left, carpal tunnel syndrome." (Petitioner's Exhibit 6).

On August 1, 2013, Petitioner was seen by Suzanne Morphen, a Nurse Practitioner, who noted that Petitioner had carpal tunnel syndrome which began six years ago, but had been getting progressively worse, more so in the right than left hand. NP Morphen noted that Petitioner was a type 2 insulin-dependent diabetic and that her diabetic condition was diagnosed 11 years ago. There was no reference to Petitioner's job for Respondent (Petitioner's Exhibit 4).

On August 7, 2013, Petitioner was seen by Dr. Michael Neumeister, a plastic surgeon. At that time, Petitioner advised Dr. Neumeister that she had bilateral hand pain, more so in the right than left, of six to seven years which she noticed while writing at work. Dr. Neumeister opined that Petitioner had bilateral carpal tunnel syndrome and recommended therapy and splinting prior to consideration of surgery (Petitioner's Exhibit 5).

Dr. Neumeister saw Petitioner on September 19, 2013, and Petitioner still had bilateral hand symptoms as well as complaints of pain radiating to the thumb, again, more so on the right than left. Dr. Neumeister gave Petitioner a Kenalog injection into the right CMC joint and recommended surgery (Petitioner's Exhibit 5).

Dr. Neumeister again saw Petitioner on October 28, 2013, and Petitioner's primary complaint was that of pain/numbness in the left hand/thumb. Petitioner advised that she had been using her left hand more because of the right hand symptoms (Petitioner's Exhibit 5).

At the direction of Respondent, Petitioner was examined by Dr. Frank Petkovich, an orthopedic surgeon, on November 13, 2013. In connection with his examination of Petitioner, Dr. Petkovich reviewed medical records provided to him by Respondent. In regard to Petitioner's job duties for Respondent, Dr. Petkovich's report stated that Petitioner had worked in the "phone bank" for the preceding two years and that her job included answering the phone and doing "some keying" on the computer. His report also noted that Petitioner did "...not describe any continuous computer or keying activities." (Respondent's Exhibit 1; Deposition Exhibit 2).

Dr. Petkovich opined that Petitioner had bilateral carpal tunnel syndrome and that the surgery recommended by Dr. Neumeister was appropriate. In regard to causality, Dr. Petkovich opined that there was not a causal relationship between Petitioner's work activities and the bilateral carpal tunnel syndrome. This was based on the fact that Petitioner did not describe any repetitive work activities which would have caused or aggravated Petitioner's bilateral carpal tunnel syndrome. Further, Dr. Petkovich opined that the condition was idiopathic but, "strongly influenced" by Petitioner's history of tobacco abuse and diabetes (Respondent's Exhibit 1; Deposition Exhibit 2).

Dr. Neumeister again saw Petitioner on June 23, 2014. At that time, Petitioner continued to complain of numbness/tingling in both hands as well as shooting pains, but more so in the left than right hand. Petitioner informed Dr. Neumeister that she worked eight hours a day for five

days a week and had done so for approximately 14 years. Dr. Neumeister restated his surgical recommendation (Petitioner's Exhibit 5).

Dr. Neumeister was deposed on July 21, 2014, and his deposition testimony was received into evidence at trial. Dr. Neumeister testified that Petitioner had bilateral carpal tunnel syndrome and bilateral CMC joint arthritis, and further treatment for both conditions was indicated (Petitioner's Exhibit 7; pp 17-18).

In regard to causality, Dr. Neumeister reviewed photographs of Petitioner's workstation and was asked a lengthy hypothetical question which purportedly described Petitioner's work duties including Petitioner working full time for five days a week. Dr. Neumeister opined that Petitioner's work duties aggravated both her bilateral carpal tunnel syndrome and bilateral CMC arthritis (Petitioner's Exhibit 7; pp 19-25).

Dr. Neumeister agreed that Petitioner had other risk factors for the development of carpal tunnel syndrome, namely, smoking, diabetes and being female. When cross-examined, Dr. Neumeister testified in greater detail why the preceding conditions were risk factors for the development of both carpal tunnel syndrome and CMC arthritis. He also agreed that obesity was a risk factor for development of carpal tunnel syndrome, but not CMC arthritis (Petitioner's Exhibit 7; pp 25-34).

Dr. Petkovich was deposed on September 29, 2014, and his deposition testimony was received into evidence at trial. Dr. Petkovich's testimony was consistent with his medical report and he reaffirmed his opinion that Petitioner's work duties did not cause or aggravate either the bilateral carpal tunnel syndrome or arthritis in Petitioner's hands. This opinion was based upon the fact that the work history provided by Petitioner was not consistent with repetitive work activities and Petitioner's other numerous risk factors, which included diabetes, smoking, high blood pressure, obesity and the fact that Petitioner was female (Respondent's Exhibit 1; pp 12-17).

When he was deposed, Dr. Petkovich also reviewed the photos of Petitioner's workstation and was asked the same hypothetical question that Dr. Neumeister was asked when he was deposed. When asked if either of the preceding changed any of his opinions in regard to causality, Dr. Petkovich stated that his opinion had not changed (Respondent's Exhibit 1; pp 17-22).

When cross-examined, Dr. Petkovich agreed that Petitioner's condition may have "manifested" while she was performing her work; however, Dr. Petkovich also stated that if someone is performing an activity and the symptoms increase or become more noticeable then it is an exacerbation but not necessarily an aggravation of the condition (Respondent's Exhibit 1; pp 26-27).

Peggy Bartling testified on behalf of the Respondent at trial. Bartling was Petitioner's supervisor and had been so for approximately five years. She stated that when Petitioner takes telephone calls, she uses a cordless headset and never holds the phone. She also testified that Petitioner did table work, but prior to being assigned to that duty, Petitioner would crochet at work. She also disagreed with Petitioner's testimony that Petitioner would have to pull staples and use a scissors for extended periods of time because Petitioner's primary job duty was answering the phone.

Sarah Robinson also testified on behalf of the Respondent at trial. Robinson is Respondent's Workers' Compensation Coordinator. Robinson testified in regard to Petitioner's attendance records for 2011, 2012 and 2013, which were received into evidence at trial (Respondent's Exhibit 4).

In regard to 2011, Robinson testified that the records indicated that Petitioner did not work for 61% of the days she was scheduled to work and 40% of the hours she was scheduled to work. For 2012, Robinson testified that the records indicated that Petitioner did not work 50% of the days she was scheduled to work and 43% of the hours she was scheduled to work. Finally, for 2013, Robinson testified that Petitioner did not work 61% of the days she was scheduled to work and 49% of the hours she was scheduled to work.

On cross-examination, Robinson was questioned about the manner in which Petitioner's missed days from work were computed. Robinson agreed that, if Petitioner missed any portion of a workday, that it was counted as the entire day when computing the percentage of days that she was scheduled to work and did not do so.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner did not sustain a repetitive trauma injury that manifested itself on July 3, 2013.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony regarding the repetitive use of her hands at work was inconsistent. Petitioner described a multitude of various hand intensive repetitive tasks that she was required to perform; however, she also testified that she spent 95% of her work day typing.

Petitioner informed her primary treating physician, Dr. Neumeister, that she worked eight hours a day for five days a week and had done so for approximately 14 years.

Petitioner's attendance records for 2011, 2012 and 2013, clearly indicated that Petitioner did not work on a regular and continuous basis for those years. The Arbitrator acknowledges that the data regarding the percentage of days Petitioner did not work is misleading because it considered any portion of a missed day from work as the Petitioner missing work for the entire day. However, the percentage of total hours not worked by Petitioner for the three years is an accurate statement of the time Petitioner worked for Respondent during that three year period of time. As is noted in the statement of facts, Petitioner did not work for 40%, 43% and 41% of the hours she was scheduled to work for 2011, 2012 and 2013, respectively.

There was no question that Petitioner had other significant risk factors for the development of her bilateral hand symptoms, including severe diabetes, obesity, high blood pressure and an extremely long history of smoking.

When Petitioner was initially seen by Dr. Mehra and NP Morphen, she informed both of them of her diabetic condition but said nothing about her work activities.

While Dr. Neumeister opined that there was a causal relationship between Petitioner's hand conditions and her work activities, this was based, in part, upon the inaccurate work history provided to him by Petitioner. Further, Dr. Neumeister agreed that Petitioner had other significant risk factors.

When Petitioner was examined by Respondent's Section 12 examiner, Dr. Petkovich, she provided him with what appeared to be the most accurate description of her work duties which did not include a significant amount of repetitive hand activities.

The Arbitrator finds the opinion of Dr. Petkovich to be persuasive.

In regard to disputed issues (J) and (K) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issues (C) and (F).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Haynes,

Petitioner,

vs. NO: 13WC 28747

Overhead Door Company,

16IWCC0212

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, notice, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 1, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

Appendix

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IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 4 2016
MJB/bm
o-3/21/16
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

HAYNES, JOHN
Employee/Petitioner

Case# 13WC028747

16IWCC0212

OVERHEAD DOOR COMPANY
Employer/Respondent

On 7/1/2015, 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 0.11% 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:

0192 CUSACK GILFILLAN & O'DAY
DANIEL P CUSACK
415 HAMILTON BLVD
PEORIA, IL 61602

0766 HENNESSY & ROACH PC
QUINN M BRENNAN
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

John Haynes
Employee/Petitioner

Case # **13** WC **28747**

v.

16IWCC0212

Overhead Door Company
Employer/Respondent

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 **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Peoria**, on **May 19, 2015**. 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. [x] 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. [x] Was timely notice of the accident given to Respondent?
F. [x] 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. [x] 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. [x] Is Petitioner entitled to any prospective medical care?
L. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other

FINDINGS

16IWCC0212

On the date of accident, **June 6, 2013**, 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 $**29,120.00**; the average weekly wage was $**560.00**.

On the date of accident, Petitioner was **45** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule as listed in Petitioner's Exhibit No 11, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay the reasonable and necessary expenses associated with the medical treatment prescribed for the Petitioner by Dr. Henry, pursuant to the medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

Arbitrator Anthony C. Erbacci

June 24, 2015
Date

13 WC 28747
ICArbDec19(b)

JUL 1 - 2015

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FACTS:

On June 6, 2013 the Petitioner was employed by the Respondent as a garage door installer, having been so employed for five years. The Petitioner testified that on June 6, 2013 he was working with Scott Dent and they were unloading garage door panels from a truck. The Petitioner testified that as he yanked on one of the door panels to remove it from the truck, he felt severe pain in his back which caused him to drop to his knee. The Petitioner testified that he tried to pull on the door panel again and he again experienced severe pain in his low back. The Petitioner testified that he tried to work through the pain the rest of the day but his co-worker had to do a majority of the work. The Petitioner testified that when they completed their tasks, they returned to the Respondent's facility to unload the vehicle and punch out.

The Petitioner testified that while he was in the Respondent's office clocking out, he mentioned his injury to Paul Sheets, one of the owners of the company. The Petitioner testified that he told Mr. Sheets that he thought he pulled something, was in pain, and that he might go get it checked out. The Petitioner testified that Mr. Sheets told him he was strong and could work through it. The Petitioner testified that the next morning, he couldn't get out of bed due to the severe pain in his low back. The Petitioner testified that he called in to the Respondent's office and spoke to Paul Sheets advising him that he was having severe back pain and couldn't make it to work that day. The Petitioner testified that he continued to have pain through the weekend and that he went to the emergency room early Sunday morning.

On June 9, 2013, the Petitioner presented to the emergency room at Pekin Hospital with complaints of back pain for 4-5 days after pulling a door off something at work. The Petitioner was diagnosed with a back strain and prescribed Norco, Naprosyn and Flexeril. He was taken off work for two days. The Petitioner returned to the emergency room at Pekin Hospital on June 11, 2013 again complaining of back pain after an injury at work 7 days earlier when he was pulling on his truck door at work. The Petitioner received a Marcaine injection into his lower back. He reported moderate relief and that he was "achy".

The Petitioner testified that he returned to his regular work for the Respondent but he continued to have pain in his low back. The Petitioner testified that his partner had to do the majority of the heavy work and that he did what he could to help. The Petitioner also testified that he reported to Andy Sheets, the Respondent's other owner, that he pulled something in his back. The Petitioner testified that he also asked Paul Sheets and Andy Sheets on several occasions to send him to the doctor to have his back evaluated. The Petitioner testified that he was terminated from his employment with the Respondent on August 15, 2013.

On August 26, 2013, the Petitioner presented to Dr. Daniel Hoffman. The Petitioner reported that while at work on June 7, 2013, he was unloading a "16 foot by 7 foot door" when he experienced severe pain in his lumbosacral spine. Dr. Hoffman noted that the Petitioner had been to the emergency room on two occasions and was released but still had lumbosacral pain radiating down his left leg. Dr. Hoffman ordered an MRI of the spine which was performed on September 9, 2013, and was reported to reveal lumbosacral degenerative

spondylosis at multiple levels. The Petitioner followed up with Dr. Hoffman on September 11, 2013, and continued to have complaints of lumbosacral pain radiating down his left leg. Dr. Hoffman diagnosed the Petitioner with a lumbosacral strain and he referred the Petitioner to an orthopedic surgeon.

On October 3, 2013, the Petitioner presented to Dr. Richard Kube on referral from Dr. Hoffman. The Petitioner complained predominantly of pain in the back with severe pain in the bilateral buttocks. He reported that it began after a maneuver at work where he was trying to pull a door out of a truck. The door stopped mid pull and the Petitioner had immediate pain in his back that took him to the ground. The Petitioner had significant pain since that time. Within a couple of days, the pain started going down to the buttocks and left leg and had continued since that time. A review of the MRI noted degenerative changes throughout, and Dr. Kube noted disc protrusions at L4-5 and L5-S1, more left sided than the right. Dr. Kube opined that the Petitioner had disc protrusions with radicular pain and back pain. He recommended epidural injections and a rehab program to try to move the Petitioner forward.

On October 14, 2013 and November 7, 2013, the Petitioner underwent transforaminal epidural steroid injections which reportedly almost eliminated the Petitioner's leg pain. On December 11, 2013, the Petitioner underwent an EMG/NCV with Dr. Edward Trudeau. The EMG was interpreted to reveal left L5 radiculopathy mild to moderate in electro neurophysiologic testing terms consistent with the clinical assessment of Dr. Kube. Dr. Trudeau suggested radiographic studies of symptomatic lower extremity joint regions to assess bony or other anatomic abnormalities; a bone scan of the same to assess degenerative, occult or inflammatory lesions and in particular, a lumbar myelogram with flexion and extension views to further define structure abnormality, both at L4-5 and L5-S1.

On December 23, 2013, the Petitioner presented to Dr. Kube for follow-up. Dr. Kube noted that the EMG/NCV revealed a left L5 radiculopathy and that there was stenosis and an annular tear which correlated with the Petitioner's complaints. Dr. Kube recommended a discogram which was performed on January 13, 2014, and was reported to be negative.

On January 22, 2014, and February 17, 2014, the Petitioner underwent bilateral L4-5 and L5-S1 facet joint block injections. On March 3, 2014, Dr. Kube noted that the facet blocks resulted in excellent pain relief and that the Petitioner's pain was virtually gone. Dr. Kube suggested the Petitioner might benefit from facet rhizotomies and he referred the Petitioner to Dr. Kevin Henry.

On April 8, 2014, the Petitioner was evaluated by Dr. Kevin Henry at the Illinois Regional Pain Institute on referral from Dr. Kube. Given the Petitioner's response to facet blocks, Dr. Henry believed that the Petitioner would be a good candidate for rhizotomy, but felt that the Petitioner needed one diagnostic median branch block to go along with the facet blocks, and if he attained significant relief with the medial branch blocks, they would consider going forward with the rhizotomy. The Petitioner followed up with Dr. Henry through February 10, 2015.

The Petitioner testified that in May of 2014, he was able to secure work driving a person (later identified as Rob Jordan) to and from work, handing the person tools, and pushing a broom. The Petitioner testified that the job does not require him to do any lifting or carrying.

Surveillance of the Petitioner was conducted on August 14, 2014. A 29-minute video tape of that surveillance demonstrated the Petitioner packing a cooler into the bed of a truck and arriving at a job site by 7:30 a.m. The Petitioner remained at the jobsite until approximately noon. The Petitioner is then observed removing golf clubs from one truck and placing them into another. The Petitioner and another person were observed arriving at a golf course and playing golf. The Petitioner is noted to move clubs from his truck to a golf cart and back; to be bent over putting on and taking off golf shoes, and after the round taking off the golf shoes and putting his regular shoes back on; to be in an out of a golf cart; to be bent over setting up tee shots as well as measuring puts; and taking golf swings.

The Petitioner testified that he had the opportunity to review the surveillance video of his activities on August 14, 2014. He acknowledged that he had gone to a job site with Rob Jordan on August 14, 2014 and that he did play nine holes of golf. The Petitioner testified that this was the first day that he had ever played golf and that Rob Jordan gave him a set of golf clubs to use. The Petitioner testified that he has played golf 6 or 7 times since the date of the surveillance.

At the request of the Respondent, the Petitioner was examined by Dr. Frank Phillips on August 28, 2014. Dr. Phillips performed a physical examination, but he did not have medical records in his possession at the time of the examination. He recommended a 20 pound lifting restriction based on the examination and sked to review the Petitioner's medical records. Dr. Phillips authored a second report on October 21, 2014, after reviewing the Petitioner's medical records and a surveillance video. Dr. Phillips noted that the surveillance video that was taken was "obviously inconsistent" with the Petitioner's pain complaints. He opined that the Petitioner suffered from a lumbar spine strain as a result of the accident, and that a course of physical therapy and possible epidural steroid injections would have been reasonable within the months following the injury. He did not believe that there was a role for facet joint blocks or a diskogram. Dr. Phillips opined that the Petitioner had reached maximum medical improvement from his work injury.

Scott Dent testified on behalf of the Petitioner. Mr. Dent testified that he was working with the Petitioner on June 6, 2013 and he corroborated the Petitioner's testimony that while pulling a garage door out of the truck, the Petitioner had a sharp pain in his back. Mr. Dent testified that while the Petitioner was pulling the door panel from the truck, he heard him grunt and then saw him lean on the truck. Mr. Dent testified that the Petitioner appeared to be in pain. Mr. Dent further testified that the Petitioner then had to take time and lay down in the truck.

Mr. Dent also testified that he remembered hearing the Petitioner tell Paul Sheets later that day that he hurt his back and was having pain. He testified that Mr. Sheets told the

Petitioner that he was a "big boy" and would be okay. Mr. Dent testified that when he came in to work the next morning, Mr. Sheets asked him what was up with the Petitioner because he wasn't coming into work and he said he hurt his back. Mr. Dent also stated that Paul Sheets told him on the following Monday that the Petitioner wouldn't be coming in for three days and that the Petitioner ended up going to the emergency room over the weekend. Mr. Dent also testified that, after the Petitioner's injury, he was doing most of the heavy work that needed to be done when they worked together.

Paul Sheets testified on behalf of the Respondent. Mr. Sheets testified that the Petitioner never told him that he injured his back, and that the Petitioner did not call in the next day stating that he couldn't work due to back pain. He did not remember asking Mr. Dent the following day about what happened to Petitioner, nor did he remember any subsequent conversations in that regard. Mr. Sheets denied any knowledge of the Petitioner being injured and he denied having any conversations with the Petitioner or Mr. Dent with regard to the injury in question.

Andy Sheets also testified on behalf of the Respondent. Mr. Sheets denied having any knowledge regarding the Petitioner's claimed injury and he testified that the Petitioner did not report a work accident on June 6, 2013 nor did the Petitioner complain of any back pain. Mr. Sheets testified that he first became aware of the Petitioner's claimed injury after the Petitioner's termination.

Amy Cole also testified on behalf of the Respondent. Ms. Cole is the Respondent's office manager and has been employed with the Respondent since 2000. Ms. Cole testified that she did not remember the Petitioner requesting an accident report with regard to a June 6 2013 accident and that had the Petitioner requested an accident report one would have been given to him. Ms. Cole testified that the Petitioner never reported a work injury, never complained of back pain, and never asked to see a doctor. Ms. Cole testified that she first learned of the Petitioner's alleged accident after his termination.

The March 23, 2015 deposition testimony of Dr. Richard Kube was admitted into the record as Petitioner's Exhibit 1. Dr. Kube testified as to the course of treatment that he rendered to the Petitioner, EMG which revealed L-5 radiculopathy, and the discogram which was negative. Dr. Kube testified that the facet blocks he administered to the Petitioner did provide the Petitioner with immediate relief of his pain which Dr. Kube opined would be consistent with facet arthropathy. Dr. Kube opined that given the Petitioner's history of injury, the contemporaneous onset of symptoms, and the results of the studies that were performed, "it seems reasonable to think that something like that could cause a sprain/strain, irritate the patient if he had some disc protrusions, irritate the stenosis and cause some radiculopathy that resolved with the epidurals and cause some of this nagging facet joint pain." Dr. Kube opined that the Petitioner's history and the mechanism of injury were "pretty consistent" with his diagnoses.

The March 31, 2015 deposition testimony of Dr. Kevin Henry was admitted into the record as Petitioner's Exhibit 2. Dr. Henry testified that his recommendation is to proceed to block the median branch nerves and, if the Petitioner obtains significant relief, proceed with a

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rhizotomy. Dr. Henry testified that he is currently treating the Petitioner with pain medication to keep him functioning while waiting on approval for the rhizotomy. Dr. Henry stated his hope is that if the rhizotomy proves successful, then he could wean the Petitioner off the pain medication. Dr. Henry opined that the Petitioner's condition of ill-being was causally related to the work injury of June 6, 2013.

Dr. Phillips' April 2, 2015 deposition testimony was admitted into the record as Respondent's Exhibit 13. Dr. Phillips opined that the Petitioner sustained a lumbar sprain/strain type injury at work in 2013 and that the Petitioner should have improved with the physical therapy and possibly the epidural injections. Dr. Phillips opined that the injections of November 4, 2013 and November 7, 2013, and the EMG of December 11, 2013 were all appropriate medical treatment but that the facet joint blocks and the discogram were not. Dr. Phillips testified that there was no evidence of any facet injury and nothing about the Petitioner's clinical evaluation suggested that to be a problem. Similarly, Dr. Phillips opined that any further injections or rhizotomies would not be related to the Petitioner's work injury. Dr. Phillips opined that the Petitioner had reached maximum medical improvement from his injury within three months of the injury and that there was no spinal contraindication to the Petitioner retuning to regular unrestricted work.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, and (E.), Was timely notice of the accident given to Respondent, the Arbitrator finds and concludes as follows:

The Petitioner testified that on June 6, 2013 he was working with Scott Dent, performing the usual duties of his employment with the Respondent. The Petitioner testified that he pulled on a door panel to remove it from the truck, he felt severe pain in his back which caused him to drop to his knee. The Petitioner testified that while he was in the Respondent's office at the end of that day, he mentioned his injury to Paul Sheets, one of the owners of the company. The Petitioner testified that the next morning, he couldn't get out of bed due to the severe pain in his low back. The Petitioner testified that he called in to the Respondent's office and spoke to Paul Sheets advising him that he was having severe back pain and couldn't make it to work that day.

On June 9, 2013, three days later, the Petitioner presented to the emergency room at Pekin Hospital with complaints of back pain for 4-5 days after pulling a door off something at work. Thereafter, the Petitioner began a course of medical treatment with Dr. Hoffman, Dr. Kube, and Dr. Henry. The Petitioner was also evaluated at the Respondent's request by Dr. Phillips. The histories of injury noted in all of the records of the Petitioner's medical treatment

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are consistent with is testimony at hearing. Additionally, the Petitioner's testimony was corroborated by the testimony of Scott Dent, who was working with the Petitioner at the time of his injury.

While the Arbitrator notes the testimony of Paul Sheets, Andrew Sheets, and Amy Cole, the Arbitrator also notes that Paul and Andrew Sheets have a direct financial interest in the outcome of this matter, and Amy Cole is still an employee of the Respondent. Scott Dent is the only witness who testified in this matter that has no apparent interest in the outcome of the matter. Scott Dent is no longer employed by the Respondent and has no apparent personal or financial interest in the outcome of this matter. Thus, the Arbitrator finds the testimony of Scott Dent to be more reliable and persuasive than the testimony of the Respondent's witnesses.

Based upon the testimony of the Petitioner, the corroborating testimony of Scott Dent, and the histories noted in the medical records, the Arbitrator finds that on June 6, 2013 an accident did occur which arose out of and in the course of the Petitioner's employment with the Respondent. The Arbitrator further finds that timely notice of the accident was given to the Respondent.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, (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, and (K.), Is Petitioner entitled to any prospective medical care, the Arbitrator finds and concludes as follows:

The findings and conclusions of the Arbitrator relating to the issues of accident and notice are adopted and incorporated herein.

Dr. Kube and Dr. Henry, the Petitioner's treating physicians, both testified that the Petitioner's condition of ill-being is causally related to the Petitioner' work injury. Dr. Phillips, the Respondent's examining physician opined that the Petitioner sustained a sprain/ strain type injury and should have reached maximum medical improvement from that injury within three months. Dr. Kube testified that the medical treatment he rendered to the Petitioner was reasonable, necessary and causally related to the Petitioner's work injury, and Dr. Kube, as well as Dr. Henry, also testified that the treatment recommended for the Petitioner by Dr. Henry was reasonable, necessary and causally related to the Petitioner's work injury. Dr. Phillips opined that the injections the Petitioner received in November of 2013 and the EMG of December 11, 2013 were all appropriate medical treatment but that the facet joint blocks, the discogram, and the treatment recommended thereafter were not.

The Arbitrator notes that the Petitioner did, in fact, improve with Dr. Kube's treatment, and that the treatment recommended for the Petitioner by Dr. Henry is not particularly invasive or extraordinary. Dr. Henry has been treating the Petitioner predominately with pain medication but has opined that if the rhizotomy proved successful, the Petitioner could be

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relieved of his pain and taken off prescription medicines. The Petitioner testified that he wants to undergo the treatment prescribed for him by Dr. Henry. While the Arbitrator notes the opinions of Dr. Phillips, the Arbitrator finds the opinions of Dr. Kube and Dr. Henry to be sufficiently credible, reliable, and persuasive to satisfy the Petitioner's burden of proof in the instant matter.

Based on the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the medical services that were provided to the Petitioner were reasonable, necessary and causally related the Petitioner's work injury on June 6, 2013. The Arbitrator further finds that the Respondent is responsible for payment of the Petitioner's outstanding medical bills as listed in Petitioner's Exhibit No. 11, subject to the Medical Fee Schedule provided for in the Act. The Arbitrator also finds that the Respondent is responsible for providing the treatment prescribed for the Petitioner by Dr. Henry.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Smith,

Petitioner,

vs. NO: 14 WC 7037

Holzhauer Auto & Motorsports Group,

16IWCC0205

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary total disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 14, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

IBIACC0802

16IWCC0205

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 3 2016
TJT:yl
o 1/25/16
51

Michael J. Brennan

Kevin W. Lamborn

DISSENT

I respectfully dissent from the majority decision. I would find that Petitioner sustained an accident in the course of his employment when he was injured while lifting tires at work on February 21, 2014. I would also find that Petitioner's current condition of ill-being is causally related to his work incident. I believe that the Petitioner testified credibly and that he indeed sustained a serious back injury at work. Accordingly, I would award Petitioner temporary total disability benefits, reasonable and necessary medical expenses, and future medical costs including the surgery recommended by Dr. Gornet.

The Petitioner was diagnosed by his first treating physician, Dr. Eavenson, with multi-level lumbar disk herniations with lumbar stenosis and foraminal encroachment. Petitioner underwent an MRI of his lumbar spine on February 25, 2014 which revealed a disk protrusion with a left paracentral extruded disk fragment producing severe stenosis on the left lateral recess at L4-L5. It also revealed disk protrusions at three other levels and a disk herniation. The Petitioner was then referred to Dr. Gornet, a board certified orthopedic surgeon with a specialty in spine surgery whose practice is devoted entirely to the study and treatment of the spine and who became Petitioner's treating physician. When Petitioner first saw Dr. Gornet on February 27, 2014, the Petitioner complained of low back pain that extended into his left buttock, left hip, and down the left leg into the anterolateral calf with numbness in his left foot. The Petitioner had previously reported back related symptoms and radiculopathy involving his left side, but not since early 2012, and on his right side in early 2013. He reported to Dr. Gornet that he had lifted a tire assembly and felt a pop in his back while working for Respondent on February 21, 2014. Petitioner's pain was not immediate or severe until the next morning. Dr. Gornet subsequently opined that Petitioner's symptoms were causally related to Petitioner's work injury on February 21, 2014.

IBIMC0802

According to Dr. Gornet, the extruded fragment on the Petitioner's left side shown by his MRI correlates to Petitioner's symptoms and injury. Furthermore, he opined that it would be impossible for a patient to have an extruded fragment such as Petitioner's in his lumbar spine for ten years. Dr. Gornet recommended that Petitioner undergo a revisionary decompression at L4-L5 and L5-S1. Dr. Gornet opined that Petitioner's need for the aforementioned surgery is causally related to Petitioner's work accident on February 21, 2014.

Dr. Gornet notably testified that Petitioner's back was not a "ticking time bomb waiting to go off" because there was no indication of that, and he worked for the Respondent for some years. In fact, the Petitioner did not miss any work due to low back pain while working for Respondent prior to his alleged accident on February 21, 2014. Dr. Gornet further testified: "All of the other objective evidence would indicate that his back was not a ticking time bomb, that he had done well after his treatment," other than some chiropractic follow-ups here and there. Petitioner did have prior low back issues, but he had a dramatic change in his symptom presentation; therefore, the causal connection between Petitioner's pre-existing condition and his current condition of ill-being was broken due to the change in his symptoms.

Petitioner underwent a Section 12 examination by Dr. Richard Lehman on July 17, 2014 at Respondent's request. Dr. Lehman opined that Petitioner's symptoms were not causally related to his work injury but were actually related to Petitioner's two previous surgeries. However, Petitioner's treating physician, Dr. Gornet, disagreed with Dr. Lehman: Dr. Gornet did not agree that Petitioner had an active problem with his back on February 21, 2014. Dr. Gornet opined that Petitioner sustained an aggravation of his pre-existing condition and a new disk injury. Furthermore, Dr. Gornet testified that Petitioner's mechanism of injury was consistent with the history provided, and that he has treated multiple patients who were injured in a similar fashion like the Petitioner.

I find Dr. Gornet's opinions to be more convincing in this matter, particularly due to the fact that Dr. Lehman, the Section 12 examining physician, is an orthopedic surgeon that specializes in sports medicine - not the spine. In fact, Dr. Lehman testified that he had not performed surgery on the spine in approximately 15 years. Although Dr. Lehman opined that Petitioner's condition was not related to his work injury, he did believe that Petitioner was a surgical candidate. Furthermore, Dr. Lehman testified that Petitioner's subjective exam was in concert with the objective evidence of Petitioner's medical issues. He did not think that Petitioner was trying to magnify his symptoms or mislead Dr. Lehman about his physical condition. Dr. Lehman also stated in his report that there were no inconsistencies with Petitioner's subjective complaints.

Petitioner testified that he would like to proceed with surgery so that he can go back to work. Dr. Gornet has recommended that the Petitioner undergo a decompression to alleviate some of the Petitioner's spine issues. I would award Petitioner the recommended surgery so that he can return to work as desired.

16IWCC0205

For the aforementioned reasons, I would find that the Petitioner proved that he sustained an injury that arose out of and in the course of his employment and award him workers' compensation benefits including temporary total disability, medical expenses incurred, and prospective medical expenses.

Thomas J. Tyrrell

FILMED 1989

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

SMITH, JOHN
Employee/Petitioner

Case# **14WC007037**

HOLZHAUER AUTO & MOTORSPORTS GROUP
Employer/Respondent

16IWCC0205

On 4/14/2015, 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 0.10% 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:

4463 GALANTI LAW OFFICES
DAVID M GALANTI
PO BOX 99
EAST ALTON, IL 62024

2593 GANAN & SHAPIRO PC
DRU A DENNIS
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

16IWCC0205

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

John Smith
Employee/Petitioner

v.

Holzhauer Auto & Motorsports Group
Employer/Respondent

Case # **14WC 007037**

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 **Mt. Vernon**, on **February 4, 2015**. 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. [x] 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. [x] 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. [x] 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. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

16IWCC0205

FINDINGS

On the date of accident, **2/21/2014**, 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 not* 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 not* causally related to the accident.

In the year preceding the injury, Petitioner earned **$64,922.00**; the average weekly wage was **$1248.50**.

On the date of accident, Petitioner was **46** years of age, *married* with **0** dependent children.

Respondent *has* paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$3,329.33** for TTD, **$-0-** for TPD, **$-0-** for maintenance, and **$-0-** for other benefits, for a total credit of **$3,329.33**.

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

ORDER

Petitioner failed to prove he sustained an accident on February 21, 2014 that arose out of and in the course of his employment and failed to prove that his current condition of ill-being in his low back is causally connected to the alleged accident. Petitioner's claim for compensation is denied and no benefits are awarded.

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

April 1, 2015
Date

ICArbDec19(b)

APR 14 2015

John Smith v. Holzhauer Auto & Motorsports Group, 14 WC 007037 (19(b))

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner contends that he injured his back while working on February 21, 2014 and is seeking an award of prospective medical care, medical bills, and temporary total disability benefits in this proceeding. Respondent disputes accident as well as causal connection, medical bills, temporary total disability benefits, and prospective medical care. Two witnesses testified at the hearing: Petitioner and Michael Garrison.

During the hearing a request was made by Petitioner's counsel to submit paycheck stubs (verifying periods of Petitioner's employment with Respondent) with his proposed decision. Respondent had no objection and leave was granted. The Arbitrator notes that she never received any paycheck stubs with Petitioner's proposed decision and, therefore, there is no "Petitioner's Exhibit 6."

The Arbitrator finds:

Petitioner underwent low back surgery in 1991 and again in 1996. (PX 4 - Pet. Ex. 4)

Petitioner filed a workers' compensation claim against Salem Tire Center on July 5, 2000 alleging a back injury on July 15, 1999. Petitioner settled his claim on December 1, 2002 for 1.5% man as a whole. (RX 6)

Petitioner injured his back on August 5, 2006 while working for Dobs Auto & Tire Center. (RX 6)

Petitioner's medical records from Illinois Southwest Orthopedics were also entered into evidence as Respondent's Exhibit #5. Petitioner was examined on November 2, 2006, by Dr. Peter Anderson. Dr. Anderson's records note that he had previously performed back surgery on Petitioner in "1990" and it was believed to have been at the L5/S1 disc level. Petitioner's presenting complaint was an episode of low back pain that was aggravated by lifting a tire at work. Petitioner told Dr. Anderson that he had gone home and a couple of days later the pain worsened to a degree that Petitioner could hardly get out of bed. Petitioner had undergone some chiropractic treatment and the pain had resolved "for the most part." Petitioner denied any real pain that day and had minimal paraspinal spasm and good flexion and extension on examination. Dr. Anderson's impression was that "Overall, [Petitioner was] doing great." The doctor noted some arthritis in Petitioner's back which was felt to be consistent with the fact that Petitioner has had two surgeries with the second one being performed by Dr. Kennedy who removed a disc and some spurs. As Dr. Anderson wrote, "He just had an episode of low back pain, which most Americans get."

Radiograph tests were taken which revealed degenerative changes in the lower lumbar spine, particularly at L4/L5 and L5/S1. Dr. Anderson recommended that Petitioner continue with his exercises and return to activity as tolerated. Petitioner was to call at anytime if he had increasing symptoms or problems. (RX 5)

Petitioner filed a workers' compensation claim against Dobs Auto & Tire Center on August 5, 2006. He settled that back injury claim on July 2, 2007. (RX 6)

Petitioner presented to Thayer Acupuncture & Chiropractic on September 22, 2009 regarding lower back pain which radiated into his left leg. In the Patient Health Questionnaire, Petitioner described his symptoms as sharp pain in his lower back and leg which had begun a couple of weeks earlier with heavy lifting. Petitioner noticed numbness and a sharp, shooting pain that was getting worse. He rated his pain at "8/10." Petitioner acknowledged seeing a chiropractor a year earlier and undergoing x-rays. He acknowledged similar symptoms in the past. Petitioner specifically noted that his left foot was numb. Petitioner underwent chiropractic treatment through January 19, 2010, a total of sixteen times. (PX 4 - Pet. Ex. 4)

Petitioner returned to Dr. Thayer's office on April 11, 2011 complaining of low back pain that began while working in his yard. He described the pain as shooting and dull and rated at "8/10." Dr. Thayer noted that Petitioner's pain was slightly radiating and his pain was increased by movement and decreased by rest. Petitioner saw Dr. Thayer four times and then failed to show for a visit on April 21, 2011. (PX 4 - Pet. Ex. 4)

Petitioner sustained a work-related injury to his left arm on December 12, 2011 for which he initially treated with Dr. Sola. Petitioner was lifting and sliding car tires with his left arm when he suffered a biceps tendon rupture. (RX 5; RX 6)

Petitioner presented to Dr. Thayer, his chiropractor, on February 1, 2012 complaining of low back pain radiating into his left leg. At the time of his initial evaluation with Dr. Thayer, Petitioner was working as a service manager for National Tire & Battery. Petitioner indicated he was lifting tires and hurt his arm, but sleeping with his cast and carrying it had increased his back pain. Petitioner reported that his low back pain began on January 31, 2012, when he woke up that morning and he continued to experience left lower back pain that gradually got worse. Petitioner's initial low back disability questionnaire on February 1, 2012, indicates that Petitioner's low back pain would come and go and was severe in nature and increased with washing and dressing himself. At that time, Petitioner could only lift very light weight and could not sit more than one-half hour, or stand longer than ten minutes without increasing pain. Petitioner's normal night's sleep was significantly reduced due to his pain and his pain restricted his social life. Petitioner indicated he could hardly do any work at all, could not drive his car as long as he wished

due to moderate back pain, and could hardly do any recreational activities because of his back. Petitioner noted that his pain was neither getting better nor worse. He rated his pain level at "10." The Questionnaire asked if Petitioner had ever had this problem before and Petitioner marked "Yes" and wrote, "After lifting heavy stuff." (RX 4, p. 21/25) Petitioner's treatment with Dr. Thayer included treatment to his lumbar spine, including the L4/L5 and L5/S1 levels. Petitioner regularly treated with Dr. Thayer through March 20, 2012 at which time Dr. Thayer noted Petitioner was at "100 % MMI." (RX 4)

Petitioner filed a workers' compensation claim in connection with the December 12, 2011 accident on February 8, 2012. That claim alleged an arm injury (RX 6). Petitioner's case was arbitrated and a decision was entered on August 20, 2012 awarding Petitioner 22 1/2% loss of use of the left arm. According to the Arbitrator's Decision Petitioner had gone to work for a different employer after his accident and recovery. He was working as a "service manager" which involved less physically demanding work as he was not required to perform any physical labor whatsoever. Petitioner's left arm strength was noted to be about half of what it was pre-accident. (RX 7)

Petitioner returned to see Dr. Thayer on March 25, 2013 complaining of lower back pain with radiation into his right leg, which he described as a low ache. (PX 4 - Pet. Ex. 4)

Petitioner again returned to see Dr. Thayer on August 13, 2013 regarding lower back pain for which he received chiropractic care. (PX 4 - Pet. Ex. 4)

Petitioner signed his Application for Adjustment of Claim in this matter on February 24, 2014. (AX 2)

Petitioner presented to Dr. Eavenson on February 24, 2014. (PX 1) Petitioner advised Dr. Eavenson he was lifting a large four-wheel drive tire off of a machine and felt two pops in his lower back on February 21, 2014. Petitioner stated he was very stiff and sore at the end of the day and he told his wife that he would probably need to see a doctor because of his pain. Petitioner also reported he had been terminated. Petitioner stated the next morning his pain was quite intense. Petitioner's complaints included low back pain, and a knife-type pain in the left buttock, with some numbness that extended into his left foot. Dr. Eavenson noted that Petitioner had undergone low back surgery in 1987 and a subsequent microdiscectomy in either 1995 or 1996. Since Petitioner's last surgery, Petitioner reported visiting two chiropractors, Dr. Thayer and Dr. Neil Reising, about "8 trips or so." Petitioner admitted he had experienced residual numbness in his feet since his prior two surgeries. Petitioner appeared uncomfortable but in no distress. Straight leg raising was positive on the left at 45 degrees and on the right at 30 degrees. Petitioner was noted to have 40 degrees of extension with sharp pain at L5/S1. Right lateral bending was full and painless; left was restricted by half. Dr. Eavenson took x-rays of Petitioner's

lumbar spine, which revealed degenerative changes at L5/S1. Dr. Eavenson diagnosed Petitioner with a lumbar disc protrusion with left lower extremity radiculitis with a history of two lumbar surgeries. Dr. Eavenson recommended an MRI of the lumbar spine, physical therapy/rehabilitation, and work restrictions consisting of no repetitive lifting, no repetitive bending, no pushing, pulling or climbing, and no lifting greater than 10 pounds. (PX 1, 235/236)

That same day, Petitioner began physical therapy with Corey Voss. Petitioner described his accident of February 21, 2014 indicating he was lifting a large 4 wheel drive tire off of a machine. He again mentioned being terminated that same day and feeling intense pain the next morning. Therapy was to be done three times a week for four weeks. (PX 1, 234/236)

Petitioner underwent an MRI of his lumbar spine on February 25, 2014. The MRI revealed a disc protrusion with a left paracentral extruded disc fragment producing severe stenosis on the left lateral recess at L4/L5. The MRI also revealed disc protrusions at L2/L3, L3/L4, and L5/S1, with a right paracentral focal disc herniation resulting in moderate stenosis of the right lateral recess at L2/L3 and moderate bilateral foraminal encroachment at L5/S1. (PX 2)

Petitioner followed up with Dr. Eavenson on February 25, 2014. Petitioner continued to have low back pain with numbness in his left leg. Dr. Eavenson reviewed the lumbar spine MRI and diagnosed Petitioner with multi-level lumbar disc herniations with lumbar stenosis and foraminal encroachment. Dr. Eavenson referred Petitioner to Dr. Gornet. Dr. Eavenson recommended continued physical therapy and Petitioner continue on his restrictions. (PX 1, 233/236)

Petitioner continued his physical therapy for the next three days. (PX 1)

Petitioner was examined by Dr. Gornet at the Orthopedic Center of St. Louis on February 27, 2014. Petitioner complained of low back pain that extended into the left buttock, left hip, and down the left leg into the anterolateral calf with numbness in his left foot. Petitioner advised Dr. Gornet that while working for Respondent on February 21, 2014, he lifted a tire assembly and felt a pop in his back. Dr. Gornet noted that Petitioner's pain was not immediate or severe, but the next morning, Petitioner's pain was quite severe and he reported it on Monday when he returned to work. Petitioner stated he was then terminated by his employer. Dr. Gornet also noted Petitioner had two previous back injuries, with subsequent surgeries, in 1988 and 1996. Petitioner advised he had undergone occasional chiropractic care subsequent to those surgeries; however, his symptoms were now constant and severe and "different than anything he had experienced in the past, at least the recent past." (PX 3, p. 10/11) Petitioner had numbness and

weakness in his left leg associated with pain, but he denied any right leg pain. Dr. Gornet reviewed Petitioner's radiographs, including x-rays and the lumbar spine MRI. He performed a physical examination. Dr. Gornet's notes don't indicate a diagnosis; however, he discussed with Petitioner the whole concept of his disc herniation and opined that Petitioner's symptoms were causally connected to his work-related injury of February 21, 2014. Dr. Gornet recommended Petitioner be taken off work and that he continue chiropractic care and physical therapy for the next six weeks with a high dose of oral steroids. If Petitioner did not improve with oral steroids, Dr. Gornet recommended epidural steroid injections to the left L4/5 and L5/S1. (PX 3, pp.8-11)

Petitioner underwent chiropractic care and physical therapy with Dr. Eavenson from March 3, 2014, through his next visit with Dr. Gornet on April 21, 2014. (PX 1)

Petitioner then returned to see Dr. Gornet on April 21, 2014. Petitioner's main complaint was low back pain to the left buttock, hip and down his left leg. Petitioner advised that the oral steroids had helped his leg pain and he felt his back was improving with physical therapy. However, Petitioner still had low back, buttock, and hip pain. Due to Petitioner's improvements, Dr. Gornet recommended holding off on steroid injections and continuing six more weeks of physical therapy. Dr. Gornet recommended Petitioner stop chiropractic care and just do physical therapy. If Petitioner was not improved, then consideration would be given for steroid injections. Petitioner was released back to light duty work with a 10-pound lifting limit. (PX 3, p. 7/11)

Petitioner underwent physical therapy, including manipulation and chiropractic adjustments, from April 22, 2014, through his next visit with Dr. Gornet on June 26, 2014. (PX 1, pp. 134-190/236)

On June 26, 2014, Petitioner followed up with Dr. Gornet. Petitioner advised he was doing better with some therapy but as soon as he discontinued the therapy and adjustments, his pain returned. Petitioner complained of pain in his low back, left buttock, and left hip. Dr. Gornet recommended epidural and transforaminal steroid injections at L4/L5 and L5/S1 on the left to help with Petitioner's radiculopathy. Dr. Gornet again released Petitioner to work light duty and continued to feel Petitioner's symptoms and need for treatment were causally connected to his work injury. (PX 3, p. 6/11)

Petitioner contacted Dr. Eavenson's office on June 26, 2014 reporting that Dr. Gornet had put a "hold" on his therapy, pending his injections. (PX 1, p. 135/236)

Petitioner underwent a Section 12 examination on July 17, 2014, with Dr. Richard Lehman at Respondent's request. In conjunction with the examination Dr. Lehman was given records from Dr. Eavenson, Dr. Gornet, physical therapy, and the MRI scan of 2/25/14. Dr. Lehman issued a report after examining Petitioner. (RX 3) According to the

report Petitioner stated he worked for Respondent and was lifting heavy tires when he had pain and discomfort in his lumbar spine and back pain, which was significant. Petitioner complained of low back pain extending into his left calf with some numbness in his left foot. Petitioner had no right-sided radicular pain. Dr. Lehman noted Petitioner underwent two prior back surgeries, one in 1986 and another in 1997. Dr. Lehman also performed a physical examination and reviewed all of Petitioner's medical records, which he extensively outlined in his July 17, 2014, report. Dr. Lehman noted Petitioner was provided with chiropractic manipulation at each visit with Dr. Eavenson, despite Dr. Gornet's recommendation to stop chiropractic care. Dr. Lehman also reviewed Petitioner's pre-existing chiropractic records from Dr. David Thayer. Dr. Lehman noted that Petitioner was evaluated for low back pain complaints in February, 2012. Dr. Thayer's records revealed Petitioner had lumbar spine pain, low back pain, with pain extending down his left leg. Petitioner's symptoms were rated 10/10. Dr. Thayer noted that Petitioner's pain complaints in 2012 were due to a job related injury. Petitioner's pain intensity was severe and Petitioner had trouble looking after himself.

Dr. Lehman diagnosed Petitioner with a soft tissue lumbar strain of his low back and pre-existing degenerative changes in his herniated disc at the left L4/L5 vertebral level as a result of his February 21, 2014, accident. Dr. Lehman opined that Petitioner's subjective complaints were in concert with his objective findings. Dr. Lehman opined that Petitioner's symptoms were not related to his alleged incident on February 21, 2014. Dr. Lehman noted that Petitioner had a history of smoking for many years, as well as a pre-existing breakdown of his lumbar spine consistent with two previous surgeries and continued problems in 2012. Dr. Lehman noted that Petitioner's problems in 2012 were absolutely the same problems he identified from his February 21, 2014, incident. Dr. Lehman opined that Petitioner's treatment regime was not medically necessary as a result of the alleged incident on February 21, 2014, because Petitioner's problems appeared to be long term in nature with chronic changes in his lumbar spine and a long history of back issues. Therefore, Dr. Lehman opined that Petitioner's treatment regime was related to his long term breakdown, long term neuroforaminal stenosis, and chronic degenerative changes that pre-existed the February 21, 2014, injury. Dr. Lehman opined that Petitioner's continued treatment, diagnosis, and potential surgery were not related to the February 21, 2014, injury. Dr. Lehman noted that Petitioner had a breakdown in his lumbar spine for a long period of time, with continued degenerative changes and neuroforaminal stenosis that pre-existed the February 21, 2014, incident. Dr. Lehman opined there was no acute component as it related to Petitioner's neural entrapment or radicular leg pain. Dr. Lehman opined Petitioner reached maximum medical improvement approximately six weeks after the February 21, 2014, injury. Dr. Lehman opined Petitioner did require work restrictions of no lifting greater than thirty pounds with limitations on his full flexion and flexion rotation of his spine. However, Dr. Lehman

opined that Petitioner's necessity for work restrictions were not related to the alleged incident on February 21, 2014. Dr. Lehman felt Petitioner had what appeared to be significant long term degenerative changes that are chronic in nature and have been problematic in the past and, again, are the same problems that are problematic at this time. (RX 3)

Petitioner underwent an epidural steroid injection with Dr. Boutwell on July 21, 2014 and again on August 4, 2014. (PX 4, pp. 8-9)

Petitioner followed up with Dr. Gornet on August 21, 2014, bringing a copy of Dr. Lehman's report with him to the appointment. According to the doctor's notes, he disagreed with Dr. Lehman's opinion that Petitioner's current problem was due to a long-term breakdown of his back and bore no relationship to his work accident. Dr. Gornet focused on the fact that Petitioner had worked for Respondent for seven years, his job regularly involved lifting activities, and there was no indication whatsoever that Petitioner had an active problem with his back in the near term around the time of his injury. Thus, "any preexisting pathology in his back would be considered non-active." While Dr. Gornet agreed that Petitioner has preexisting disc pathology and some disc degeneration, he felt the question was whether or not Petitioner had "sufficient symptoms to warrant any treatment prior to his alleged accident in the near term." According to Dr. Gornet, there was no indication Petitioner had an active problem with his back on February 21, 2014 and Petitioner's previous low back surgeries had no relevance on his current symptoms, other than the fact that the previous surgeries weakened Petitioner's discs and disc mechanisms. Dr. Gornet opined that it was impossible for Petitioner to have an extruded disc fragment in his lumbar spine for ten years, even though he presumed Petitioner's lumbar discs were in a weakened state. Dr. Gornet opined that Petitioner sustained an aggravation of his pre-existing condition, as well as a new disc injury. Dr. Gornet did not believe Petitioner was a candidate for a lumbar spine fusion, as Petitioner had a multi-level problem. Therefore, Dr. Gornet recommended a revision decompression surgery at L4/L5 and L5/S1 on the left. Dr. Gornet opined that the recommended decompression surgery would alleviate Petitioner's stabbing pain in his left buttock and left leg, but it would not fix his back pain. Dr. Gornet opined he was unsure whether Petitioner's back pain could actually be fixed. Dr. Gornet recommended a CT myelogram prior to the recommended surgery. However, Dr. Gornet did not recommend any additional conservative care, including physical therapy or chiropractic treatment, at that time. (PX 3, p. 5/11)

Petitioner underwent continued chiropractic manipulation and physical therapy with Dr. Eavenson from September 8, 2014, through October 2, 2014. According to the September 8, 2014 visit (PX 1, p. 134/236) Petitioner had called Dr. Gornet regarding continuing with physical therapy until surgery was approved and Dr. Gornet told him he could. The

physical therapy and chiropractic records indicate that Petitioner underwent two lumbar epidural injections with Dr. Boutwell, but advised the injections did not help his pain. Petitioner also stated that while undergoing therapy, his symptoms and pain were greatly reduced and improving, and he was able to get through his activities of daily living. (PX 1, pp. 111 - 134/236)

Petitioner underwent a CT myelogram of his lumbar spine on October 6, 2014. The CT revealed multi-level degenerative disc disease and central canal stenosis primarily involving the L2/L3 and L3/L4 disc levels with a component of congenital central canal stenosis at these levels. There was also severe disc desiccation with a diffuse annular disc bulge at the L5/S1 level, with no central canal stenosis. The radiologist, Dr. Doucek, opined the disc bulge contributed to the left lateral recessed stenosis and encroached upon the exiting left S1 nerve root. (PX 2)

Petitioner followed up with Dr. Gornet on October 6, 2014. Dr. Gornet reviewed the CT myelogram, opining it revealed lateral recessed stenosis and foraminal stenosis at L4/L5 and L5/S1, particularly on the left. Dr. Gornet again opined that Petitioner aggravated his pre-existing stenosis, particularly on the left side, as a result of the February 21, 2014, alleged work injury. He also believed Petitioner had a disc injury at L4/L5 with an extruded fragment, which represented a new injury. (PX 3, p. 4/11)

Petitioner returned to Dr. Eavenson's office for chiropractic care from October 7, 2014, through November 10, 2014. (PX 1, pp. 79 - 110/236) Each record during that period indicates Petitioner underwent continued chiropractic manipulations and physical therapy for his lumbar spine. The record from November 10, 2014, notes that Petitioner cancelled his appointment for that date as he was seeing Dr. Gornet that day. He then called back after his appointment and stated that Dr. Gornet wanted him to hold off on therapy until he got his injections. (PX 1, p. 79/236)

Dr. Gornet testified by way of his evidence deposition on November 10, 2014. (PX 4) Dr. Gornet is a board certified orthopedic surgeon with a specialty in spine surgery. Dr. Gornet was first board certified in 1987. Dr. Gornet testified that Petitioner came under his care at the referral of Dr. Eavenson. His testimony regarding his examinations of Petitioner was consistent with his office notes. Dr. Gornet diagnosed Petitioner with a lumbar spine disc herniation with a free fragment. (PX 4, p. 6) Dr. Gornet opined that Petitioner's disc herniation and free fragment were causally related to his February 21, 2014, work accident. (PX 4, p. 6) He recommended high dose oral steroids, chiropractic care, and physical therapy. (PX 4, p. 7)

Dr. Gornet testified that when Petitioner did improve with physical therapy and chiropractic care, he discontinued the chiropractic care and recommended injections.

Petitioner underwent two epidural steroid injections, the first on July 21, 2014, and the second on August 4, 2014. (PX 4, pp. 7 - 9) Due to Petitioner's failure to improve after receiving injections, Dr. Gornet recommended a repeat decompression of Petitioner's lumbar spine at L4/L5 and L5/S1 on the left. (PX 4, pp. 9 - 10) Dr. Gornet opined that his recommendation for surgery was based on the consistency between Petitioner's objective findings on physical examination and the lumbar spine MRI and Petitioner's failure with non-operative, conservative care, and epidural injections. (PX 4, p. 10)

Dr. Gornet acknowledged that prior to the deposition Petitioner's attorney had him review some records from Dr. Thayer dated from October of 2009 through August 13, 2013. Dr. Gornet testified that the notes were consistent with what Petitioner had told him about his back condition when they first met. He further testified that the March 25, 2013 office visit noted pain in Petitioner's right buttock, right hip and right leg which was completely different than Petitioner's original pain presentation to him. (PX 4, pp. 10 - 12)

Dr. Gornet opined that Petitioner should continue his 10 pound restriction, essentially sedentary work, with no repetitive bending or lifting and alternate between sitting and standing as needed. (PX 4, p. 13) Dr. Gornet opined that Petitioner was not at maximum medical improvement but that he would reach maximum medical improvement after the recommended surgery and his symptoms plateaued. (PX 4, p. 13) During the deposition Petitioner's attorney stipulated that if Dr. Gornet didn't prescribe any "therapy, chiropractic therapy, after [4.21.14] he would stipulate that it wasn't reasonable or necessary. (PX 4, p. 14)

On cross-examination, Dr. Gornet acknowledged that if the event Petitioner described did not occur, he could not connect Petitioner's injury to it. (PX 4, pp. 15, 17) When asked whether someone can herniate a disc by sneezing, rolling over in bed, or almost any activity, Dr. Gornet opined that a disc can herniate if the disc is subjected to force that exceeds what it can handle. In the current claim, Dr. Gornet admitted Petitioner has pre-existing disc degeneration, known pre-existing back surgery, so presumably Petitioner's back was in a weakened state. Despite Petitioner's back being in a weakened state, Dr. Gornet opined there is no indication that simple activities of daily living would herniate Petitioner's lumbar disc. However, Dr. Gornet admitted that the history Petitioner gave him was that Petitioner lifted a tire, noticed a pop in his back, but did not have immediate or severe pain until he went home, went to bed, and woke up the next morning. Despite this history provided by Petitioner, Dr. Gornet opined it was impossible for Petitioner to suffer the disc pathology while he was sleeping overnight. Dr. Gornet opined that Petitioner's back condition would not have ultimately needed treatment but for the alleged February 21, 2104, accident despite Petitioner's weakened back condition and continued chiropractic treatment through 2013. Dr. Gornet stated that Petitioner had done well after his prior surgeries, other than what was reflected in the chiropractic notes, been able to

work for his employer for seven years, and there was no indication that his back was a ticking time bomb waiting to go off. (PX 4, pp. 15 - 19)

Petitioner resumed therapy and chiropractic treatment on November 11, 2014, and continued with it through January 26, 2015, when he again returned to see Dr. Gornet. (PX 1, pp. 7 - 78/236)

Dr. Lehman, Respondent's Section 12 examiner, testified by way of evidence deposition on November 12, 2014. (RX 2) Dr. Lehman is a board certified orthopedic surgeon with a specialty in sports medicine. Dr. Lehman was first board certified in 1988. Dr. Lehman testified he performed an independent medical examination of Petitioner on July 17, 2014. In preparation for that examination, Dr. Lehman reviewed extensive medical records regarding Petitioner's low back treatment from Dr. Eavenson, Dr. Gornet, Dr. Thayer, as well as all of Petitioner's diagnostic films. Dr. Lehman noted that prior to Petitioner's alleged February 21, 2014, accident, Petitioner was evaluated for low back pain and symptoms, specifically after Petitioner was sleeping and stated his back went out. On February 1, 2012, Petitioner woke up and had lower quadrant back pain and radicular pain down his left leg, indicating his pain was a 10/10. Dr. Lehman noted Petitioner had low back surgery in 1987 and a subsequent low back surgery in 1996. (RX 2, pp. 5-9)

After taking a history from Petitioner and performing a physical examination, Dr. Lehman diagnosed Petitioner with a herniated disc at L4/L5 with positive dermatomal signs at L5. Dr. Lehman opined that Petitioner's diagnosis was not related to the alleged February 21, 2014, accident. Dr. Lehman also opined that the alleged February 21, 2014, accident did not cause or aggravate Petitioner's disc pathology. Dr. Lehman explained that even if the February 21, 2014, accident occurred, he did not believe it was a cause or exacerbation of Petitioner's low back pain. Dr. Lehman explained that Petitioner had two previous low back surgeries, so Petitioner obviously had a lot of trouble with his back for a long period of time. Dr. Lehman noted that in 2012, where Petitioner's symptoms actually started in 2011, Petitioner had identical symptoms that were complained of in the current claim. Based on Petitioner's pre-existing problems, Dr. Lehman opined that Petitioner's symptoms were due to long-term degenerative changes consistent with stenosis and breakdown of his lumbar spine. Dr. Lehman explained this is consistent with the natural progression of degenerative changes in Petitioner's lumbar spine, including Petitioner's two prior nerve decompression surgeries. (RX 2, pp. 9 - 12)

When asked if his opinion on causation might change if the evidence showed that when Petitioner lifted the tire he noticed a pop in his back, finished his day, went home, went to sleep, and awoke with an intense and constant pain for the first time, Dr. Lehman responded, "No, sir." (RX 2, p. 12)Dr. Lehman opined that the pop Petitioner felt in his back on the date of the alleged accident was a soft tissue pop. Dr. Lehman explained that

if Petitioner suffered an acute herniated disc at the time he felt the pop, Petitioner would not have been able to go to sleep. Dr. Lehman opined that patients with acute herniated discs get transported to the emergency room because they are rendered immobile. Additionally, Dr. Lehman noted Petitioner had a well-documented history of having the same characteristics, same set of symptoms, and same radicular nerve pain prior to the alleged accident. Dr. Lehman further opined that someone with an acute herniated disc is in absolute agony, rendering them unable to walk, and unable to go to sleep. Dr. Lehman advised that a patient with an acute herniated disc is usually transported to the hospital and does not usually go home and see how it feels overnight. (RX 2, pp. 12 - 13, 23-25)

Dr. Lehman diagnosed Petitioner with a soft tissue strain as a result of the work accident. Dr. Lehman opined, within a reasonable degree of medical certainty, that Petitioner's low back strain would have resolved within four to six weeks of the alleged accident, or maybe even quicker. Dr. Lehman opined that Petitioner should have work restrictions and no lifting greater than 30 pounds with limitations to flexion and rotation of his spine. However, Dr. Lehman opined that Petitioner's restrictions were not related to the alleged February 21, 2014, accident. Dr. Lehman opined that the necessity for restrictions was related to Petitioner's long-term degenerative changes in his spine and Petitioner's herniated disc that was chronic. (RX 2, pp. 12 - 15)

On cross-examination, Dr. Lehman admitted that Petitioner's subjective complaints were in concert with his objective examination. (RX 2, p. 19) Dr. Lehman opined that Petitioner's lumbar spine MRI clearly showed arthritic and degenerative changes, including severe stenosis at the left lateral recess and hypertrophic changes at L4/5 and L5/S1. Dr. Lehman opined that radicular symptoms can wax and wane over time without any treatment. Dr. Lehman explained that when you have a herniated disc you have symptoms that can resolve, but frequently the symptoms become more problematic with things that are inconsequential, like brushing your teeth, or closing a car door. However, Dr. Lehman explained that even though the patient will associate their back pain with an inconsequential action, their pain is really just a matter of normal history of the disease process. (RX 2, pp. 19 - 25) Dr. Lehman admitted Petitioner was a surgical candidate, but the surgery was not related to the alleged February 21, 2014, accident. (RX 2, p. 23) Dr. Lehman explained that the natural history of the degenerative disc disease process progresses independently of any care or injury, so the degenerative disc disease hits a point of critical mass and the only answer is surgery due to the nerve root's inability to exit the neuroforamen. Dr. Lehman acknowledged that he no longer performs spine surgery, having stopped approximately fifteen years earlier. (RX 2, p. 17)

Dr. Lehman explained that in his experience, patients can have an acute herniated disc due to an innocuous event. Dr. Lehman explained that a patient can herniate a disc without having any trauma involved. If a patient has a bad disc or a bad neuroforamen, Dr.

Lehman opined that any mechanism, even as simple as bending over to tie your shoes, can cause a herniated disc. (RX 2, pp.26) Dr. Lehman acknowledged entering into an agreement with the Missouri State Board of Registration for the Healing Arts regarding a situation in which he acknowledged issuing a written report containing aspects of a physical examination which had not been conducted and for which he was reprimanded. (RX 2, pp. 25 - 28) Dr. Lehman acknowledged that he did not review any medical records from 2013. (RX 2, p. 30)

Petitioner was last seen by Dr. Gornet on January 26, 2015. Dr. Gornet noted that Petitioner's case was going to trial in early February and he would await a decision. In the interim, Dr. Gornet opined that Petitioner was able to work light duty with no lifting greater than ten pounds and no repetitive bending. Dr. Gornet still recommended an L4/L5 and L5/S1 left decompression surgery. (PX 3, pp. 1-3/11)

Petitioner continued to treat with Corey Voss and Dr. Eavenson from January 26, 2015 through February 2, 2015. On the 26th, he reported lower back stiffness in the morning. On the 27th he reported tightness in his lower back and otherwise feeling the same as the day before. Dr. Eavenson noted Petitioner was "Stiff as a board" on the 27th and his condition remained unchanged on January 29th. Motion was slightly better. Petitioner again reported back tightness to Mr. Voss. The last physical therapy and chiropractic record from February 2, 2015, notes that Petitioner had increased pain in his low back after he sat on his wife's couch to watch the Super Bowl. Petitioner could barely get up afterwards and had increased pain in his low back and left lower extremity. (PX 1)

At the arbitration hearing Petitioner testified that on February 21, 2014 he was employed by Respondent as one of two service advisors and his duties included checking customers in, preparing invoices, reviewing invoices with customers, and getting a technician to perform the work. He further testified that he occasionally helped the technician if needed. Petitioner's immediate supervisor/manager was Jason Evans.

Petitioner further testified that he had previously worked for Respondent between May of 2008 and October of 2008 at which point he was laid off. He was then called back to work for Respondent in February of 2009 and stayed there until around June of 2011. During that time he was a technician and he was also promoted to service advisor. Petitioner testified that he quit in June of 2011 to go and work for National Tire as a service manager.

Petitioner testified he was re-hired by Respondent in April, 2012, as a service advisor. Petitioner testified he continuously worked from April, 2012, until February 21, 2014, as a service advisor. Petitioner's typical duties as a service advisor were to check customers in, start invoices, review the invoice with the customer, and then have a technician perform the customer's work on their vehicle. Petitioner testified the technicians worked

under him, but sometimes he would help the technicians with physical work if they were backed up. Petitioner denied missing any work due to his lower back.

Petitioner testified that on February 21, 2014, he reported to work about 7:30 a.m. After lunch, he was helping change tires on a truck. Petitioner testified he took the tires off the truck and took them to the quick lane to dismount them and mount them on the wheels. Petitioner testified it was the second or third tire he was lifting on the tire machine when he felt a "pop, pop" in his lower back. According to Petitioner the tires weighed 150 to 180 pound each. The tires were on an F-250 diesel truck, which is a large pickup truck.

Petitioner further testified that at the time of the alleged accident, he did not feel any low back pain -- just the pops. Petitioner continued his job duties, including changing the tires. Petitioner testified the accident occurred between approximately 1:30 and 2:00 in the afternoon.

Petitioner testified that he did not report the injury on the date of the accident. Petitioner testified he did not feel any pain at the time of the accident and did not suspect he suffered an injury. Petitioner did add that about 4:15 p.m. he went to get a customer from uptown and as he got out of the truck he felt some stiffness in his back, but no knifing pain down his leg or anything like that. He further added that he was in shock over being fired at the end of day and really didn't even think to say anything to them. Petitioner explained that he was fired about 4:50 p.m. He believed that he was feeling some stiffness between the time of the accident and his termination.

After being terminated, Petitioner got into his car and drove to his residence in Edwardsville, Illinois, approximately 52 miles from Respondent's facility. Petitioner testified that he felt pretty stiff getting out of his car and he felt worse than he had after the incident. He did not have any leg pain at that time. Petitioner testified that after he woke up the next morning, he experienced a jabbing, knifing pain down his left leg and could hardly get up out of bed. He denied any pain down his right leg. Petitioner's left leg pain went all of the way into his calf and almost down to his ankle.

Petitioner acknowledged having back surgery in 1988 and returning to full duty work thereafter. He also recalled having low back surgery with Dr. Kennedy in 1996. Since then Petitioner described having some minor flare-ups "here and there" for which he would go to a chiropractor, Dr. Thayer. He also recalled seeing Dr. Reising in the late 1990's. Petitioner described the temporary "flare-ups" as some aches and pains and sometimes he couldn't stand straight up and would have to lean to the right or left. His last couple of visits had been for his right side. Petitioner denied missing any time from work due to his low back in the two years prior to his 2014 accident.

Petitioner acknowledged that his attorney referred him to Dr. Eavenson who, in turn, referred him to Dr. Gornet. Petitioner testified he tried to be as accurate as possible with the doctors. Dr. Gornet referred Petitioner to Dr. Boutwell for some injections which provided no relief. It is Petitioner's understanding that Dr. Gornet would like to perform surgery.

Petitioner testified he would like to proceed with the surgery recommendation from Dr. Gornet. Petitioner testified he wants to be able to lift normal weight again without continued pain. Petitioner's pain complaints at the time of arbitration were aches and pains, but he was no longer experiencing pain down to his left ankle. Petitioner testified he is able to drive for approximately an hour before his low back pain begins. Petitioner testified that the physical therapy really helps a lot.

Petitioner denied any injuries to his low back since February 21, 2014. Petitioner has not worked since February 21, 2014.

On cross-examination, Petitioner testified that after the alleged accident, he continued to work full duty for the rest of the day. Petitioner did not have any pain in his back that was preventing him from continuing his work or that was noticeable. He acknowledged that he was working by himself at the time of the accident and no one was around him. At the end of his work day on February 21, 2014, Petitioner met with his supervisor, Mike Garrison, and was terminated from work. Petitioner was terminated due to four customer complaints in one month. Petitioner agreed that when he met with Mr. Garrison, he did not say anything about the alleged accident.

Petitioner testified on cross-examination that his typical job duties with Respondent included checking in customers and doing whatever work was necessary to keep up with the flow through the shop, including changing tires and changing oil. However, Petitioner testified that the focus of his job was to check in customers versus doing any physical labor. He estimated that he changed tires everyday. Petitioner testified that if the technicians were not behind and did not need any additional help, then he would not do any physical labor. Petitioner also testified that his job with Respondent was more physical than his previous job with National Tire.

Petitioner admitted on cross-examination that he had a prior workers' compensation claim in 2012. He denied having any left leg symptoms after 1996.

On redirect examination Petitioner was asked if he would disagree with Dr. Thayer's records if they revealed some left leg complaints and Petitioner responded "Not at all."

Petitioner testified he reported the work accident on the following Monday, after being terminated on the previous Friday. Petitioner testified he was in emotional distress at the

time of his termination, but was in no physical distress, including any back pain. Petitioner testified that had he had physical back pain when he met with Mr. Garrison at the time of his termination on February 21, 2014, he would have advised Mr. Garrison of the work injury at that time.

Gary Michael Garrison testified on behalf of Respondent. Mr. Garrsion is the general manager for Respondent. Mr. Garrison's duties as a general manager included managing all employees in the business. Mr. Garrison does all of the hiring and terminations for the company. Mr. Garrison testified that work accidents are usually reported to him.

According to Mr. Garrison, Petitioner worked for Respondent on and off from 2007 until 2014 and was terminated on two occasions while working for Respondent. The first occasion was when Petitioner was terminated for striking/laying hands on another individual. Petitioner was rehired in 2012 and subsequently terminated on February 21, 2014, at which time Petitioner was terminated for customer complaints.

Mr. Garrison testified that he terminated Petitioner on Friday, February 21, 2014. Mr. Garrison personally met with Petitioner to terminate Petitioner for cause. At the time of their meeting, Petitioner did not advise Mr. Garrison of any work accident. Mr. Garrison testified it was not until after Petitioner was terminated that Petitioner first mentioned a work accident -- doing so as he walked out the door. Mr. Garrison did not have any knowledge of how the accident occurred, what time of day the accident occurred, or what injury Petitioner was alleging was caused by the alleged work accident at that time.

Mr. Garrison testified Petitioner was a service advisor/writer. According to Mr. Garrison's testimony, Petitioner's typical duties included explaining car problems to the customers and having a technician work on those problems. Petitioner also sold different products and different services to customers. Mr. Garrison testified Petitioner was not required to do any physical labor as a service writer. Mr. Garrison testified that his only knowledge of Petitioner's accident he had was from other employees who stated Petitioner was lifting a tire.

On cross-examination, Mr. Garrison testified that he did not recall Petitioner working for Respondent in May of 2008 and being laid off in October of 2008. All he could remember were the two occasions he had previously testified about.

Mr. Garrison testified that he is in charge of both service and sales, but he spends very little daily time supervising the service workers. Mr. Garrison testified there is a service manager that watches over the service workers. Mr. Garrison testified that in his twenty year career with Respondent, he has never seen a service advisor doing any physical labor with Respondent, including changing tires. Mr. Garrison admitted Respondent routinely does work on the owners' family's cars. Specifically, if the owners' son wanted work

done on his car, he would probably go directly to the service advisor to have work done rather than going to the general manager. Mr. Garrison testified that the owner's son typically drives demo cars, including pickup trucks and larger vehicles. Mr. Garrison testified that Respondent does not have a progressive system of discipline, including written warnings. Mr. Garrison testified that he did not think Petitioner had any idea he was being terminated on February 21, 2014, at the time of their meeting. He could not recall if Petitioner appeared shocked by his termination. He reiterated that Petitioner told him he was hurt as he left. Mr. Garrison did not recall receiving a call from Petitioner the next day to tell him he was hurt.

On redirect examination Mr. Garrison acknowledged that Petitioner may have begun working for Respondent in 2007.

Petitioner was called to testify in rebuttal. Petitioner testified that he worked for Respondent three times and he was completely unaware he was being terminated when he went to work the morning of February 21st. He did not recall telling Mr. Garrison that same day that he was injured but then added that he might have said something on the way out but he was in so much distress that he didn't remember if he did or not. He did recall calling him on Monday and letting him know. Petitioner thought he would see Mr. Garrison once or twice a week for maybe 30 - 45 minutes.

On cross-examination Petitioner again testified that he didn't recall telling Mr. Garrison anything as he walked out the door but he wasn't having any physical back pain at that time.

The Arbitrator concludes:

Issue (C): "Did an accident occur that arose out of an in the course of Petitioner's employment by Respondent?"

Petitioner failed to prove he sustained an accident on February 21, 2014 that arose out of and in the course of his employment with Respondent. In so concluding, the Arbitrator relies heavily upon Petitioner's lack of credibility and questionable motivation.

Liability in this instance hinges on Petitioner's credibility. A claimant's testimony alone may not suffice to prove an accident occurred when that testimony is not credible. Petitioner's alleged injury was not witnessed and was not mentioned to Respondent until after he was terminated. Thus, for liability to be established, Petitioner must be deemed a credible and believable witness. The Arbitrator is unable to reach that conclusion. In support thereof, she notes the following.

Of great significance to this Arbitrator are the striking similarities between Petitioner's prior low back injuries/complaints and his complaints/account of the accident herein. In 2006 Petitioner sought medical attention for low back pain that was aggravated after lifting a tire at work. Petitioner, as here, had gone home and a couple of days later noticed pain so severe, he could hardly get out of bed. In 2009 Petitioner sought treatment for lower back pain with radiating left leg pain that had begun a couple of weeks earlier with heavy lifting. Petitioner's pain level was "8/10" and his symptoms included numbness in his left foot. On February 1, 2012 when Petitioner again went to Dr. Thayer, he completed a Confidential Patient Data Sheet. At that time Petitioner indicated he was lifting tires and hurt his arm but was relating his low back pain to the cast on his arm. He described his lower back pain as "10/10" with sharp pain radiating down his left leg. His symptoms were noted to be worse in the morning and aggravated by "just about anything." He acknowledged having similar symptoms "after lifting heavy stuff." His pain was described as fairly severe, it was painful to look after himself, and he was slow and careful in his actions. Petitioner acknowledged he could only lift very light weights, could hardly perform any work at all, could not drive his car as long as he desired due to moderate back pain, and had moderate sleep disruption. Petitioner also stated his back pain was interfering with his ability to engage in recreational activities nor could he walk more than a mile or sit for more than an hour due to pain. These prior accidents and records suggest similarity in the mechanism of injury and far more problems with Petitioner's low back and left leg than he alluded to in his testimony.

Petitioner testified that he lost no time from work in the two years before his alleged accident. However, he never testified to the absence of lower back pain and/or left leg complaints. Additionally, Petitioner's recollection of his prior condition was not altogether accurate. He testified that he might have seen a chiropractor maybe eight times before his alleged accident. Based upon the records, it was more frequent than that and the nature of the symptoms and complaints was more serious than the "minor flare-ups here and there" which Petitioner testified to. Also, on direct examination Petitioner denied having any left leg complaints/symptoms after 1996 and it was only after his attorney asked him about Dr. Thayer's records and possible notations of left leg complaints, that Petitioner changed his testimony. In the end, the Arbitrator views Petitioner's testimony as an attempt to downplay the true nature of his back and left leg symptoms before his alleged accident. His records speak for themselves and contradict his testimony.

Petitioner testified to (and the medical records corroborate) that he felt a "pop/pop" in his back when lifting a tire but no other symptoms. At his hearing, however, he also attempted to insinuate that something was going on with his back after the alleged accident because he noticed stiffness as the day progressed and when getting out of a truck after picking up a customer. Yet, Petitioner only mentioned stiffness and soreness at the end of the day to

which he told his wife he was probably going to need to see a doctor. Petitioner could have had his wife testify to corroborate his condition the evening of the alleged accident; however, he did not.

It is also troubling in this particular case that before seeking any medical treatment for the alleged injury Petitioner went to an attorney and then initiated treatment with the doctor his attorney referred him to.

While there is some disagreement between the parties as to when Petitioner first mentioned his accident to Respondent, both parties agree it occurred after Petitioner's termination. Either it occurred on the way out the door on the evening of the 21st or it occurred on Monday, the 24th. Setting aside why Petitioner would tell Dr. Gornet he reported his accident on Monday when he returned to work after being fired on Friday, notice was not disputed. Either way, what is significant is that the alleged accident was not mentioned until after the termination and after Petitioner had completed his day's activities, which included finishing up on changing the tire that allegedly hurt his back. Petitioner remained physically active at work after the alleged accident and denied experience any pain complaints in his back or left leg.

It is also noted that Petitioner has several prior workers' compensation claims ranging from 1991 to 2012. Petitioner had at least one other prior incident of lifting a tire, awakening with low back pain and being hardly able to get out of bed, and injuring his low back. Petitioner's prior work accidents and symptoms, so similar to that of the current alleged accident, suggest that Petitioner is familiar with the workers' compensation system and compensability of work accidents.

Petitioner's credibility is further called into question after reviewing Dr. Gornet's records and deposition and the records of Dr. Eavenson/Corey Voss. On June 26, 2014 Petitioner contacted Dr. Eavenson's office advising that Dr. Gorent had discontinued physical therapy pending Petitioner's injections. Petitioner again contacted Dr. Eavenson's office on September 8, 2014 stating that Dr. Gornet, via telephone, had authorized physical therapy again. Dr. Gornet's testimony and office notes do not corroborate those representations of Petitioner. Petitioner then cancelled his appointment with Corey Voss on November 10, 2014 indicating that he was seeing Dr. Gornet that same day. Petitioner later called back to Mr. Voss "after his appointment" stating that the doctor wanted him to hold off on therapy until he got his injection. (PX 1, p. 79/236) First, Petitioner was not seen by Dr. Gornet on November 10, 2014. That was only the date of Dr. Gornet's deposition. Second, Dr. Gornet did not testify concerning any additional injections being recommended. Dr. Gornet did not testify on November 10, 2014 that Petitioner was to hold off on therapy until after another injection. Again, there is no corroboration for Petitioner's statements.

Additionally, Petitioner testified that he quit working for Respondent in June of 2011 of his own accord. However, Mike Garrison from the Respondent testified Petitioner was actually terminated in June of 2011 for striking another person. Petitioner never refuted this. Petitioner's testimony that he quit when, in reality, he was fired, is detrimental to his credibility.

Issue (F): "Is Petitioner's current condition of ill-being causally related to the injury?"

Even, assuming arguendo, that Petitioner did sustain an accident that arose out of and in the course of his employment with Respondent on February 21, 2014, Petitioner failed to prove that his current condition of ill-being in his low back is causally related to that accident.

Petitioner admitted at arbitration that he did not have any pain at the time of the February 21, 2014, work accident. Petitioner testified that his pain did not occur until he woke up the next morning, at which time his pain was severe. The medical records that pre-existed the February 21, 2014, work accident indicate that Petitioner had prior incidents of low back pain after getting out of bed. Additionally, Petitioner had pre-existing symptoms prior to the work accident on February 21, 2014, that were the same as after the February 21, 2014, accident. Specifically, in 2011-2012, Petitioner was evaluated by Dr. Thayer for low back pain that extended into his left leg. Petitioner also saw Dr. Thayer in August of 2013 for low back pain without mention of either leg.

Dr. Gornet testified that he reviewed Petitioner's pre-existing records from Dr. Thayer, but opined that the pre-existing records were irrelevant as Petitioner's symptoms were down his right leg instead of his left leg. Dr. Gornet focused on the March 2013 visit with Dr. Thayer since it addressed Petitioner's right leg rather than discussing the totality of the other records -- simply stating that they were consistent with what Petitioner had initially told him. However, to this Arbitrator, Petitioner was no more forthright with Dr. Gornet than he was before her at the hearing concerning the nature, severity, and longevity of his back and left leg/foot problems. Dr. Gornet based his causation opinions on the fact that Petitioner's prior symptoms were different and not the same as his symptoms under the current claim. However, it is clear from reading the pre-existing records that Petitioner did have the same low back symptoms up through at least August of 2013 as he did after the February 21, 2014, accident and he had very similar complaints in February of 2012, including the left leg complaints.

Dr. Lehman adequately outlined the existing records in both his July 17, 2014, report, as well as his evidence deposition taken in November of 2014. Dr. Lehman noted that Petitioner's low back pain and radicular symptoms into his left leg pre-existed the alleged

work accident on February 21, 2014, which were the same symptoms Petitioner experienced after the alleged accident on February 21, 2014. Dr. Lehman also noted Petitioner's back was in a weakened state due to his chronic, long-standing problems that have extended over 25 to 30 years. Dr. Lehman opined that due to Petitioner's long-standing, continuous low back problems that caused Petitioner's back to be in a weakened condition, Petitioner's low back condition was not only continuous over time due to the natural progression of his degenerative condition, but also could be aggravated by any inconsequential event without any trauma. Based on Dr. Lehman's review of Petitioner's pre-existing records, as well as Dr. Lehman's extensive explanation of the degenerative process in Petitioner's weakened lumbar spine, Dr. Lehman's opinions are felt to be more persuasive than those of Dr. Gornet. That Dr. Lehman did not review the 2031 Thayer records doesn't diminish his opinions given the more significant weight of the other pre-existing records. That there was additional treatment in 2013 for Petitioner's lower back further strengthens Dr. Lehman's opinions.

Dr. Gornet admitted that Petitioner's back was in a weakened state, but opined it was impossible for Petitioner's back to become painful without an inciting trauma. Despite noting that Petitioner's back was in a weakened condition and Petitioner had degenerative changes throughout his spine, Dr. Gornet believed Petitioner suffered an acute injury. Dr. Gornet's opinions are not supported by the evidence as the only evidence of an acute injury rests solely on Petitioner's credibility. Additionally, as Dr. Lehman testified, if Petitioner suffered an acute disc fragment and herniated disc, he would have been in severe pain immediately. However, Petitioner admitted he was not in immediate pain after the accident. Petitioner admitted it was only after he went to bed and woke up the next morning that pain was severe and he could not get out of bed. Based on these facts, Dr. Lehman's opinion is more persuasive than Dr. Gornet's as Dr. Lehman's opinion considers Petitioner's complete low back history and treatment, as well as the onset of Petitioner's symptoms.

Issue (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 charges?"

As indicated above, Petitioner failed to prove a compensable work accident that arose out of and in the course of his employment. Additionally, notwithstanding the accident, Petitioner failed to prove his current condition of ill-being is causally related to the work accident. Therefore, the issue of medical bills is moot.

In support of the Arbitrator's Decision relating to (K): "Is Petitioner entitled to any prospective medical care?"

As indicated above, Petitioner failed to prove a compensable work accident that arose out of and in the course of his employment. Additionally, notwithstanding the accident, Petitioner failed to prove his current condition of ill-being is causally related to the work accident. Petitioner's claim for any and all prospective medical care is denied.

In support of the Arbitrator's Decision relating to (L): "What temporary benefits are in dispute?"

As indicated above, Petitioner failed to prove a compensable work accident that arose out of and in the course of his employment. Additionally, notwithstanding the accident, Petitioner failed to prove his current condition of ill-being is causally related to the work accident. Petitioner's claim for any and all temporary total disability benefits is denied.

****

STATE OF ILLINOIS	)	☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF ADAMS	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cynthia Gernenz,

Petitioner,

vs.

NO: 14 WC 18544

16IWCC0208

Brickford Of Champaign,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, causal connection, medical, prospective medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 10, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

16IWCC0208

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 3 2016
o031016
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

GERNENZ, CYNTHIA
Employee/Petitioner

Case# 14WC018544

16IWCC0208

BRICKFORD OF CHAMPAIGN
Employer/Respondent

On 7/10/2015, 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 0.08% 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:

0874 FREDERICK & HAGLE
PATRICK J HANLON
129 W MAIN ST
URBANA, IL 61801

2965 KEEFE CAMPBELL BIERY & ASSOC
LINDSAY R VANDERFORD
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

16IWCC0208

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

RECEIVED

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CYNTHIA GERNENZ
Employee/Petitioner

Case # 14 WC 18544

v.

Consolidated cases: _____

BICKFORD OF CHAMPAIGN
Employer/Respondent

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 Molly Dearing**, Arbitrator of the Commission, in the city of **Quincy**, on **May 6, 2015**. 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **January 17, 2014**, 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 not* causally related to the accident.

In the year preceding the injury, Petitioner earned **$5,762.08**; the average weekly wage was **$360.13**.

On the date of accident, Petitioner was **48** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$4,160.37** for advances of permanent partial disability benefits that have been paid, for a total credit of **$4,160.37**.

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

ORDER

Respondent shall pay all reasonable and necessary medical services for dates of service from January 17, 2014, to January 30, 2014 relative to Petitioner's left and right knees, as provided in Sections 8(a) and 8.2 of the Act, and subject to the fee schedule. All medical bills incurred subsequent to January 30, 2014 are denied as unrelated to Petitioner's work accident. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Temporary total disability benefits and prospective medical treatment are denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for temporary or permanent disability, if any.

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.

Arbitrator Molly Dearing

July 3, 2015
Date

JUL 10 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CYNTHIA GERNENZ
Employee/Petitioner

v. Case # 14 WC 18544

BICKFORD OF CHAMPAIGN
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On her date of accident, Petitioner was forty-eight years of age. Arb. X 1. She was employed by Respondent as a certified nursing assistant and she had been so employed since September 2013. Petitioner has been licensed as a certified nursing assistant for seven years. As a certified nursing assistant, Petitioner's job duties included bathing, dressing, moving, and feeding elderly residents and residents with Alzheimer's disease. Petitioner testified that she cared for seven patients on a daily basis while employed by Respondent.

Petitioner testified that on January 17, 2014 at approximately 9:00 a.m., she put a resident to bed and as she turned around to exit the room, she tripped over a bed alarm cord. Petitioner fell forward onto the floor of the resident's room, which she described as thin carpeting overlaying a concrete surface, and her knees contacted the ground. Petitioner testified that she felt sharp pain in both of her knees following the fall and "for a few days" had difficulty walking due to pain in her left knee. Petitioner completed her shift at 2:30 p.m. She notified her supervisor, Karen Olivera, of her fall, and an accident report was completed approximately one week thereafter.

On January 23, 2014, Petitioner presented to Dr. David Zeman upon referral from her primary care physician, Dr. Swearingen. Dr. Zeman's records indicate bilateral knee pain with "[n]o known trauma." "She denied any history of injury involving either of her knees. She did state that she has a very strong family history of osteoarthritis with at least one family member needing knee replacements by the age of 40…She did trip over a cord last week, although she did not sense any injury of either knee. She has been having a lot more pain since then." Petitioner reported clicking, popping, buckling, giving way, catching, locking pain on pivoting, and some swelling. A physical examination revealed a positive patellofemoral compression test on the left knee but not the right, no tenderness to manual pressure anywhere on the knee, range of motion from two degrees of hyperextension to one hundred twenty degrees of flexion bilaterally with increased pain at the end point of flexion, positive Apley's test on the left, but negative McMurray's, pivot shift, and posterior sag tests. Petitioner's knees were stable on varus, valus and anterior and posterior stressing with no visible swelling. X-rays of the knees revealed mild degenerative changes involving the medial tibiofemoral compartments bilaterally, though no radiographic evidence of an acute displaced osseous fracture or dislocation of the left or right knees. Dr. Zeman's impression was osteoarthritis bilaterally, though he noted that "[t]his is not clearly the source of her symptoms." He instead opined that Petitioner was suffering from patellofemoral pain that accounted for most of her

symptoms. Dr. Zeman recommended an MRI. An MRI of the left knee of January 27, 2014 revealed "[n]o convincing findings of meniscal tears", degenerative changes including significant cartilage loss involving the medial femoral condyle with joint space narrowing. PX 2. Petitioner testified that Dr. Zeman's notation of January 23, 2014, in which Petitioner denied any history of injury involving her knees and indicated a strong family history of osteoarthritis, was inaccurate.

On January 29, 2014, Petitioner returned to Dr. Zeman and reported "not currently [experiencing] any pain in her left knee. The pain intensified after an incident around January 17, 2014, and has been subsiding ever since. At this point, she feels that she is able to perform all of her work duties and other functions as needed without any other treatment." Petitioner rated her pain as a zero on a ten-point scale, but stated that she had a pain of a level two in her lower leg. Dr. Zeman's assessment was mild degenerative changes likely stable without any sign of internal derangement. He released her to return on an as needed basis with a trial of anti-inflammatory medication. PX 2, RX 1. Petitioner testified that Dr. Zeman's January 29, 2014 record, which reflects that she denied experiencing any pain at that time in her left knee, that she was able to perform all of the functions of her job, and did not require any follow-up examinations, was incorrect, and she testified that she suffered persistent pain in both knees following her work accident of January 17, 2014.

On February 20, 2014, Petitioner returned to Dr. Zeman and reported continued difficulties with her knees more so on the right than the left. She had "successfully" returned to work and reported managing to function in spite of her symptoms. After reviewing Petitioner's MRI, Dr. Zeman's opined that Petitioner suffered from patellofemoral symptoms, "possibly with limited progress due to the noncompliance." Dr. Zeman encouraged her to add weight to isometric quadriceps exercises and continue the use of Ibuprofen. PX 2.

On March 6, 2014, Petitioner presented to Dr. Zeman and complained of significantly worsened pain in both knees with her right knee being more painful than her left. She reported working eight consecutive days that she believed contributed to the intensification of her pain. Dr. Zeman recommended Synvisc injections and Depo-Medrol injections, and an MRI of the right knee. PX 2.

An MRI of the right knee of March 13, 2014 revealed a tear of the posterior root ligament attachment side of the medial meniscus with mild extrusion of the meniscus from the joint space, multifocal areas of cartilage loss most notably involving the medial femoral condyle and medial tibial plateau with significant reactive marrow edema, and moderate joint effusion. PX 2.

On April 8, 2014, Petitioner presented to Dr. Robert Gurtler for problems with her right knee upon referral by Dr. Zeman. Petitioner reported bilateral knee pain after falling at work on January 20, 2014, which she stated remained at a level of seven on a ten-point scale. She indicated she experienced "a little bit of pain" beginning on November 1, 2013, but reported increased and continued pain in her knees since her work accident. A physical examination revealed positive effusion, positive medial joint line tenderness, and positive McMurray's on the right knee. Dr. Gurtler noted that Petitioner "has every sign of a medial meniscus tear" and he recommended a right knee arthroscopic medial meniscectomy. PX 2. Dr. Gurtler completed a Carle Illness/Injury Report on April 8, 2014, at which time he placed work restrictions on Petitioner of no standing or sitting longer than fifteen minutes. PX 2, RX 5. Petitioner testified that Dr. Gurtler indicated an incorrect date of injury on that Report, and that she effectuated a correction on the face of the form

to reflect the accurate date of accident of January 17, 2014.

A right knee MRI of August 15, 2014 revealed a tear within the posterior root of the medial meniscus with associated medial meniscal extrusion, severe chondromalacia in the medial compartment with a small amount of associated subchondral marrow space edema, mild chondromalacia in the patellofemoral compartment, and moderate-sized knee joint effusion with findings unchanged since March 13, 2014. A left knee MRI of August 15, 2014 revealed extrusion of the medial meniscus worsened since the prior study dated January 27, 2014, a tear of the posterior meniscal root not seen on the prior study, severe chondromalacia in the medial compartment with full-thickness cartilage loss along the weight bearing surface and associated subchondral marrow space edema that "has developed since 1/27/2014", moderate sized joint effusion and moderate chondromalacia in the patellofemoral compartment. PX 2.

On September 15, 2014, Petitioner underwent bilateral arthroscopic medial meniscectomies with Dr. Gurtler, and she returned to him thereafter for post-operative care.

On January 15, 2015, Petitioner presented to Dr. Gurtler and complained of feeling "miserable" in both her left and right knees. "She can hardly walk. The pain level has markedly increased, especially since October." Petitioner presented with marked varus deformity in both knees, and walked with an antalgic limp on both sides. Her pain was increased by initiation of any activities. Dr. Gurtler noted that Petitioner had exhausted conservative treatment and he recommended bilateral total knee replacements to increase her functionality. PX 2.

Petitioner testified that she continues to experience swelling in both knees that has been present since her work accident. Petitioner testified that she worked for Respondent from the fall of January 17, 2014 until the end of March 2014. Thereafter, she obtained alternate employment as a certified nursing assistant with Champaign-Urbana Rehab, which involved lighter duty work. Petitioner testified that she separated from that employment after five days on April 3, 2014 because the pain in her knees was too severe to continue in that position. Petitioner testified that she has not been able to return to work since that time. Petitioner testified that she remains under the care of Dr. Gurtler, whom she stated has placed work restrictions on her that prevent her from returning to her capacity as a certified nursing assistant.

Petitioner testified to experiencing symptomatology and undergoing treatment to her bilateral knees prior to her work accident on January 17, 2014. She testified that "[i]t wasn't really pain" she experienced in her knees prior to her work accident, but rather achiness, "[j]ust enough to notice that it just felt achy." Since her fall, however, she testified that she has "always had pain...." Petitioner denied requiring specific treatment or experiencing any swelling, locking, pain on pivoting or catching in her knees prior to her work accident, but testified that such symptomatology was present persistently since her accident of January 17, 2014. Petitioner stated that since that time, one knee is generally more painful than the other, and that Dr. Zeman and Dr. Gurtler encouraged her to focus on which knee was more problematic on the dates of her treatment visits.

Petitioner's treating medical records from dates of service prior to her work accident of January 17, 2014 were admitted into evidence. On December 18, 2012, Petitioner presented to Dr. Swearingen and complained of right shoulder and left knee discomfort "that by history and examination is suggestive of underlying degenerative disease. There is a strong family history of degenerative arthritis she states. Examination does not suggest active inflammatory disease." X-rays

of the left knee were ordered. RX 1. On April 23, 2013, Petitioner presented to Dr. Swearingen with complaints of periodic low back discomfort and increasing achiness in her right knee, particularly with stair climbing. "She notes that both of her parents have had arthritic problems that required joint replacements." Petitioner was advised to return if her problems persisted. RX 1. On November 1, 2013, Petitioner presented to Dr. Swearingen and reported right knee discomfort with a dull aching sensation and stiffness and soreness after inactivity. "Glucosamine used over the last year does not seem to have made much difference." Petitioner denied swelling or locking, but reported occasionally giving way. She reported a history of "[m]ultiple family members with knee arthritis and having had knee joint replacements." Dr. Swearingen ordered a right knee x-ray, and modalities of treatment, including over-the-counter medications, physical therapy, bracing, steroid injections, and orthopedic consultation, were discussed. RX 1.

On December 30, 2013, Petitioner returned to Dr. Swearingen and complained of a "chronic achy discomfort in both distal thighs that radiates into the lower legs. This seems to emanate from her knees posteriorly. Her discomfort is worsened with flexion of her knees. She also notes occasional sharp pains in the back of the right knee. No recent trauma or change in activities. Family history positive for early degenerative joint disease. Right knee x-ray suggested early degenerative joint disease." Dr. Swearingen ordered a CBC, sedimentation rate, CRP and rheumatoid factor test for concerns regarding inflammatory arthritis. Petitioner was to be contacted with the results and an orthopedic consult was suggested as a treatment option. RX 1.

Petitioner testified regarding her family history of knee difficulties. Specifically, she stated that her sister underwent surgical intervention to her bilateral knees, though she was unaware of the type of procedure or the condition that necessitated the procedure due to their estranged relationship. Petitioner testified that she has not spoken to her sister in over twenty years and learned of her sister's surgery from her Godmother. Petitioner also testified that her father had a unilateral total knee replacement at seventy-three years of age resultant from a fall one year prior. Petitioner testified that her mother also underwent a unilateral total knee replacement at seventy-eight years of age precipitated by a fall. Petitioner testified that her parents had not undergone any knee procedures prior to their respective total knee replacement procedures. She remains in contact with her parents and testified that she is very familiar with their medical histories. Petitioner denied that her parents had knee difficulties prior to their individual accidents, and she stated that she is unaware of any family history involving osteoarthritis of the knees or other surgical procedures.

Petitioner's Facebook post of May 16, 2014 was admitted into evidence. Therein, Petitioner posted a flyer regarding Plexus Slim, which Petitioner described as a weight loss system, that solicits "Ambassador[s]" and encourages individuals to "[j]oin my team" in which one can "buy your products at wholesale and help others as you get healthy and gain income...." Petitioner commented in her Facebook post of May 16, 2014, "[c]ome see me! I will have a Plexus Booth at the CU Sunday Market. It is at the Fluid Center in Champaign from 8 to 4. Come find out what Plexus can do for you! It is not just about weight loss. Plexus offers you many health benefits. Looking forward to seeing you!!!" Petitioner testified on cross examination that she could not recall whether she was present at the CU Sunday Market on May 18, 2014, though on re-direct examination, Petitioner acknowledged that she attended the CU Sunday Market that day with a friend to assist her in selling Plexus Slim.

Dr. Robert Gurtler testified by way of evidence deposition on March 5, 2015. Dr. Gurtler is a board-certified orthopedic surgeon and is the Chairman of the Orthopedics and Sports Medicine

Department at Carle Physician Group. He has been an orthopedic surgeon for thirty years. Dr. Gurtler testified that he diagnosed Petitioner with bilateral medial meniscus tears upon his initial evaluation on April 8, 2014. Dr. Gurtler described the menisci as "weight distributors or cushions and loss of that cushion is directly related to increasing arthritis." Dr. Gurtler recommended Petitioner undergo bilateral arthroscopic surgical procedures, which he performed on September 15, 2014, and he testified that intraoperatively, he found bare bone lesions in the medial compartment indicative of advanced arthritic changes as well as torn medial meniscus in both knees. Dr. Gurtler opined that, based upon Petitioner's history that her pain began on her date of accident, her bilateral meniscal tears were caused by the direct fall onto both knees during her work accident, and that the meniscal tears in turn exacerbated her underlying arthritic condition and accelerated the need for total knee replacements. Dr. Gurtler testified that, although direct trauma is not a common cause of a torn medical meniscus, "[i]t can" occur. PX 1. Dr. Gurtler testified that Petitioner had preexisting arthritis before the fall while employed with Respondent, and acknowledged that Petitioner may have experienced knee pain prior to the fall, but nonetheless opined that Petitioner's meniscal tears and subsequent loss of function of the menisci accelerated her arthritic process. Dr. Gurtler explained that symptoms caused by a torn medial meniscus are not static, but instead tend to wax and wane depending on activity level. Dr. Gurtler testified that he was "pretty sure" he did not review the records of Dr. Zeman of January 23, 2014 or January 29, 2014, and he testified he did not review any records of Dr. Swearingen. Dr. Gurtler testified that he would not recommend that Petitioner return to work as a certified nursing assistant in a nursing home setting after undergoing total knee replacements, as she would need to avoid such heavy physical labor after those procedures. Dr. Gurtler testified that he restricted Petitioner from work as a certified nursing assistant from April 8, 2014 to the present. PX 1.

Petitioner underwent an examination with Dr. Michael Nogalski pursuant to Section 12 of the Act on June 17, 2014 and he testified by way of evidence deposition on March 9, 2015. Dr. Nogalski is board certified in orthopedic surgery and he testified that he predominantly treats patients with knee and shoulder conditions. On June 17, 2014, Petitioner reported to Dr. Nogalski that she tripped over a bed alarm cord on January 17, 2014 as she walked out of a patient's room and fell face down with her arms in front of her. She believed she fell more on her knees than on her hands. Petitioner reported that she completed her shift and began to experience pain and swelling in her right knee that evening. Petitioner denied currently experiencing pain in her left knee, but indicated that it aches. She noted a present burning sensation in her right knee and pain inside and in the back of the right knee. Petitioner complained of difficulty placing weight on the right knee and reported that her pain is exacerbated by walking. Petitioner denied experiencing any previous problems in either knee prior to January 17, 2014. After conducting a physical examination of Petitioner and reviewing her imaging studies and medical records, Dr. Nogalski's impression was bilateral knee pain without clear mechanical findings unrelated to Petitioner's work accident and he diagnosed her with osteoarthritis. Dr. Nogalski opined that Petitioner's bilateral meniscal tears were not caused by Petitioner's work accident and instead resulted from her osteoarthritic condition. He explained that Petitioner's imaging studies revealed that "the meniscus was extruding. So that means that there's enough chondrosis and wear and tear that the meniscus is actually being pushed out because there's wear and tear on the joint. So there are other findings on tests, so to speak, that could support a chronic tear, or a whole tear, versus a new one." Dr. Nogalski testified that Petitioner's reported mechanism of injury of falling directly onto her knees did not correlate with a meniscal tear and was instead more consistent with a diagnosis of a contusion. He opined that Petitioner's work accident of January 17, 2014 temporarily aggravated her preexisting osteoarthritic condition that returned to a baseline condition and for which she was at maximum medical

improvement as of January 30, 2014, and he relied upon Dr. Zeman's note of January 29, 2014, which indicated that Petitioner was able to perform her job duties, did not require any scheduled follow-up treatment, and was without any clinical indication of significant issues that warranted further treatment. Dr. Nogalski testified that, "[t]here wasn't a solid history, or really a history around the time of the claimed event, which supported an injury to the knees. There was a second visit that suggested that in retrospect. But her history, as provided by Dr. Zeman, as well as the MRI findings and my clinical evaluation, all supported an osteoarthritic condition in both knees. I did not believe that the osteoarthritis was related to the 1-17-14 event." RX 2.

Dr. Nogalski testified that symptomatology indicative of a medial meniscus tear include pain, swelling and catching or locking of the knee, and that positive examination findings for same include joint line tenderness as well as mechanical symptoms, such as clicking, popping, locking or pain with rotation. Dr. Nogalski acknowledged that he did not review the MRI films of August 15, 2014 or MRI reports regarding the findings of same. Dr. Nogalski also performed an impairment rating in accordance with AMA Guide to Evaluation for Permanent Impairment, Sixth Edition, and he opined that Petitioner sustained 0% impairment of the right and left lower extremity. RX 2.

After reviewing the subsequent reports of Dr. Gurtler, Dr. Nogalski issued an addendum report dated January 30, 2015. Therein, he states that Petitioner's diagnosis remained unchanged and he reiterated his opinion that Petitioner's direct fall onto her knees did not cause her meniscal tears. Dr. Nogalski again pointed to Dr. Zeman's records that "documented that Ms. Gernenz was not having any pain at the end of January of 2014 in the left knee and had noted subsidence of her right knee pain. Dr. Zeman did not feel that she had any internal derangement. Her MRI studies as well were strongly supportive of degenerative meniscal tears and degenerative osteoarthritic issues with bone marrow signal changes corresponding to osteoarthritis. There also was not, in my 6/17/14 exam, anything suggesting mechanical effect of the meniscal tissues from her degenerative tears." Dr. Nogalski did not believe Petitioner required work restrictions relative to her work injury and he opined that Petitioner's bilateral arthroscopic procedures were neither medically necessary nor causally related to her work accident. He testified that because Petitioner's meniscal tears resulted from an osteoarthritic condition and did not involve a mechanical feature, he did not believe an arthroscopy would alleviate her condition at that time, "and it didn't look like it did in retrospect." Dr. Nogalski opined that Dr. Gurtler's recommendation for bilateral total knee replacements are reasonable and necessary in the treatment of Petitioner's bilateral osteoarthritic knee condition, though unrelated to her work accident. RX 2, 3.

CONCLUSIONS OF LAW

In regard to disputed issue (C), the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of her employment. In so concluding, the Arbitrator notes that Petitioner proffered uncontroverted evidence that on January 17, 2014, she tripped on a bed alarm cord in a resident's room, fell forward, and landed on her knees. Petitioner testified that she reported the injury to Karen Olivera, her supervisor, who, in the week following the accident, completed an accident report documenting her fall. Petitioner's testimony regarding her work accident is corroborated by the history she provided to Dr. Zeman upon initial presentation on January 23, 2014 that "[s]he did trip over a cord last week, although she did not sense any injury of either knee." PX 2. While Dr. Zeman's record of January 23, 2014 indicates that Petitioner denied a history of trauma to her knees, the Arbitrator finds that same, in light of the history in its entirety, suggests a lack of a significant injury rather than a complete absence of a work accident. The

Arbitrator further finds that Petitioner's mechanism of injury, that is, tripping on a bed alarm cord, is a risk distinctly associated with her employment of caring for residents of Respondent's facility and occurred in the performance of her customary job duties. Therefore, the Arbitrator concludes that Petitioner sustained an accident on January 17, 2014 that arose out of and in the course of her employment.

In regard to disputed issue (E), the Arbitrator finds that Petitioner provided Respondent timely notice of her work accident. Pursuant to Section 6(c) of the Act, an injured employee must give notice to the employer as soon as practicable, but no later than 45 days, after sustaining an accidental injury arising from the employment. 820 ILCS 305/6(c). "Compliance with the requirement is accomplished by placing the employer in possession of the known facts related to the accident within the statutory time period, namely 45 days." *Gano Electric Contracting v. Industrial Comm'n*, 260 Ill.App.3d 92, 98 (1994). In this case, Petitioner testified that she notified her supervisor, Kathy Olivera, of her fall on her date of accident, and that Karen Olivera completed an accident report documenting her fall within a week thereafter. Petitioner further testified that she was not given a copy of the report nor allowed access to it, and Respondent failed to proffer any evidence to contradict Petitioner's testimony that she timely notified Respondent of her work accident. Therefore, the Arbitrator concludes that Petitioner provided Respondent timely notice in accordance with Section 6(c) of the Act.

In regard to disputed issue (F), the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that her current condition of ill-being is causally related to her work accident. In so concluding, the Arbitrator finds significant that, upon presentation to Dr. Zeman approximately two following her work accident on January 29, 2014, Petitioner denied pain, reported good functionality in performing her work duties, and did not require additional follow-up treatment. PX 2. Petitioner did not return for treatment for three weeks thereafter, and this period of time, coupled with her treating records following the work accident, indicate that approximately two weeks subsequent thereto, her condition improved, and that her complaints relative to her work accident resolved and/or returned to a baseline condition. PX 2.

Further, the Arbitrator finds probative the similarity of Petitioner's reported complaints and symptomatology prior to her work injury with that of her condition preceding her bilateral arthroscopic meniscectomies, and additionally finds significant the distinction between those complaints and her current condition of ill-being. The Arbitrator notes that when Petitioner sought treatment for her bilateral knee complaints on November 1, 2013, approximately ten weeks prior to her work accident, she displayed an altered gait due to discomfort in her right knee and she rated her right knee pain as a six on a ten-point scale. She demonstrated a negative McMurray's and Apley's signs, as well as full range of motion with some pain at the endpoint of flexion. On December 30, 2013, approximately two week preceding her work accident, Petitioner reported discomfort in both legs and knees, and rated her level of pain as a seven on a ten-point scale. RX 1. Approximately eight weeks following her work accident on March 10, 2014, Petitioner, as she did prior to her work accident, reported pain primarily in her right knee, and demonstrated negative McMurray's and Apley's signs, and full range of motion with pain at the endpoints of flexion. She denied interval swelling, buckling, giving way, and locking. Upon initial presentation to Dr. Gurtler on April 8, 2014, Petitioner reported right knee pain, which she again rated as a seven on a ten-point scale, and denied her knees giving way or buckling. On January 15, 2015, she reported to Dr. Gurtler that her pain had increased since October 2014 and she exhibited decreased range of motion. Petitioner presently complains of pain in both knees, an inability to walk without the utilization of an

ambulation aid, and testified to presently experiencing constant swelling, popping, locking and catching in both knees. PX 2.

Essentially, Petitioner's complaints prior to undergoing her bilateral medial meniscectomies are identical to those she experienced before her work accident. See PX 2, RX 1, 2. The Arbitrator finds it probative that these symptoms – discomfort and pain of six to seven on a ten-point scale, full range of motion with some pain at the endpoints of flexion, with no persistent swelling or mechanical symptoms – are different from the symptoms she reports currently experiencing, which include catching, popping, swelling, increased pain, and decreased range of motion. PX 2. The Arbitrator notes that Petitioner's complaints upon examination by Dr. Nogalski on June 17, 2014, including pain inside and in the back of the right knee as well as aches in her left knee into her calf and shine bone, are virtually identical to those she reported to Dr. Swearingen on December 30, 2013, three weeks prior to her work accident. RX 2, PX 2. The aforementioned evidence undermines the suggestion of a relationship of her condition of ill-being, which necessitated bilateral medial meniscectomies and currently requires bilateral total knee replacements, to her work accident of January 17, 2014, and instead demonstrates that the degenerative processes relative to Petitioner's bilateral osteoarthritic condition that prompted her pre-accident complaints and treatment is solely causally related to her current condition.

The Arbitrator recognizes that at Arbitration, Petitioner differentiated her current bilateral knee conditions from that prior to her work accident. Specifically, she testified that she experienced mere achiness prior to the accident compared to that of pain subsequent thereto. However, her treating records do not support her testimony, as the records of Dr. Swearingen demonstrate that Petitioner reported sharp pain in her right knee less than three weeks prior to the work accident and she rated her level of symptomatology as a seven on a ten-point scale, which suggests she was experiencing more severe complaints prior to the work accident than she acknowledged at Arbitration. RX 1. Petitioner also testified to persistent swelling and pain in her knee since her date of accident, though those complaints are not borne out in, and instead are contradicted by, her treating medical records. PX 2. While Petitioner denied symptoms of swelling, locking or catching in her knees prior to her work accident, and testified to the experiencing the same currently, the Arbitrator notes that such symptoms were not persistently present in the months subsequent to her work accident. Petitioner did not exhibit effusion in her right knee or joint line tenderness until approximately two months after her work accident, and she did not develop difficulties in her gait until approximately nine months following same. Simply put, the preponderance of the credible evidence, including the complaints, functional limitations, and physical examination findings enumerated in her treating records, coupled with the progression of Petitioner's knee condition, demonstrate a causal relationship of her current condition to her osteoarthritis rather than her work accident of January 17, 2014.

Moreover, in concluding that Petitioner's current condition of ill-being is not causally related to her work accident, the Arbitrator finds the opinions of Dr. Nogalski to be more persuasive than those of Dr. Gurtler, and accordingly, places greater weight on same. The Arbitrator notes that Dr. Nogalski's opinions are based upon more complete, relevant evidence than the opinions of Dr. Gurtler, in that Dr. Nogalski reviewed Petitioner's pre-accident records of Dr. Swearingen, as well as her post-accident medical records and studies in formulating his opinions, whereas Dr. Gurtler acknowledged that he did not review the treating records of Dr. Swearingen prior to the accident and he was confident he did not review the records of Dr. Zeman dated January 23, 2014 and January 29, 2014. PX 1. Given that Dr. Gurtler's causation opinion is premised upon Petitioner's

report of an onset of symptomatology contemporaneously with the work accident that persisted to the present (PX 1), the Arbitrator finds these records pertinent and Dr. Gurtler's inability to review them significant because the records demonstrate evidence inconsistent with Dr. Gurtler's understanding of the history of Petitioner's bilateral knee condition. The Arbitrator recognizes that Dr. Nogalski did not review Petitioner's MRI studies of August 15, 2014. However, the Arbitrator finds the same inconsequential in this case because the studies do not undermine Dr. Nogalski's opinions, and the studies are more relevant to Petitioner's diagnosis than to the issue of the causal connection of that diagnosis to her work accident.

Furthermore, Dr. Nogalski's opinions are consistent with and supported by Petitioner's treating medical records, whereas Dr. Gurtler's opinions are based a history of illness inconsistent with Petitioner's treating medical records. Dr. Nogalski's opinion that Petitioner's work accident caused a temporary aggravation of Petitioner's preexisting osteoarthritic condition is supported by her treating records of Dr. Zeman of January 23, 2014 and January 29, 2014, which demonstrate that Petitioner's knee condition improved following her work accident, she was able to perform her job duties as a certified nursing assistant less than two weeks subsequent thereto, and required no follow-up appointment. PX 2. On the other hand, as discussed above, Dr. Gurtler's causation opinion is founded upon Petitioner's reported history of an immediate onset of pain contemporaneously with the work accident that persisted thereafter, which is inconsistent with Dr. Zeman's treating records. PX 2.

Additionally, Dr. Nogalski's opinions regarding the etiology of Petitioner's bilateral medial meniscus tears are well-founded in the record, more so than those of Dr. Gurtler. Dr. Nogalski opined that Petitioner's meniscal tears were caused by "chondrosis and wear and tear" of her osteoarthritic condition, all of which pre-existed her work accident, and that her work accident aggravated her underlying condition so as to become temporarily symptomatic. RX 2. Dr. Gurtler, on the other hand, opined that Petitioner's direct blow to the knees caused the meniscus tears, which then in turn accelerated the development of her arthritis. PX 1. Dr. Nogalski testified that Petitioner's mechanism of injury, namely a direct blow to the knees, is not consistent with tears of the menisci (RX 2), and Dr. Gurtler similarly acknowledged that it was merely possible that the direct trauma mechanism could cause such pathology. PX 1. Dr. Nogalski's opinions regarding the chronic osteoarthritic condition of Petitioner's knees are supported by Petitioner's x-rays and bilateral MRI studies, which failed to reveal any pathology indicative of trauma of sufficient pressure on the knees so as to cause significant injuries such that meniscal tears would likely be present in the absence of any twisting or torqueing mechanism. Petitioner's imaging studies and intra-operative findings instead demonstrated extrusion of the medial menisci, significant cartilage loss, and articular surface damage. PX 2. Dr. Gurtler's opinions seem to fail to consider or appreciate those findings as being suggestive of a degenerative etiology rather than a traumatic one, whereas Dr. Nogalski appears to have considered both acute and degenerative theories, ultimately opining that Petitioner's medical records, x-rays, imaging studies, intra-operative findings, and reported mechanism of injury strongly supported the latter. RX 2. The Arbitrator notes the aforementioned distinction of opinions of the two physicians solely to exemplify that Dr. Nogalski's opinions are more consistent with the evidence in the record than are the opinions of Dr. Gurtler, and why the Arbitrator accordingly finds the totality of Dr. Nogalski's opinions more persuasive in this case.

Lastly, the Arbitrator finds Petitioner's testimony at Arbitration suspect. Petitioner took issue with the histories contained in her treating records of Dr. Swearingen, Dr. Zeman, and Dr. Gurtler which reflect a strong family history of osteoarthritis and that a family member had required

a total knee replacement prior to the age of forty. Petitioner also took issue with the histories contained in the records of Dr. Zeman of January 23, 2014 and January 29, 2014, in which Petitioner denied any injury to her knees and denied any pain in her knees at that time, respectively. The Arbitrator notes that Petitioner denied any difficulties in either knee prior to her work accident upon examination by Dr. Nogalski, and similarly indicated an absence of a significant history of prior knee complaints during treatment with Dr. Gurtler. The Arbitrator finds the histories given to these physicians disingenuous in that they are inconsistent with her treating records, which indicate complaints and treatment to both knees prior to her work accident. PX 2. The Arbitrator also notes that Petitioner's testimony that she could barely walk for a few days after her accident does not comport with Petitioner's report to Dr. Zeman on January 23, 2014 in which she denied any injury to her knees. PX 2. The Arbitrator finds the reverberation and striking similarity of Petitioner's family medical histories contained in the records of Dr. Swearingen, Dr. Zeman, Dr. Gurtler and Dr. Nogalski compelling, and the Arbitrator accordingly finds those histories, as well as the histories contained in Dr. Zeman's records of January 23, 2014 and January 29, 2014 more dependable than Petitioner's testimony. The Arbitrator finds that the totality of the evidence calls into question the veracity of Petitioner's testimony and reliability as the historian in this case.

Based upon the foregoing and the record in its entirety, the Arbitrator concludes that Petitioner has failed to prove by a preponderance of the credible evidence that her current condition of ill-being and need for prospective medical treatment is causally related to her work accident. The Arbitrator finds that, in accordance with the opinions of Dr. Nogalski, Petitioner suffered a temporary aggravation of her pre-existing arthritic condition as a result of her work accident that returned to a baseline condition, and for which she was at maximum medical improvement as of January 30, 2014 and does not require any work restrictions as a certified nursing aid. The Arbitrator further finds that Petitioner's continued complaints and functional limitations thereafter, which necessitated bilateral arthroscopic meniscectomies and presently require total knee replacements, are solely related to her severe osteoarthritic condition in both knees, and that the work accident did not necessitate those procedures or require any further treatment.

In regard to disputed issue (J) and in accordance with the Arbitrator's foregoing conclusions, the Arbitrator finds that the medical services Petitioner received from the date of her accident through January 29, 2014 to both knees were reasonable and necessary, and casually related to her work accident of January 17, 2014. The Arbitrator finds that, in accordance with the opinions of Dr. Nogalski, Petitioner was at maximum medical improvement for her bilateral knee conditions relative to her work injury as of January 30, 2014. Respondent shall pay all reasonable and necessary medical services from the date of accident to January 30, 2014, as provided in Sections 8(a) and 8.2 of the Act, and subject to the fee schedule. All medical bills subsequent to January 30, 2014 are denied as unrelated to Petitioner's work accident. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In regard to disputed issue (K) and in accordance with the Arbitrator's foregoing conclusions, Dr. Gurtler's recommended course of prospective medical treatment, namely bilateral total knee replacements, is denied.

In regard to disputed issue (L) and in accordance with the Arbitrator's foregoing conclusions, temporary total disability benefits from April 4, 2014 through May 6, 2015 are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joey Jones,
Petitioner,
vs.
Gilster Mary Lee,
Respondent,

NO: 14WC 23144

16IWCC0210

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Petitioner, herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 22, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 4 2016
MJB/bm
o-3/21/16
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

JONES, JOEY
Employee/Petitioner

Case# 14WC023144

GLISTER MARY LEE
Employer/Respondent

16IWCC0210

On 6/22/2015, 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 0.10% 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:

1239 KOLKER LAW OFFICES PC
BILLY A HENDRICKSON
9423 W MAIN ST
BELLEVILLE, IL 62223

0693 FEIRICH MAGER GREEN RYAN
BRANDY JOHNSON
2001 W MAIN ST
CARBONDALE, IL 62903

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Joey Jones
Employee/Petitioner

v.

Gilster Mary Lee
Employer/Respondent

Case # 14 WC 023144

Consolidated cases: N/A

16IWCC0210

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 **Collinsville**, on **April 24, 2015**. 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. [x] 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. [x] 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. [x] 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. [x] Is Petitioner entitled to any prospective medical care?
L. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **7/17/13**, 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 not*** 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**8,713.80**; the average weekly wage was $**390.75**.

On the date of accident, Petitioner was **45** years of age, ***single*** with **0** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

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

Respondent is entitled to a credit of $**695.75** for medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove he sustained an accident on July 17, 2013 that arose out of and in the course of his employment with Respondent or that his current state of ill-being was causally related to a compensable work accident. Petitioner's claim for compensation is denied and no benefits are awarded.

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.

Signature of Arbitrator

June 21, 2015
Date

ICArbDec19(b)

JUN 22 2015

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner has filed an Application for Adjustment for an accidental injury on July 17, 2013. (Ax2). Specifically, Petitioner alleged a twisting injury to his left knee. At the Hearing, Petitioner was the sole witness.

On July 18, 2013, Petitioner was seen at the office of Dr. James Wade, his primary care physician, for a regularly scheduled follow-up appointment. (PX2 at 2). Under the "[s]tatus of [c]urrent [c]hronic [c]onditions" section, Dr. Wade listed a left knee cartilage tear. (RX3 at 30). Left knee pain was documented. *Id.* Petitioner was referred to Dr. Michael Hughes. (PX3 at 8).

On July 18, 2013 Petitioner called in sick for his 11:00 p.m. – 7:00 a.m. shift and spoke to Robert Otto. (PX 1)

On July 22, 2013, Petitioner saw Dr. Hughes and reported left leg pain since twisting his knee while stepping off of a forklift on July 13, 2013. (PX3 at 9). In another part of the report an accident on July 17th is referenced. Petitioner reported hearing a pop, experiencing swelling, and having difficulty weight bearing on the left leg. *Id.* It was noted that Petitioner was working. Petitioner was using a neoprene brace with side struts to aid in knee stability. *Id.* On exam, there was a large effusion within the knee. (PX3 at 10). There was no distinct quadriceps or patellar tenderness to palpation. *Id.* Petitioner had distinct, medial joint line tenderness and mild, lateral joint line tenderness to palpation. *Id.* He could perform open chain full knee extension, lacked 5 degrees of extension, and could only flex the knee 90 degrees due to effusion. *Id.* The knee was stable to both varus and valgus stress. *Id.* Petitioner's Lachman exam and anterior drawer testing were both grade 2B. *Id.* His posterior drawer was a grade zero. *Id.* X-rays did not show any signs of advanced osteoarthritis, but there was some calcification along the posterior aspect of the distal femur along the arterial vascular channels. *Id.* Dr. Hughes suspected an ACL tear, probable meniscus tear, and bone contusions. *Id.* An MRI was ordered and Petitioner was instructed to use ice and the brace as needed for comfort. No work restrictions were imposed. *Id.*

On July 22, 2013 Petitioner completed an accident report for Respondent referencing an accident date of July 17, 2013 in which he stepped off the back of the reach truck and twisted his left knee. (PX 1)

On July 31, 2013, Petitioner returned to Dr. Wade with complaints that included left leg pain. (RX3 at 28). On August 13, 2013, a left knee MRI showed a chronically torn anterior cruciate ligament (ACL); complex tears of the medial meniscus body and posterior horn, including a displaced inferior leaflet oblique flap tear in the meniscus body and posterior meniscal root complex tear; mild degenerative chondorsis in the medial compartment; slight lateral patellar subluxation; and small to moderate joint effusion. (PX4 at 1-2). The MRI report specifically noted the ACL was chronically torn and atrophied. (PX4 at 1). The lack of bone and soft tissue edema was noted to favor a chronic tear. *Id.*

On August 19, 2013, Dr. Wade documented an ACL tear and a cartilage tear under the "[s]tatus of [c]urrent [c]hronic [c]onditions" section. (RX3 at 22). On the same day, Dr. Hughes diagnosed a medial meniscus tear and an ACL tear that appeared chronic in nature. (PX3 at 16). Petitioner complained of instability symptoms and the knee giving out. *Id.* He reported a similar knee injury approximately eight years ago and episodes of instability since that time. *Id.* He denied left knee pain prior to the alleged accident on July 17, 2013. *Id.* Dr.

Hughes discussed this prior incident with Petitioner and noted the ACL tear may have occurred then given its chronic nature. *Id.* He indicated the medial meniscus tear could have been new pathology given the lack of pain before July 17, 2013. *Id.* On exam, the knee had moderate effusion and his left quadriceps showed atrophy. *Id.* Petitioner had full extension and 110 degrees of flexion. *Id.* He had a noticeable pivot-shift exam. *Id.* Dr. Hughes reviewed the MRI and found no evidence of a bone bruise. *Id.* He recommended Petitioner undergo physical therapy and ordered an ACL brace. *Id.* Dr. Hughes felt surgery would be indicated if the brace failed and Petitioner did not get his strength and full range of motion back with therapy. *Id.*

Petitioner continued to have visits with Dr. Wade between November 1, 2013 and June 3, 2014. None of the entries after August 19, 2013, refer to the left knee condition or any of the treatment for it. (RX 3)

On July 1, 2014 Petitioner signed his Application for Adjustment of Claim herein. (AX 2)

On July 30, 2014, Petitioner presented to Dr. Nathan Mall for right shoulder and left knee pain. Petitioner heard about Dr. Mall through his attorney and primary care physician. His presenting questionnaires appear more focused on alleged right shoulder problems rather than a left knee problem, although the left knee is mentioned. Petitioner reported that, while stepping out of his forklift on July 18, 2013, he twisted his left knee. (PX6 at 18). He stated he felt a pop, discomfort in the knee, and had immediate swelling. *Id.* He told Dr. Mall he reported the incident to his foreman right away. *Id.* Petitioner complained of medial-sided knee pain and instability. *Id.* He felt his knee would give way with various types of activities. *Id.* He also had a knee injury 10 to 15 years ago that caused severe pain and use of a brace. (PX6 at 20). He reported he did not have instability feelings until the alleged accident on July 17, 2013. *Id.* On exam, Petitioner's left knee had full range of motion. (PX6 at 19). There was mild effusion and medial joint line tenderness. *Id.* He was stable to varus, valgus, and posterior drawer testing. *Id.* He had 5/5 quadriceps strength. *Id.* Petitioner's Lachman was 2B and his pivot glide and McMurray's exams were positive. *Id.* Dr. Mall diagnosed ACL and medial meniscal tears. *Id.* He indicated the MRI showed clear evidence of an acute injury with moderate size effusion. *Id.* Physical therapy for quadriceps strengthening was recommended, but Dr. Mall felt an ACL reconstruction and partial medial meniscectomy would be needed. *Id.* He found Petitioner sustained a work injury that resulted in symptoms of instability and medial-sided knee pain. (PX6 at 20). Dr. Mall opined the need for treatment, including surgery, was causally related to the alleged accident. Petitioner also advised the doctor that he was no longer working for Respondent having been terminated. Light duty restrictions were imposed. *Id.*

On August 27, 2014, Petitioner continued to have symptoms of instability in the left knee with twisting maneuvers and activities of daily living. (PX6 at 24). Dr. Mall noted the quadriceps strength was much better and symmetric to his right leg. *Id.* On October 1, 2014, Dr. Mall noted Petitioner had gone back to wearing his brace, but continued to have feelings of instability. (PX6 at 27). Petitioner had good range of motion, mild effusion, and medial joint line tenderness. *Id.* Dr. Mall felt an ACL reconstruction was the only way to improve the instability symptoms. *Id.*

On October 7, 2014, Dr. Michael Nogalski, an orthopedic surgeon, performed a Section 12 exam. (RX1 at 1; RX2 at 3). He was deposed on December 8, 2014; and authored a supplemental report on April 2, 2015. (RX1 at 9; RX2). Petitioner reported that, while stepping out of his forklift on July 18, 2013, he twisted and fell to the ground. (RX1 at 1). He pulled himself up and finished his shift. *Id.* He was in pain, limped, and had fairly significant difficulty walking. *Id.* Petitioner reported a left knee injury 8 to 10 years ago. (RX2 at 2). Although he could not remember exactly what happened, he believed his knee was treated at St. Elizabeth's Hospital. *Id.* He was walking without problems within a few days. *Id.* At the time of the Section 12 exam, Petitioner complained of knee soreness and felt as though it buckled and gave out on him. *Id.* He indicated "'it

almost brings [him] to tears.'" *Id.* Petitioner had to watch how he stepped and walked. *Id.* His neoprene brace seemed to help. *Id.* On exam, the left knee lacked effusion and had full range of motion with complaints of pain at the end of flexion. (RX1 at 3). He had mild patellofemoral crepitus and mild, medial joint line tenderness. *Id.* His meniscal signs were not conclusively positive and there was some pain with tibiofemoral rotation. *Id.* Petitioner had a positive Lachman's and negative posterior drawer testing. *Id.* There was no instability to valgus and varus stress and he had 5/5 to strength testing in flexion and extension. *Id.* Patellofemoral compression resulted in mild tenderness and his hip range of motion was slightly tight with some mild pain during internal rotation. *Id.* Petitioner's gait was normal. *Id.*

Dr. Nogalski reviewed the MRI and noted what appeared to be an old ACL tear. (RX1 at 3). He advised that "[t]ypically a bone bruise would remain a 'smoking gun' to an acute anterior cruciate ligament injury or tibiofemoral subluxation," but there was a relative lack of any bone marrow signal changes that would correspond to an acute tear. (RX1 at 3, 5; RX2 at 15-16). Likewise, there was no evidence of tibiofemoral subluxation episode that would be consistent with an ACL injury. (RX1 at 5). The lack of bone marrow signal changes was a "distinct objective strike against an acute ACL injury or tibiofemoral subluxation which would have reasonably provided objective data" to suggest Petitioner injured his ligament or had significant instability. (RX1 at 9). Dr. Nogalski disagreed with Dr. Mall's assertion that a bone bruise would disappear from the MRI within 3-4 weeks, opining acute ACL tears have a bone bruise for a minimum of 6-12 weeks. (RX1 at 5; RX2 at 48). Chronic ACL tears do not have bone bruises. (RX2 at 48). The MRI was also found to show some medial compartment chondrosis; a complex tear of the posterior horn of the medial meniscus; mild effusion; and some mild signal changes along the marginal aspect of the medial tibial plateau. (RX1 at 3). Dr. Nogalski testified chronic meniscal tears were typically complex in nature and there were configurations on the MRI that would support a chronic meniscal tear. (RX2 at 48-49). He did not believe the mild edema below the meniscal tear was severe enough to indicate an acute injury. (RX1 at 5). He explained the chondrosis would "most strongly support some bone marrow edema along the marginal aspect of the tibial plateau with degenerative meniscal tear." *Id.* Dr. Nogalski found the swelling noted by Dr. Hughes on July 22, 2013, was not indicative of an acute injury inside the knee because the fluid was not aspirated to check for blood. (RX2 at 23-24).

Dr. Nogalski reviewed the police video from July 17, 2013, and noted Petitioner appeared to be walking comfortably. (RX1 at 5). He observed, at one point, Petitioner lifted his right leg up and pulled on his ankle. *Id.* Petitioner appeared to have easy, fluid movement and easy support of his body on the left leg. *Id.* He moved easily without any sign of antalgia or difficulty walking. *Id.* Dr. Nogalski noted that, if Petitioner had sustained a knee injury from the alleged accident, he would expect Petitioner to be limping severely and his ability to support his body weight on the left leg would be significantly compromised. (RX2 at 25-26). Petitioner's ability to move about and bear weight on the police video was "extremely inconsistent with an injury to the left leg." (RX2 at 25). Petitioner showed no signs of an injury to his left leg on the video. (RX2 at 26).

Dr. Nogalski diagnosed a chronic ACL tear, a complex medial meniscal tear, and subjective symptoms. (RX1 at 5). He testified the alleged accident on July 17, 2013, was not, and could not have been, a cause or causative factor of Petitioner's knee condition. (RX2 at 27). He further testified the alleged accident did not cause a pre-existing ACL and/or meniscal condition to become symptomatic. (RX2 at 36-37, 49-51). He noted Petitioner had given several different accounts of the alleged accident and was moving comfortably on the police video. (RX1 at 5-6). The history of the injury also did not suggest the amount of force involved was not sufficient to cause an ACL tear. (RX2 at 49). Petitioner's MRI did not have any acute findings and there was a lack of objective findings to validate Petitioner's subjective complaints. (RX1 at 5-6; RX2 at 20). Dr. Nogalski explained Petitioner had no objective evidence of functional instability and noted it was "clear that he did not

suffer a tibiofemoral subluxation or an instability episode at the time of his claimed injury nor did he have an unstable knee in the time frame right after that" during which he was seen on police video. (RX1 at 7). There was no suggestion of the alleged accident injuring any other ligaments or of laxity in other areas of the knee that would evidence an injury that caused other ligaments or structures to be unstable to contribute to ACL abnormality. (RX2 at 50). Dr. Nogalski did not believe Petitioner sustained a knee injury other than a strain by report. (RX1 at 6). He explained that, if Petitioner actually did twist his knee at work, the mechanism of injury would be compatible with a strain, but noted Petitioner appeared to be doing just fine after the alleged accident based on the police video. (RX2 at 42, 53). He did not see any clear, objective evidence that Petitioner had a strain injury on the video. (RX2 at 54). Dr. Nogalski concluded Petitioner was at maximum medical improvement, could work full duty, and incurred no permanent partial impairment from the alleged accident. (RX1 at 6-7). He believed Petitioner may benefit from physical therapy and a cortisone injection for inflammation, but testified the need for treatment was not causally related to the alleged accident. (RX2 at 28-29).

On January 14, 2015, Petitioner returned to Dr. Mall reporting continued instability problems. (PX6 at 36). He had to protect what he did at work, how he walked down steps, and how he performed any type of twisting maneuver. *Id.* Dr. Mall watched the police video from July 17, 2013, and questioned Petitioner about the altercation. *Id.* Petitioner stated his adrenaline was "quite high" because his son was being attacked. *Id.* Dr. Mall did not see anything in the video that showed a clear, non-injury to the knee. *Id.* He observed Petitioner had a slight limp in the video and demonstrated the ability to lift his right leg off the ground. *Id.* The video did not cause Dr. Mall to change his opinions on causation. *Id.* He indicated that, after an ACL tear, people will typically have some pain for a few hours and then some pain or feelings of instability for a couple of hours. *Id.* The injured individuals would then typically be able to walk fairly easily with a minimal limp that same day and could stand on just the injured leg. *Id.* He did not feel Petitioner's appearance on the video was inconsistent with an ACL injury earlier that day. *Id.* Dr. Mall had seen patients with pre-existing partial ACL injuries that go on to have full tears or become symptomatic after a new injury. *Id.* The patients, after the new injury, have increased feelings of instability, but little to no discomfort. *Id.* Dr. Mall continued to recommend an ACL reconstruction. (PX6 at 37). He felt Petitioner either sustained a complete ACL rupture at the time of the alleged work accident or sustained further tearing of a prior ACL injury. *Id.* Regardless of which scenario was correct, Dr. Mall noted the symptoms of instability were new since July 17, 2013, and causally connected to the alleged accident. *Id.* On April 8, 2015, Petitioner complained of knee instability and advised he had to walk very carefully. (PX6 at 38). His exam lacked a couple degrees of extension and Dr. Mall continued to recommend surgery. *Id.*

Petitioner's case proceeded to arbitration on April 24, 2015. Petitioner testified he had been employed by Respondent for less than one year as a stand-up forklift driver. He stacked pallets and staged areas to be loaded into trucks. He entered and exited the forklift from 100 to 200 times a day. *Id.* Exiting the forklift required Petitioner to step down approximately one foot. *Id.*

Petitioner further testified that he had a pre-existing left knee injury from a wrestling incident 8 to 15 years ago. (PX3 at 16). He testified he had a little pain subsequent to the injury and some instability, but he was able to perform normal activities. His only treatment may have been an emergency room visit. In July of 2013, Petitioner was 5'9" inches in height, weighed 243 pounds. (PX3 at 9).

At the time of the injury, Petitioner was working the 11:00 p.m. to 7:00 a.m. shift. He claims that, at approximately 6:30 a.m. on July 17, 2013, he stepped off the forklift and experienced left leg pain. (PX1). He fell to the ground and then pulled himself up using a skid. He stood and tried to shake off the pain, but was

unable to put all his weight on his leg. Petitioner stated the pain was present the "whole night," and described it as "terrible" and "agonizing." He experienced pain, swelling, difficulty weight bearing, difficulty walking, and had a limp right after the accident. These symptoms lasted the rest of the day. He finished the remainder of his shift.

Petitioner testified that around 8:20 p.m. on July 17, 2013, Petitioner was one of approximately ten people involved in an altercation. (RX5 at 5). Petitioner testified that there had been problems with his brother's kids and he cautioned his children to stay inside. Petitioner was in the shower, preparing for work, when he heard something going on. He testified he went outside, observed fighting that included bats and clubs, and tried to break up the altercation. Petitioner stated he was not physically involved in the fight, but was "standing there getting [sic] back and forth trying to stop people from getting hurt seriously." He testified that, during the altercation, his left leg was not attacked, struck, or injured. The police responded to the altercation and, afterward, Petitioner called in sick to work. He stated he did not go to work for his overnight shift because he did not want the fighting to recommence. He returned to work the evening of July 18, 2013. (RX7).

Once the police arrived, Petitioner was questioned and cited for fighting in public. (RX5 at 5). The officer documented Petitioner's statement that he was involved in the fight because he was not "going to sit back and let people talk shit to him." (RX5 at 5). Petitioner denied making this statement at the hearing. The report also documented that Petitioner stated that he "almost called the Police himself but thought that letting everyone fight would end the conflict." (RX5 at 5). While the police were on scene, the officer's dashboard camera recorded Petitioner walking backwards; stepping off the curb onto the road; walking to the police car; walking in front of the police car; standing; and standing on just his left leg. (ReX6). Petitioner admitted he was cited, but testified he was charged with disorderly conduct. Court records show he was cited for, and pled guilty to, fighting in public. (RX10).

Petitioner testified he reported the alleged work accident the next day.

Petitioner testified he continued to see Dr. Wade after August 19, 2013, and was prescribed Vicodin and a TENS unit.

Petitioner testified that he continued to work after July 17, 2013, supporting himself on his right leg and leaning his knee into to the forklift for stability. He leads with his right leg; watches how he steps and uses stairs; and fears heights due to the possibility his knee would give out. He has a daily, steady pain on the inside of the knee and intense pain when his knee gives out or goes off balance. At the time of arbitration Petitioner was no longer working for Respondent.

The Arbitrator concludes:

1. Petitioner's Credibility.

Petitioner was not a credible witness. As the following examples will illustrate, Petitioner's testimony was inconsistent with medical histories, frequently exaggerated, and often misleading. First, Petitioner gave different accounts of his accident to various providers. He told Dr. Nogalski he fell to the ground while never mentioning a fall to other providers. Second, he testified he was in "terrible" and "agonizing" pain immediately after his accident and tried to "shake it off" but it was there the whole night but he was able to finish his whole shift. The Arbitrator notes that Petitioner's alleged accident occurred only thirty minutes before his shift was to

end. He then went home and despite his pain, sought no immediate medical treatment. He also planned on coming in to work that night until the unfortunate events with the police earlier in the evening on the 17th. He then saw Dr. Wade on the 18th but failed to mention a work accident – at least the doctor did not record one. That visit was not scheduled because of Petitioner's alleged accident; rather, it was an already scheduled visit to review lab tests. While Dr. Wade's records are difficult to decipher, the notes under "HPI" may suggest a one week history of knee pain. What is quite clear, however, is that the doctor documents under "Status of Current chronic Conditions" a "left knee cartilage tear." How did the doctor know Petitioner had a cartilage tear? Dr. Wade could have possibly provided great insight and cleared up a number of questions about that first visit, but he was no deposed. This, too, is troubling.

The Arbitrator also notes that Petitioner testified he reported the accident on July 18th to Mr. Otto but that it took a week or two for the accident report to be completed. Again, Petitioner exaggerated the situation. The Accident Report was completed within four days of its being reported. The Arbitrator also does not believe Petitioner was honest and forthright about his prior left knee problem as, at trial, he was trying to minimize its importance. Petitioner testified to minimal problems and no need for medical care after his earlier left knee event. Yet, he told Dr. Mall, he had worn a brace. Petitioner denied any periods of instability before July 17, 2013; yet, the histories contained in the medical records suggest the opposite (Dr. Hughes' o/v 8.19.13, PX 3). Petitioner testified about getting Vicodin and a TENS unit from Dr. Wade along with seeing him between August of 2013 and July of 2014 (with the suggestion of those visits being for his left knee). Petitioner's records with Dr. Wade don't corroborate that whatsoever. Petitioner never mentioned any left knee problems during that time. (RX 3) No bills for Vicodin or a TENS unit were submitted by Petitioner. Finally, the Arbitrator notes Petitioner's convenient ability to not recall certain events when asked about them during trial. In the end, Petitioner did not come across as genuine regarding his prior left knee problems, the accident itself, or how he felt thereafter. The Arbitrator also notes that Petitioner's visit to Dr. Mall came after he filed his Application for Adjustment of Claim and was no longer working for Respondent. Petitioner's testimony about his termination with Respondent suggested he was not at all pleased by what occurred and, therefore, his motivation in pursuing treatment with Dr. Mall and, indeed, his claim is questionable.

2. IN REGARD WITH DISPUTED ISSUE "C," Accident:

Relying greatly on Petitioner's lack of credibility, the Arbitrator concludes that Petitioner failed to prove he sustained an accident on July 17, 2013.

In order to receive benefits under the Act, a claimant must prove by the preponderance of the evidence that he sustained an accidental injury arising out of and in the course of his employment. *Quality Wood Products Corp. v. Industrial Commission,* 97 Ill.2d 417, 423 (1983). An injury is considered "accidental" for purposes of worker's compensation if it is caused by the performance of an employee's job. *Peoria County Belwood Nursing Home v Industrial Commission,* 115 Ill.2d 524, 529-30 (1987).

Petitioner in this case had the burden of proving he incurred an accidental injury to his left knee on July 17, 2013. Because the alleged accident was uncorroborated by witnesses, the credibility of Petitioner becomes paramount. In this case, multiple inconsistencies in the evidence render Petitioner's testimony concerning the alleged accident incredible. The arbitrator finds that Petitioner had failed to meet his burden and notes the following inconsistencies in the evidence.

Petitioner testified the alleged accident occurred the morning of July 17, 2013, and he reported it the next day. On July 22, 2013, which was five days after the alleged accident, he provided Dr. Hughes with a July 13, 2013,

date of injury. (PX3 at 9). Dr. Mall was told the date of accident was July 18, 2013, and that Petitioner reported the accident right away. (PX6 at 18). Dr. Nogalski was also told the date of injury was July 18, 2013. (RX1 at 1). The accident report showed the alleged accident was reported to Robert Otto the evening of July 18, 2013, *i.e,* two shifts later and after the altercation. (PX1 at 2). Even if the Arbitrator factors in the discrepancy between the date of July 17 and July 18 as being due to Petitioner working an overnight shift, that doesn't explain the reference to a July 13th accident, a date which would correlate with the history contained in Dr. Wade's office note of July 18, 2013 (if that is what it actually says – ie. a one week history of knee pain). The report of different dates for the alleged accident and when Respondent was notified weigh against Petitioner's credibility.

At the hearing, Petitioner provided a description of the accident. He testified that he was exiting the forklift and, when he stepped down, "pain just hit [him] in the leg and [he]went to the ground." However, he told Dr. Hughes and Dr. Mall that he twisted his knee when stepping off the forklift and heard a pop. (PX3 at 9; PX6 at 18). He reported twisting his knee and falling to the ground when he saw Dr. Nogalski. (RX1 at 1). Petitioner's descriptions of the alleged accident are inconsistent. He did not testify to twisting his knee or hearing a pop at the hearing. He did not mention a fall, presumably from his knee giving out, to Dr. Hughes or Dr. Mall. No pop was reported to Dr. Nogalski..

Petitioner testified that he had swelling, difficulty weight bearing, and difficulty walking right after the alleged accident. These symptoms lasted for the rest of the day. *Id.* He reported similar symptoms to Dr. Hughes, Dr. Mall, and Dr. Nogalski. (PX3 at 9; PX6 at 18; RX1 at 1). Petitioner described the pain from the alleged injury as "terrible" and "agonizing." However, Petitioner was shown on the police video the evening of the alleged accident and displayed the ability to walk and put weight on his left knee without any apparent difficulty. Further, although Dr. Mall indicated it was possible the Petitioner could have injured his meniscus and ACL and only had a few hours of problems before being able to walk fairly easily and weight bear on just the left leg, the arbitrator does not find this opinion to be persuasive. Petitioner did not testify to only experiencing pain and/or instability for a few hours following the alleged accident. He, instead, testified to having swelling, difficulty weightbearing, and difficulty walking for the rest of the day. Petitioner's own testimony differentiates his condition from the situation described by Dr. Mall.

Petitioner initially testified that he had a prior knee injury 10-15 years ago, but only had some pain after the date of the injury and no medical care. He later admitted he may have gone to the emergency room and had some periods of instability after the injury. However, he told Dr. Hughes he had injured his knee eight years ago and had episodes of instability since that time. (PX3 at 16). Dr. Mall documented a prior knee injury that occurred 10-15 years ago that caused severe pain and use of a brace. (PX6 at 20). Dr. Nogalski recorded a prior injury 8-10 years ago and treatment at St. Elizabeth's Hospital. (RX1 at 2). Petitioner's portrayal of his pre-existing left knee injury as minor at hearing is not substantiated by the medical evidence. The medical records and MRI indicate he sustained a serious pre-existing knee injury, which likely included an ACL tear, and had some episodic instability. This could also explain Petitioner's failure to follow-up with Dr. Hughes who suspected and documented their discussion of a chronic pre-existing left knee problem (ACL tear).

Petitioner's credibility was further diminished by his testimony about the altercation the evening of July 17, 2013. Petitioner testified he was not physically involved in the fight and was only trying to break it up. He contended he was cited for, and pled guilty to, disorderly conduct. However, according to the police report, Petitioner told the responding officer that he was involved in the fight because he was not "going to sit back and let people talk shit to him." (RX5 at 5). The report also documented that Petitioner stated that he "almost called the Police himself but thought that letting everyone fight would end the conflict." (RX5 at 5). Court records

show he was cited for, and pled guilty to, fighting in public. (RX10). The arbitrator finds the police report and court records to be more credible than Petitioner's testimony. The arbitrator further finds it unbelievable that Petitioner was unaware of the true nature of the charges against him and to which he pled guilty.

In this case, Petitioner allegedly incurred a work injury on the morning of July 17, 2013. He neither reported the accident that day nor sought medical treatment. The alleged accident was not witnessed. Petitioner was then engaged in an altercation the evening of July 17, 2013. Video of Petitioner immediately after the altercation show no signs of the disabling left knee injury described in the evidence. It was only after the altercation that Petitioner sought medical treatment and reported an accident. To meet his burden, Petitioner had to provide credible evidence establishing a work accident occurred on July 17, 2013. The Arbitrator finds Petitioner was not credible in his testimony at hearing or in his reports to the doctors. Petitioner has not met his burden of showing a work accident occurred on July 17, 2013, and, accordingly, his claim is denied.

3. IN REGARD WITH DISPUTED ISSUE "F," Causal Connection:

To prevail on a claim for benefits, Petitioner must establish that his or her current condition of ill-being is causally connected to a work-related injury. *Elgin Bd. of Educ. School Dist. U-46 v. Illinois Workers' Compensation Com'n,* 409 Ill.App.3d 943, 949 (1st Dist. 2011). The accidental injury need neither be the sole or primary causative factor, as long as it was a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Industrial Comm'n,* 207 Ill.2d 193 (2003). Every natural consequence that flows from an injury arising out of and in the course of employment is compensable unless such injury is caused by an independent intervening accident which breaks the causal connection between the employment and the claimant's condition of ill-being. *Greaney v. Industrial Commission,* 358 Ill. App. 3d 1002, 1013 (2005); *Teska v. Industrial Commission,* 266 Ill. App.3d 740, 742 (1994). An independent, intervening accident breaks the chain of causation between a work-related injury and an ensuing disability or injury. *Teska*, 266 Ill. App. 3d at 742.

For the reasons previously discussed, this claim is barred by Petitioner's failure to prove that a compensable work accident occurred on July 17, 2013. However, the Arbitrator also concludes that, even if the accident had been proven, Petitioner's claim would still be denied on the basis of causation.

Petitioner has been diagnosed with ACL and medical meniscal tears of the left knee. As discussed above, Petitioner allegedly injured his knee the morning of July 17, 2013. He did not seek treatment for his symptoms that day despite allegedly experiencing swelling, pain, difficulty weight bearing, and difficulty walking. Later that evening, Petitioner was involved in an altercation. It was only after the altercation Petitioner sought medical treatment and reported the injury. Further, video of Petitioner immediately after the altercation shows him walking without difficulty and weight bearing on his left leg.

Petitioner testified to a prior left knee injury and the MRI shows a chronic ACL tear. (AT. 22, 35-37; PX4). The medial meniscus pathology was a complex tear and the nature of this type of tear, as explained Dr. Nogalski, is typically chronic. (RX2 at 48-49). Based on Petitioner's MRI, exam findings, and the capabilities he showed on the police video, Dr. Nogalski could not find a medical causal relationship between Petitioner's condition of ill-being and a work accident on July 17, 2013. (RX1 at 5-6; RX2 at 27, 36-37, 49-51). He concluded the tears were chronic and the alleged accident did not cause an aggravation of the condition. (RX2 at 49-51). Dr. Mall found Petitioner's knee condition was causally related to the alleged accident. (PX6 at 20). His opinion appears to be greatly dependant on Petitioner's report that he was asymptomatic before July 17, 2013. As Petitioner has been found incredible, the foundation of Dr. Mall's opinion is greatly weakened. It is also worth noting Dr. Mall did not have any knowledge about the altercation until after Petitioner's third

appointment. (PX6). By that point, he had already formed opinions on causation. *Id.* Dr. Mall did not change his opinions after learning of the altercation and viewing the police video; explaining patients with ACL/meniscal tears can have symptoms for a few hours and then be able to walk fairly easily with a minimal limp that same day and be able to bear weight on just the injured leg. (PX6 at 36). Dr. Mall's explanation is inconsistent with Petitioner's description of his symptoms post-injury. (AT. 17, 28). Petitioner's failure to provide Dr. Mall with an accurate history detracts from the opinions' credibility and the arbitrator finds Dr. Nogalski's opinions to more believable.

The Arbitrator is also greatly troubled by Petitioner's significant gap in treatment in 2013 and 2014 (almost a year). When Petitioner did resume treatment he did not go back to Dr. Hughes; rather, he went to a new doctor, Dr. Mall. Of note, Petitioner had signed his Application for Adjustment of Claim within a week or two of seeing Dr. Mall. At that time Petitioner was not working for Respondent and he had no private insurance.

There is insufficient evidence in this case to prove Petitioner's condition of ill-being was caused by a work accident on July 17, 2013. Moreover, even if he sustained a knee injury stepping out of the forklift, the altercation later that evening was an independent, intervening event that broke the chain of causation. Petitioner had pre-existing tears in his knee. The video suggests no left knee problems. His movements are in stark contrast to his testimony of agonizing and terrible pain. Even if he had an accident, he failed to prove the requisite causal connection between that accident and his current condition of ill being.

Petitioner's claim is denied. No benefits are awarded. All remaining issues are moot.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sara Hoyle,
Petitioner,

vs. No: 14 WC 28294

McAlister's Deli,
Respondent.

16IWCC0221

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability, Section 19(k) and Section 19(l) penalties, and Section 16 attorneys' fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission hereby remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission modifies the Arbitrator's Decision by vacating the penalties awarded under Section19(k) and the attorneys' fees awarded under Section 16. In McMahan v. Industrial Commission, 183 Ill.2d 499, 515 (1998), the Supreme Court held that Section 19(l) penalties are in the nature of a mandatory "late fee" while Section 19(k) penalties and Section 16 attorneys' fees are to be awarded on a discretionary basis where there is evidence of unreasonable conduct on the part of the employer.

16IWCC0221

In the matter at hand, the Commission finds the Arbitrator's award of Section 19(l) penalties to be appropriate, as the Respondent failed to set forth in writing the basis for its delay of payment of benefits. However, the Commission finds that Respondent's conduct as a whole – in particular its actions as to procuring and subsequently relying upon the opinions from its Section 12 examiner Dr. Peter Mirkin – does not evince vexatious or unreasonable conduct as envisioned under Section 19(k) of the Act. The Commission notes that without an award under Section 19(k) of the Act, there remains no basis for an award of attorney fees under Section 16 of the Act. The Commission concludes that the awards under Section 19(k) and Section16 of the Act should be vacated.

IT IS THEREFORE ORDERED BY THE COMMISSION that the awards of penalties under Section 19(k) and the attorneys' fees under Section 16 are vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the penalty of $3,330.00 (October 16, 2014 (date of demand of benefits) to February 4, 2015) as provided in Section 19(l) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay reasonable and necessary medical services, pursuant to the Medical Fee Shedule, of $7,350.21 to Heartland Regional Medical Center, $864.00 to Carterville Family Practice, and $7,354.00 to Herrin Hospital, as provided in Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits of $253.00/week for 34 & 4/7 weeks, commencing June 8, 2014 through February 4, 2015, as provided in Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the Petitioner's upcoming visit with Dr. Koth.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under § 19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

16IWCC0221

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $ 25,500. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 4 2016

Joshua D. Luskin

Charles J. DeVriendt

o-02/09/16
jdl/ac
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Ruth W. White

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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

HOYLE, SARA
Employee/Petitioner

Case# **14WC028294**

McALISTER'S DELI
Employer/Respondent

16IWCC0221

On 4/14/2015, 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 0.10% 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:

0355 WINTERS BREWSTER CROSBY ET AL
LINDA J CANTRELL
11 W MAIN PO BOX 700
MARION, IL 62959

1109 GAROFALO SCHREIBER HART ET AL
JAMES R CLUNE
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

☐ 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
19(b)

Sara Hoyle
Employee/Petitioner

v.

McAlister's Deli
Employer/Respondent

Case # **14-WC-28294**

Consolidated cases: **N/A**

16IWCC0221

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 **Mt. Vernon**, on **February 4, 2015**. 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **06/07/2014**, 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 $**9,974.64**; the average weekly wage was $**191.82**.

On the date of accident, Petitioner was **24** years of age, **married** with **1** dependent child.

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

Respondent shall be given a credit of $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**2,500.00** for other benefits, for a total credit of $**2,500.00**.

Respondent is entitled to a credit of $**0.00** for any medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the Medical Fee Schedule, of $7,350.21 to Heartland Regional Medical Center, $864.00 to Carterville Family Practice, and $7,354.00 to Herrin Hospital, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$253.00/week** for **34 4/7** weeks, commencing **6/08/14** through **2/04/15**, as provided in Section 8(a) of the Act.

Respondent shall pay to Petitioner penalties of $**1,537.05**, as provided in Section 16 of the Act; $**4,355.27**, as provided in Section 19(k) of the Act; and $**3,330.00 (10/16/14 demanded benefits to 2/04/15)**, as provided in Section 19(l) of the Act.

Petitioner's request for prospective medical care is allowed and Respondent is ordered to authorize and pay for Petitioner's upcoming visit with Dr. Koth.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

Signature of Arbitrator

April 2, 2015
Date

APR 14 2015

FINDINGS OF FACT AND CONCLUSIONS OF LAW

At the time of arbitration the disputed issues included accident; causal connection; medical bills; temporary total disability benefits; prospective medical care; and penalties and attorney's fees. Respondent's attorney requested leave to submit a response to the Petition for Penalties and Fees with his proposed decision. No such response was received by the Arbitrator. Therefore, there is no "Respondent's Exhibit 3." Petitioner was the sole witness testifying at the hearing.

The Arbitrator finds:

On June 8, 2014, Petitioner reported to the emergency room of Heartland Regional Medical Center. (PX 2, pp. 2 - 10) Petitioner complained of injury to her head with brief loss of consciousness, low back pain, coccyx pain, and left and right gluteus maximum pain, after having fallen the day before when she slipped in tea. She denied any similar symptoms in the past. (PX 2) A Nurse's Note also indicated that Petitioner was carrying a bucket of water when she fell. (PX 2, p. 6) A CT Scan of Petitioner's head was negative and a CT Scan of her lumbar spine revealed a disc bulge at level L5-S1. (PX 2, pp. 11-12) She was prescribed Norco and Cyclobenzaprine and provided a work release form, Petitioner was instructed to follow up with Dr. James Alexander in five to six days.

On June 8, 2014 Petitioner and Perry Austin communicated via cell phone and texting. Mr. Austin texted "OK. Get better. Paperwork will get started tomorrow." (RX 4)

Later that same day at 9:02 p.m. Petitioner contacted Perry Austin via her cell phone texting:

> Hey Perry it's Sara again. Sorry to bother you but I was just gonna say don't worry about the workers comp papers as long as you made that report I'm okay with that. I'm not trying to make it hard on you...I think I'm going to be okay. (RX 4)

Mr. Austin responded "Ok glad to hear you're doing better." (RX 4)

On June 12, 2014, Petitioner was evaluated by her primary care physician, Dr. Nekzad, at Carterville Family Practice. (PX 4) Dr. Nekzad recorded a history of Petitioner falling at work on June 7, 2014 with a brief loss of consciousness. He further noted Petitioner's back pain was radiating into her legs. Dr. Nekzad continued Petitioner's pain medication and ordered her off work.

On June 19, 2014, Dr. Nekzad ordered an MRI as Petitioner's pain made it difficult for her to "get up and down", climb stairs or take care of her 2-year old child. (PX 4) She experienced a stabbing pain in her lumbar spine. Dr. Nekzad refilled Petitioner's pain medications and ordered her not to drive while taking the medications.

The MRI taken on June 25, 2014 revealed a moderate disc protrusion effacing the thecal sac at L5-S1, minimal bilateral neural foramen stenosis at L4-5, mild left greater than right neural foramen stenosis at L5-S1, no central canal stenosis, multilevel facet and liagamentum flavum hypertrophy, and mild degenerative disc disease at L5-S1 with intervertebral disc dessication. (PX 4, p.-022) On July 8, 2014, Dr. Nekzad opined Petitioner was not a surgical candidate and referred her to physical therapy. (PX 4, p.-023) Petitioner started physical therapy at Herrin Hospital on July 30, 2014, which was interrupted when she was hospitalized for a kidney infection the first week of August, 2014. (PX 4, p.-026) On August 15, 2014, Petitioner followed up with Dr. Nekzad who ordered her to resume physical therapy to assist with her back pain. Petitioner was also noted to be experiencing some anxiety and depression. (PX 4-026; PX 6, p. 109)

Petitioner filed her Application for Adjustment of Claim in this matter on August 21, 2014.

As of August 28, 2014 the physical therapist noted Petitioner could lift her 2 year old with complaints of increasing pain, could stand for one hour with increased pain complaints, could sleep comfortably, and was independent with her home exercise program. Petitioner's pain level was rated at "4/10" when at its worse. (PX 6, p. 00110)

On September 19, 2014, Petitioner returned to see Dr. Nekzad. She reported that her symptoms were unchanged and that physical therapy only helped for about an hour. Dr. Nekzad ordered Petitioner to continue physical therapy and indicated Petitioner should remain off work. (PX 4, pp.030-032)

On October 7, 2014 an Employer's First Report of Injury was completed by Respondent. (RX 1)

On October 16, 2014 Petitioner's attorney e-mailed Paul Wilson requesting the adjuster's contact information for Petitioner's workers' compensation claim. That same day, Mr. Wilson advised her that it was Rosemary Scumaci at AmTrust Group. (PX 8, pp. 126-127) On October 16, 2014 Petitioner's attorney e-mailed Ms. Scumaci requesting that temporary total disability (TTD) benefits for Petitioner be paid. She also enclosed "pertinent medical bills and records." (PX 8, p. 128)

On October 21, 2014, Dr. Nekzad noted Petitioner's lumbar condition was worsening and physical therapy was aggravating her symptoms. (PX 4, p.033) Dr. Nekzad stated she would start pain management tomorrow (October 22, 2014). Petitioner was to return within one month. (PX 4, pp.033-034)

Petitioner signed an Amended Application for Adjustment of Claim on October 27, 2014.

On November 5, 2014 Petitioner's attorney faxed Ms. Scumaci a demand for TTD benefits from June 7, 2014 to the present. (PX 8, pp. 129-130)

On November 6, 2014, Petitioner was evaluated at Johnston City Community Health Center by FNP Youngblood for moderately severe depression and lumbago. This was Petitioner's initial visit with FNP Youngblood. FNP Youngblood noted Petitioner was having a difficult time functioning as she had a depressed mood, difficulty falling asleep and staying asleep, diminished interest or pleasure, feelings of guilt, loss of appetite and restlessness. Petitioner also reported stress in personal life due to leaving her abusive husband. With regard to her back Petitioner indicated her symptoms began six months earlier when she fell at work. She had recently undergone an MRI and physical therapy. No back examination was conducted at that visit. (PX 7, p.0111) According to a "Referral Communication Form" of the same date Petitioner was being referred to an osteopath for evaluation and treatment. (PX 7, p. 0115)

On November 10, 2014 Tamra Horn from FNP Youngblood's office documented a telephone call with Petitioner's mother. According to it, Ms. Horn tried to reach Petitioner but couldn't and got her mother. She told her an appointment had been set with Dr. Koth for April 8, 2015 and she could call and try to get in sooner if there was a cancellation. (PX 7, p.0116)

On November 13, 2014 Petitioner's attorney e-mailed Mr. Wilson regarding Petitioner's claim being set for hearing on December 1st in Herrin and enclosing copies of pleadings. Counsel further represented that same was being sent to Ms. Scumaci who, to date, had failed to respond to any phone calls or demands for payment of TTD or medical bills. (PX 8, p. 131)

On November 24, 2014, the nurse practitioner Youngblood refilled Petitioner's pain medication -- both for her anxiety and depression as well as her lumbago. Ms. Youngblood noted Petitioner reported ongoing difficulty with functioning and no change in her emotional symptoms from the last visit. Xanax was only working for about 1.5 hours. No back examination was noted. (PX 7, pp.-0117 - 00120)

Petitioner's attorney and Ms. Scumaci spoke on November 25, 2014. On that same date additional medical records were sent to Ms. Scumaci and she was notified that Petitioner had met with "Dr. Griffith" that day. A copy of Petitioner's current off work slip was to be forthcoming. (PX 8, pp. 132-133)

Petitioner returned to see Nurse Youngblood on November 25, 2014 requesting a work note for her back. Petitioner's mood and affect appeared improved. No particular findings regarding a back exam were noted. In a note dated November 25, 2014 Nurse Youngblood stated that Petitioner was under her care and that Petitioner could not return to work at the present time and until further notice. (PX 7, pp. 00121 - 00123)

Petitioner underwent an examination at the request of Respondent on December 19, 2014. That examination was conducted by Respondent's independent medical examiner, Dr. Mirkin. Dr. Mirkin reveiwed reports from Dr. Nekzad from July through October of 2014. He also had the MRI scan report and First Report of Injury. After the exam, he issued a written report. In it he stated that Respondent filled out a First Report of Injury on October 7, 2014, indicating Petitioner had slipped and fell and "strained" her back. On examination Petitioner's lumbar spine was 70 percent of normal. She had an exaggerated pain response to light palpation of her lumbar spine. She complained of pain when her head was compressed and her legs distracted -- all indicative of positive Waddell's signs. Her motor and sensory exam was intact. She had no lower extremity atrophy. She could heel and toe walk. She could squat and rise from a squatting position. Straight leg raise in the sitting position was to 100 degrees and elicited neither back pain nor leg pain. She had no radicular symptoms.

Dr. Mirkin was of the opinion that Petitioner had sustained a lumbar contusion and that the amount of time she had been off work was unnecessary. He felt she was at maximum medical improvement and could work without restrictions. He saw no evidence of disability or need for pain management or surgery. (RX 1)

Petitioner returned to see Nurse Youngblood on December 23, 2014. With regard to her depression, the office notes indicate ongoing symptoms as shown in previous visits. Petitioner was having trouble concentrating and felt tired with little energy. With regard to her back, she was given a medication refill. Petitioner was to return in three months. (PX 7, pp. 00124-00125)

According to Commission records, Respondent's counsel entered his appearance on December 4, 2014.

By e-mail dated December 29, 2014 Petitioner's attorney notified Respondent's attorney that she had not yet received a PPD advance of $2500.00 as agreed to when Petitioner continued the previously scheduled December 1st 19(b) hearing so that an IME could be held on December 19, 2014. (PX 8, p. 134)

On January 5, 2015 Dr. Mirkin issued a supplement report after reviewing a CT scan dated June 8, 2014 taken of Petitioner's lumbar spine as well as therapy notes/records. He noted that the therapy discharge summary dated August 7, 2014 indicated Petitioner had stopped attending physical therapy for unknown reasons. He read the CT scan of Petitioner's spine as negative. His earlier opinions remained unchanged. (RX 2)

The PPD advancement was received on January 9, 2015. (PX 8, p. 134)

At the arbitration hearing, Petitioner, who is 25 years old, testified that she began working for Respondent in September, 2012. As of June 7, 2014 Petitioner worked as a Shift Leader working approximately 25 to 30 hours per week. Petitioner testified she began her shift at 8:00 a.m. on June 7, 2104. Part of her job duties as a shift leader included brewing tea and preparing to open the store. Petitioner testified that she was brewing tea and the tea basket fell

into the tea, requiring her to discard the tea in a sink located outside the kitchen doors. The tea urn weighed approximately 45 pounds and was full. While carrying the urn to the sink to dump it and start a new pot, Petitioner slipped on water near the sink and fell backward onto her buttocks and she believed that she struck the back of her head. Petitioner testified she lost consciousness and when she woke her clothes were saturated with tea. The accident occurred at approximately 9:30 a.m.

Petitioner testified that she yelled for her manager, Perry Austin, who was in the kitchen when she fell. Mr. Austin helped her off the floor and sat her in a chair. Petitioner and Mr. Austin were the only employees in the store at the time of the accident as the store did not open until 10:30 a.m. Petitioner testified that when she regained consciousness the back of her head hurt and it felt like her tailbone was broken making it difficult to walk. Petitioner also testified that her lower back hurt. Petitioner worked her shift until 2:00 or 4:00 p.m. the day of the accident.

Petitioner was not scheduled to work the day after the accident. She did report to the emergency room at Heartland Regional Medical Center complaining of pain in the back of her head, neck and back. Petitioner recalled CT Scan results revealed a bulging lumbar disc, inflammation, but no concussion. Petitioner was given a work release form upon discharge which she testified she delivered to her employer on her way home from the hospital. She gave the work slip to either her general manager, Perry Austin, or the kitchen manager, Holly Shultz.

Petitioner testified she followed up with her primary care physician, Dr. Nekzad, as instructed by the emergency room physician. Petitioner stated her doctor took her off work until further notice and gave her an off work slip. She testified she was "pretty positive" she took the work slip to Respondent the day of her doctor's appointment and gave it to either Perry Austin or Holly Schultz. She underwent an MRI at Herrin Hospital at the direction of Dr. Nekzad which revealed a moderate L5-S1 disc protrusion. Dr. Nekzad prescribed physical therapy and medication. Petitioner began physical therapy in July but stopped due to being hospitalized for a kidney infection. After being discharged she resumed physical therapy. Dr. Nekzad also prescribed pain management. Petitioner testified she could not obtain pre-authorization for pain management by the workers' compensation insurance carrier; therefore she did not receive such treatment.

Petitioner testified that her primary care physician, Dr. Youngblood, at Johnston City Community Health Center referred her to Dr. Koth, at Orthopedic Institute of Southern Illinois. Petitioner testified she is scheduled to see Dr. Koth in April, 2015. Petitioner's primary doctor has ordered her off work pending further notice and has prescribed Ultram.

Petitioner testified she has never been prescribed light duty restrictions or advised to return to work following her accident. She was given off work slips from her treating physicians and has not been released from treatment since the date of accident. Respondent has not offered any light duty position to Petitioner, nor has it requested any additional off work slips or medical

documentation since June 12, 2014 when Petitioner provided her manager with Dr. Nekzad's off work slip. Respondent never requested that Petitioner fill out an accident report.

On cross-examination Petitioner testified she was not aware of any light duty work opportunities with Respondent, nor has Respondent offered her light duty work. She testified she has not been terminated or put on inactive status. Respondent has not contacted Petitioner to inquire about her return to work. Petitioner testified that after she retained counsel in August, 2014, she was instructed by her attorneys not to communicate directly with Respondent. Petitioner acknowledged that she is a Type 1 diabetic and occasionally has health issues, like her kidney infection, related to that condition. She agreed that her kidney problems caused some lower back pain. Petitioner also acknowledged that she underwent no drug testing after the accident and that she texted Perry Austin on June 8, 2014. She acknowledged that she has received no benefits since the accident.

Petitioner testified that she is able to drive, go shopping, and care for things around her house. Since her therapy ended and pain management wasn't approved, she basically sits at home.

Petitioner testified that she sometimes feels pain in her back; otherwise, it's a sharp, stabbing pain. The pain goes from below her waist/beltline to her buttocks. Petitioner denied any ongoing leg pain. She finds it difficult to sit or stand for long periods of time. It hurts to pick up her three year old daughter. Climbing stairs must be done slowly.

Petitioner denied any difficulties performing her job before June 7, 2014.

On redirect examination Petitioner explained that she still has the same symptoms she had prior to being hospitalized for her kidney infection. She also testified that Mr. Austin never asked her to fill out an accident report.

Respondent did not call any witnesses.

The Arbitrator concludes:

Issue C. Did an accident occur that arose out of and in the course of Petitioner's employment on June 7, 2014?

Petitioner sustained an accident on June 7, 2014 that arose out of and in the course of Petitioner's employment with Respondent. This conclusion is based upon Petitioner's credible and unrebutted testimony, the First Report of Injury (mentioned in RX 1), and the histories contained in various medical records which corroborate Petitioner's testimony. Petitioner was engaged in a task required by her job at the time of her accident. She was in the course of her employment.

Issue D. Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner's current condition of ill-being in her low back is causally related to her accident of June 7, 2014. This conclusion is based upon a chain of events and the treating medical records. Dr. Mirkin believed Petitioner had sustained a lumbar contusion but felt that it had resolved by the date of his report. Additionally, Dr. Mirkin does not mention anywhere in his IME report that Petitioner sustained a prior injury to her lumbar spine or that Petitioner's symptoms are caused by another source. Dr. Mirkin's report does not indicate he reviewed any medical records related to Petitioner's hospitalization in July/August, 2014 (related to her kidney infection) or whether it contributed to or caused Petitioner's lumbar pain. Petitioner testified that her lumbar symptoms existed prior to her hospitalization and her symptoms did not change after her kidney infection resolved, which is supported by her medical records.

It does not appear from Dr. Mirkin's report that he reviewed the actual MRI performed on June 25, 2015, although he agreed that the MRI report showed a moderate disc protrusion at L5-S1. Dr. Mirkin's opinion that Petitioner sustained a "lumbar contusion" is unsupported by the objective medical records and testimony introduced at arbitration.

Petitioner's head and arm injuries appear to have resolved.

Issues J. & K. Were the medical services that were provided to Petitioner reasonable and necessary and is prospective medical care appropriate pursuant to Section 8(a)?

At Arbitration, the Petitioner placed the following bills into evidence:

(1)	Heartland Regional Medical Center (PX-1)	$ 7,350.21
(2)	Carterville Family Practice (PX-3)	$ 864.00
(3)	Herrin Hospital (PX-5)	$ 7,354.00

There was no question raised at arbitration as to the reasonableness or necessity of the charges incurred. A review of the medical records presented at arbitration by Petitioner show that the treatment received by Petitioner was appropriate. Respondent's Section 12 examiner, Dr. Mirkin, opined that physical therapy was appropriate treatment for Petitioner's injury and he did not state that any prior treatment received by Petitioner was unreasonable or unnecessary. (RX1)

Based upon the evidence presented at arbitration, the Arbitrator finds that the above charges were reasonable and necessary and causally related to the accidental injuries sustained by Petitioner on June 7, 2014. Accordingly, the Arbitrator awards the medical bills in the amount of $15,568.21 subject to the Medical Fee Schedule.

The Arbitrator further awards compensation as provided by Section 8(a) of the Act for future medical treatment as the medical evidence supports a referral to a neurologist to treat her lumbar disc injury. Dr. Mirkin's Section 12 report is void of any medical evidence that Petitioner sustained a "lumbar contusion" and is directly contradictory to objective diagnostic studies supporting her injury. Even he acknowledged that her MRI showed a disc protrusion at L5-S1. While he read the CT lumbar scan as being negative he provided no explanation for that conclusion and the radiologist and Dr. Nekzad interpreted it differently and consistent with what the subsequent MRI showed. Furthermore, Dr. Mirkin was the only physician noting positive Waddell's signs. No other doctor has questioned her veracity. It is also interesting that Dr. Mirkin expressed his opinions of December 19, 2014 in terms of "I think," thereby suggesting less than certainty in his opinions. He then issued a subsequent report; however, it was not based upon a subsequent exam of Petitioner. Furthermore, his analysis of Petitioner's physical therapy records was not insightful. Petitioner stopped attending physical therapy in July/August of 2014 due to her kidney infection. Apparently, the doctor was not aware of that. It also doesn't appear he had any updated information concerning Petitioner's ongoing care since October of 2014 and her ongoing need for pain medication. Respondent is ordered to authorize and pay for Petitioner's appointment with Dr. Koth.

Issue L. What amount of compensation is due for temporary total disability benefits?

Based on the above findings of accident and causal connection, the Arbitrator hereby finds Petitioner is entitled to temporary total disability benefits related to the accident of June 7, 2014. Petitioner was provided a work status form by the emergency room on June 8, 2014, which she delivered to the Respondent. Petitioner was taken off work by her primary care physician, Dr. Nekzad, on June 12, 2014. Petitioner has remained off work through the course of her treatment, including physical therapy in August and September, 2014. In September, 2014, Dr. Nekzad noted Petitioner was not improving with physical therapy and ordered pain management, which Petitioner did not undergo due to insurance reasons. On November 25, 2014, Petitioner was ordered to remain off work until further notice.

Petitioner's treating physicians have consistently ordered Petitioner off work while she underwent treatment. Respondent failed to introduce any evidence at arbitration that Petitioner's time off work was unreasonable or unnecessary. Dr. Mirkin's IME report was not prepared until December 19, 2014 and was not received by Petitioner or Respondent's counsel until January 20, 2015. (PX8, pp.0135-0136) For over seven (7) months Petitioner was allowed to treat at the direction of her physicians without any opinion from Respondent that her treatment or time off work was unreasonable or unnecessary. Further, Respondent never contacted Petitioner to inquire when she intended to return to work or to request updated off work slips.

The Arbitrator hereby awards temporary total disability benefits for the period June 8, 2014 through February 4, 2015.

While Dr. Mirkin is of the opinion that Petitioner can return to work without any restrictions and is of the opinion she is at maximum medical improvement, his reasoning is not

persuasive. In his January 2015 addendum report he comments on Petitioner's attendance with physical therapy, noting she had stopped in August of 2014. Dr. Mirkin was not aware of Petitioner's hospitalization in July. That would explain why Petitioner on August 7, 2014 was noted to have stopped attending. He saw no evidence of disability or need for surgery or pain management. While he felt she didn't need to be off work for the amount of time she had been, he didn't state what an appropriate amount of time would be. While he felt the CT scan of Petitioner's lumbar spine was negative he agreed that the MRI showed a moderate disc protrusion at L5/S1. The radiologist reading the CT scan taken on June 8, 2014 noted it, too.

The Arbitrator hereby awards temporary total disability benefits for the period June 8, 2014 through February 4, 2015.

Issue M. Should penalties or fees be imposed upon Respondent?

Based upon the evidence presented by Petitioner and Respondent at Arbitration, the Arbitrator finds that Respondent's failure or refusal to pay compensation as provided in Section 8(a) of the Act was unreasonable and vexatious.

Petitioner sustained an accidental injury on June 7, 2014. On August 14, 2014, Petitioner's counsel mailed the Application for Adjustment of Claim to McAlister's Deli. On October 16, 2014, Petitioner's counsel e-mailed Paul Wilson at Charter Insurance who insured McAlister's Deli to obtain insurance information. (PX9, p. 0127) On October 16, 2014, Petitioner's counsel e-mailed the insurance adjuster, Rose Scumaci, making a written demand for benefits and providing her with supporting medical records and bills. (PX9, p. 0128)

On November 5, 2014, Petitioner's counsel sent a fax to Rose Scumaci again requesting a response to the demand for benefits. (PX9, pp. 0129-0130) Rose Scumaci failed to respond to Petitioner's phone calls, emails or faxes; therefore Petitioner emailed a Notice of 19(b) Hearing to Paul Wilson at Charter Insurance. (PX9, p. 0131) The 19(b) hearing was scheduled for December 1, 2014. On December 1, 2014, Respondent agreed to advance $2,500 to Petitioner to allow Respondent time to obtain a Section 12 examination, in exchange for continuing the 19(b) hearing.

On December 29, 2014, Petitioner still had not received the $2,500 payment that was promised in exchange for continuing the December 1, 2014 hearing. (PX9, p. 0134) The IME was performed on December 19, 2014. Petitioner emailed James Clune demanding the $2,500 payment and advising the case was going to be reset in January, 2015, with penalties, for failure to pay benefits and no reasonable basis for nonpayment. (PX 9, p. 0134) The advance payment of $2,500 was not received by Petitioner until January 9, 2015.

The Section 12 report was not received by Petitioner or Respondent's counsel until January 20, 2015. (PX9, pp. 0135-0136) Even after receiving the IME report, Respondent did not pay any medical bills or temporary total disability benefits. Dr. Mirkin's report did not find any of Petitioner's medical care to be unreasonable or unnecessary.

Petitioner filed her Petition for Penalties on November 19, 2014. (PX 9) Respondent did not file a response to the Petition. There is no evidence in the record from which the Arbitrator can determine why Respondent did not pay benefits to Petitioner. Respondent disputed accident but presented no witnesses to contradict Petitioner's testimony nor did it include the First Report of Injury as an exhibit. Respondent received prompt notice of the accident as evidenced, at a minimum, by the text messages between Petitioner and Mr. Austin. Respondent never presented Petitioner with a "written explanation of the basis" of its denial of benefits as required by Section 7110.70 of the Rules. As a result of Respondent's refusal/denial of benefits, Petitioner has received no temporary total disability benefits or payment of medical bills. Only when pressed to obtain a report pursuant to Section 12 did Respondent advance a payment and, even then, that payment was not entirely timely.

Respondent's failure or refusal to pay any medical or temporary total disability benefits to Petitioner without a reasonable basis for denying same for over seven months following the accident represents a rebuttable presumption of unreasonable delay.

Accordingly, and as set forth in Petitioner's proposed decision, the Arbitrator awards penalties as provided by Sections 19(k) in the amount of $4,355.27, Section 19(l) penalties in the amount of $3,330.00, and Section 16 attorneys' fees in the amount of $1,537.05.

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STATE OF ILLINOIS)
) SS
COUNTY OF WILL)

BEFORE THE ILLINOIS WORKERS COMPENSATION COMMISSION

Javier Canales
Petitioner,

vs. NO: 02 WC 16163

Enterprise Pallets, Inc.,
Respondent,

ORDER

This case comes before the Commission on Petitioner's Motion for payment of medical bills incurred, penalties, and garnishment fees in regard to a settlement contract approved by this Commission on June 14, 2006. The Motion was presented before Commissioner Charles J. DeVriendt on December 18, 2015 in New Lenox, Illinois. Pursuant to Commissioner's Exhibit E, Respondent received notice of this hearing on December 12, 2015. Respondent did not appear. The Commission, after considering the evidence orders the Respondent to pay the Petitioner the total amount of the medical bills, the garnishment fees and 50% of the total amount because the non-payment of the medical bills were clearly unreasonable and vexatious.

Petitioner presented the Commission with Exhibit B a listing of Creditors Collection Bureau of three medical providers and the balance due them. Attached to that exhibit is an itemized breakdown of each bill. Riverside Medical Center is due and owing $4,187.00. Community Anesthesia is due and owing $1,350.00 and $1,020.00. This comes to a total of $6557.00.

In addition, thereto, Petitioner underwent garnishment and was charged a fee of $83.54. This occurred 7 times for a total of $584.78. (Exhibit C)

The Commission on June 14, 2006 approved this settlement. One of the terms of the settlement was that Respondent assumed sole responsibility for all medical and surgical expenses that occurred as a result of this injury. The Commission finds that all of

the above bills were a result of the injury on February 1, 2002 and were necessary and reasonable. The Commission finds that Respondent's failure to pay these bills, almost ten years after the date of approval was vexatious and unreasonable. Respondent must pay, in addition to the above listed medical bills, 50% of that amount as penalties under Section 19(k) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent must pay the Petitioner $10,712.67.

DATED: MAR 2 2 2016

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

CJD/hsf
R: 12/18/15
049

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sheri Ledgerwood,

Petitioner,

vs. NO: 02 WC 66253

State of Illinois/Department of Natural Resources,

Respondent.

16IWCC0197

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident causal connection, medical expenses, travel expenses, temporary total disability benefits and permanent disability benefits, hereby reverses the Arbitrator's Decision and finds that Petitioner sustained accidental injuries arising out of and in the course of her employment with Respondent on June 17, 2001, that her current condition of ill-being is causally related to the June 17, 2001 work accident and that Respondent is liable for medical expenses incurred in the treatment of such accident, as well as temporary total disability benefits and permanent disability benefits as a result of said accident.

It is unrebutted that Petitioner worked at Jake Wolf Fish Hatchery on June 17, 2001 removing muck from a pond and disposing of it in a nearby forested area. It is unrebutted that Petitioner found a tick in her hair once she got home after spending the day removing muck from a pond and disposing of the muck in a nearby forested area. And it is unrebutted that she developed aches and pains, specifically joint pain, and fatigue, after spending the day removing muck from a pond, disposing of the much in a forested area, and finding a tick in her hair. The Commission notes that there is nothing in the record to indicate that Petitioner spends her time off in wooded areas where ticks are abundant. However, the Commission further notes, that the record establishes that her job with Respondent requires that she work in areas where ticks are usually found.

As explained by the court in *Dodson v. Industrial Commission*, 308 Ill.App.3d 572, 575-576 (1999):

> [w]hether an employee's injuries "arose out of" the employment may be determined under two different approaches. First, an injury arises out of the employment where its origin stems from a risk connected with, or incidental to, the employment. *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. "A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties." *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. Second, an injury arises out of the employment where it is caused by some risk to which the employee is exposed to a greater degree than the general public by virtue of his employment. *Orsini*, 117 Ill. 2d at 45.

There is no question that Petitioner's job exposes her to the risk of tick bites to a greater degree than the general public. Furthermore, as explained in *Organic Waste Systems v. Industrial Commission*, 241 Ill.App.3d 257, 260 (1993):

> [I]t is well established that a finding of a causal relationship may be based on a medical expert's opinion that an accident "could have" or "might have" caused an injury. (*Mason & Dixon Lines, Inc. v. Industrial Comm'n* (1983), 99 Ill. 2d 174, 457 N.E.2d 1222, 75 Ill. Dec. 663.) Further, a chain of events which demonstrates a previous condition of good health, accident and subsequent injury resulting in disability may be circumstantial evidence to prove a causal nexus between the accident and claimant's injury. *International Harvester v. Industrial Comm'n* (1982), 93 Ill. 2d 59, 442 N.E.2d 908, 66 Ill. Dec. 347.

Again, there is nothing in the record to indicate that Petitioner could have encountered the tick she found in her hair on June 17, 2001 somewhere else. It would also defy common sense to claim that Petitioner could not have possibly gotten the tick at work after spending the day out in a wooded area and, basically, swamp land. Therefore, based on the totality of the evidence, the Commission finds that Petitioner has, by a preponderance of the evidence, established that she suffered a work related injury, i.e. tick bite, on June 17, 2001.

Next, the Commission notes that Dr. Crist issued a narrative report on December 10, 2014, explaining that there is a "highly significant likelihood her illness was caused by an infection from a tick bite." (PX7) While the Commission notes that Dr. Taylor's tests for Lyme Disease came back negative, Dr. Crist's considerably more detailed Lyme Western Blot tests came back positive for Lyme Disease. Subsequent Lyme Western Blot tests conducted continued to be positive for Lyme Disease. And while Petitioner continued to have aches and pains, fatigue and joint pain for a substantially long time, her symptoms improved with treatment once she started to undergo the proper treatment regimen under Dr. Crist for Lyme Disease.

16IWCC0193

Prior to seeing Dr. Crist, Petitioner saw Dr. Taylor and Dr. Slagle, both of whom failed to properly diagnose her Lyme Disease, which resulted in continued and worsening symptoms of aches and pains and fatigue. Once Petitioner was properly diagnosed as having Lyme Disease by Dr. Crist, the treatments provided by Dr. Crist improved Petitioner's condition and managed her symptoms. The Commission notes that it was not until Petitioner was diagnosed as having Lyme Disease that Petitioner's symptoms improved with treatment.

Therefore, based on the results of the Lyme Western Blot tests, Dr. Crist's findings and opinions, and the medical records, the Commission finds that Petitioner's condition of ill-being, i.e. Lyme Disease, is causally related to the June 17, 2001 accident.

Based on the above finding, the Commission hereby awards medical expenses incurred in the treatment of Petitioner's Lyme Disease, totaling $40,358.60. The Commission denies Petitioner's claim for travel expenses, noting that Petitioner admitted that during her trips to St. Louis for treatment she also took the opportunity to visit her son and/or eat out and some hotel stays were dictated by caution over weather. (T.20,30-31)

The Commission notes that Petitioner was taken off work from August 2, 2001 through August 24, 2001, when Dr. Slagle released Petitioner to return to work with restrictions. (PX1,RX1,PX4,RX2) Therefore, the Commission awards temporary total disability benefits for that period, totaling 3-2/7 weeks.

Regarding permanent disability, the Commission notes that Petitioner has had to undergo treatment for a considerably long time, and continues to do so for management purposes. Petitioner goes to Dr. Crist about every three months for bioidentical hormone replacement pellets, which are inserted into her side, in order to manage her condition. The Commission notes that Petitioner continues to experience aches and pains, but these symptoms "come and go." (T.16) Based on the medical records, findings and opinions of Dr. Crist, and Petitioner's testimony regarding her condition, the Commission finds Petitioner has suffered a 15% loss of use of the person as a whole as a result of the work accident under Section 8(d)2 of the Act.

So that the record is clear, and there is no mistake as to the intentions or actions of this Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical / legal perspective. Furthermore, we have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent. Finally, one should not and cannot presume that we have failed to review any of the record made below. Though our view of the record may or may not be different than the arbitrator's, it should not be presumed that we have failed to consider any evidence taken below. Our review of this material is statutorily mandated and we assert that this has been completed.

IT IS THEREFORE ORDERED BY THE COMMISSION that that the Decision of the Arbitrator, filed on March 31, 2015, is reversed as stated above.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $475.37 per week for a period of 3-2/7 weeks, from August 2, 2001 through August 24, 2001, that being the period of temporary total incapacity for work under

Section 8(b) of the Act. 16IWCC0197

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $427.84 per week for a period of 75 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused the 15% loss of use of the person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay the sum of $40, 358.60 in medical expenses pursuant to Sections 8(a) & 8.2 of the Act. Respondent shall have credit for amounts paid under Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under Section 19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

DATED: MAR 17 2016
MJB/ell
o-01/25/16
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LEDGERWOOD, SHERI
Employee/Petitioner

Case# 02WC066253

16IWCC0197

ST OF IL DEPT OF NATURAL RESOURCES
Employer/Respondent

On 3/31/2015, 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 0.13% 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:

2249 HARVEY & STUCKEL
DAVID STUCKEL
101 S W ADAMS ST SUITE 600
PEORIA, IL 61602

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

5116 ASSISTANT ATTORNEY GENERAL
GABRIEL CASEY
500 S SECOND ST
SPRINGFIELD, IL 62706

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9205

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

MAR 31 2015

RONALD A. HARDIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Sheri Ledgerwood
Employee/Petitioner

Case # **02** WC **66253**

v.

State of Illinois - Department of Natural Resources
Employer/Respondent

16IWCC0197

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 **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Peoria**, on **February 13, 2015**. 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. [x] 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. [x] 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. [x] 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. [x] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [x] TTD
L. [x] 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 **June 17, 2001**, 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 not*** 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**37,079.12**; the average weekly wage was $**713.06**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**1,086.65** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**1,086.65**.

ORDER

The Petitioner's claim for compensation is denied.

No benefits are awarded herein.

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.

Arbitrator Anthony C. Erbacci

March 27, 2015
Date

MAR 31 2015

headache, nausea. . . . For three days, had numbness of the legs, then noticed a large lymph node in the left groin. Came in to see me on 7/20/01 and I thought she had a UTI and treated her with Levaquin. She did not improve. She continues to be extremely tired." Dr. Taylor's assessment was possible ehrlichiosis and she prescribed ehrlichiosis antibody testing and continued the Petitioner off work. The Petitioner returned to Dr. Taylor on August 13, 2001 and reported that she felt better with the exception of some joint pain and discomfort in her left foot and left groin. Dr. Taylor suggested a repeat ehrlichiosis titer, as the previous test was negative, and that the Petitioner see Dr. David Slagle. The assessment on that date was "Recent febrile illness with elevated liver enzymes, back pain, suprapubic pain, and arthropathy, resolving." On August 21, 2001 Dr. Taylor noted that the Petitioner was "feeling well except for some joint aches." Dr. Taylor noted that the Petitioner was scheduled to see Dr. Slagle and that the Petitioner's illness with fever and elevated liver enzymes appeared to be resolved.

On August 22, 2001 the Petitioner saw Dr. Slagle with complaints of persistent fatigue with diffuse arthralgias. It was noted that the Petitioner reported that, in early June, she noticed a large tick at the nape of her neck which she removed and discarded. It was also noted that the Petitioner reported that the tick "was large but not engorged". Dr. Slagle noted that the Petitioner's ehrlichiosis test was negative and he diagnosed her as having "Acute febrile illness characterized by fever, headaches, diffuse arthralgias/arthritis, severe fatigue, leukocytosis, and low level liver enzyme elevation". Dr. Slagle recommended repeat Ehrlichia serology as well as testing to rule out mononucleosis, Hepatitis B and Leptospirosis.

The Petitioner testified that after talking to some of her co-workers, she sought treatment with Dr. Charles Crist in Columbia Missouri. The records of Dr. Charles Crist demonstrate that he saw the Petitioner on September 18, 2001 and that the Petitioner reported that she was bitten on her head by a tick at the beginning of June, 2001. The Petitioner's complaints at that time included achy joints, pain, difficulty sleeping, numbness and swelling in her left leg and foot, tingling in her hands, fatigue and depression. Dr. Crist apparently diagnosed the Petitioner as having borreliosis and the Petitioner continued to treat with Dr. Crist through January of 2015.

In a December 10, 2014 letter report directed to the Petitioner's attorney, Dr. Crist indicated that the Petitioner's diagnosis was borreliosis, or Masters' disease, and he opined that "there is a highly significant likelihood her illness was caused by an infection from a tick bite." Dr. Crist also reported that the Petitioner's condition was better than it was in 2001 but that she continued to have chronic back pain, headaches, neck pain, cognitive problems and low energy. Dr. Crist indicated that it was possible that the Petitioner might need additional medical care including prescriptions for hormones, vitamin B12 and trazodone for sleep.

The Petitioner testified that her symptoms continue through the present time and that from time to time they are severely increased. The Petitioner testified that she continues to take medications and she continues to see Dr. Crist every three months for surgical insertion of bioidentical hormones.

16IWCC0197

FACTS:

On June 17, 2001, the Petitioner was employed by the Respondent at the Jake Wolf Fish Hatchery which is located in the Sand Ridge State Park. The Petitioner testified that her job duties included raising fish, maintaining and cleaning fish tanks and ponds, and collecting and distributing fish. The Petitioner described that the hatchery is located in a very rural forested area and that there were fish ponds located around the grounds. The Petitioner testified that her job duties also required her to assist in the cleaning of the fish ponds which would become filled with muck.

The Petitioner testified that on June 17, 2001 she worked taking muck from the bottom of an emptied fish pond out to a weedy overgrown field where the muck was dumped. The Petitioner testified that this work required her to travel through a wooded area into an area of high grass. The Petitioner testified that after returning home at the end of that work day, she was dirty and needed a shower. She testified that while she was in the shower, she felt something in her hair, which she removed, and discovered was a tick. The Petitioner described the tick as "a little bitty brown one" which she thought to be a deer tick. On cross-examination, the Petitioner testified that she picked the tick out of her hair.

The Petitioner testified that ten to fourteen days later, she experienced the onset of flu-like symptoms which included body aches and pains, a stomach ache, a fever, and passing out. She testified that she then sought treatment with Dr. Lizbeth Taylor, her primary care physician, who took her off work and referred her to Dr. David Slagle. The Petitioner testified that she saw Dr. Slagle on August 22, 2001and that he examined her and continued her off work. The Petitioner testified that she then decided to treat with Dr. Charles Crist, a physician located in Springfield, Missouri, as a result of conversations with some co-workers. The Petitioner testified that Dr. Crist diagnosed her as having Lyme disease and that she continues to treat with Dr. Crist through the present time.

The medical records of Dr. Lizbeth Taylor demonstrate that the Petitioner was seen by Dr. Taylor on June 26, 2001and it was noted that the Petitioner reported feeling better the last three days after having "recently treated with illness of dysuria, myalgia, fever, chills and pelvic discomfort." The Assessment on that date was "Probable viral illness with elevated liver enzymes and abdominal pain, could have been UTI, treated with Levaquin and improved." Dr. Taylor ordered CBC, liver function and sed rate tests.

The Petitioner returned to Dr. Taylor on July 20, 2001 with literature about Lyme's disease and ehrlichiosis and complaints of fever and swelling in the left groin. Dr. Taylor's assessment was "Fever, lymphadenitis. No history of rash. Consider ehrlichiosis and rule out Lyme disease." Dr. Taylor ordered a Lyme disease titer and prescribed doxycycline. The Petitioner followed up with Dr. Taylor on July 23, 2001 and Dr. Taylor noted that she had checked the Petitioner for Lyme's disease and the test was negative.

On July 30, 2001 Dr. Taylor noted that the Petitioner "Found a tick in her hair on 6/17/01 and developed a high fever the next day, legs were numb. . . . She had a fever,

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CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds and concludes as follows:

It is axiomatic that the Petitioner bears the burden of proving all the elements of her claim by a preponderance of the credible evidence. The Arbitrator finds that the Petitioner failed to meet that burden here. In so finding, the Arbitrator notes the following.

The Petitioner testified that she found a tick in her hair when she showered after returning home from work on June 17, 2001. The records of Dr. Taylor whom the Petitioner saw on June 26, 2001, July 20, 2001, July 23, 2001 and July 30, 2001, do not specifically mention the presence of a tick until the visit of July 30, 2001. At that visit, the Petitioner reported finding a tick on her neck on June 16, 2001. The August 22, 2001 note of Dr. Slagle indicates that the Petitioner reported that in early June, she noticed a large tick at the nape of her neck which she removed and discarded. It was also noted that the Petitioner reported that the tick "was large but not engorged". The Arbitrator finds it curious that there is no specific mention of a tick in the medical records until over one month after the tick was allegedly discovered.

While it might not be unreasonable to infer from the Petitioner's testimony that a tick landed on her while she was working for the Respondent on June 17, 2001, there is nothing else in the record which supports that inference. While the Petitioner may have spent more time at work that day than she did elsewhere, and while the environment at work may have been good habitat for ticks, she was also exposed to the possibility of a tick landing on her at any other time during that day, or any other day, that she was outdoors. Further, the Arbitrator notes that there is nothing in the record which demonstrates that the Petitioner was actually bitten by a tick. While the Petitioner's testimony that she found a tick on her person while showering is undisputed and consistent with the histories noted in the medical records, there is nothing in her testimony or the medical records which indicates that she was bitten by the tick. The Petitioner testified that she noticed the tick in her hair and that she removed the tick and discarded it. The Petitioner did not testify that the tick was attached to her person or that she was unable to remove the entire tick, and the record of Dr. Slagle indicates that the tick "was large but not engorged."

Similarly, while the Petitioner testified that her symptoms began after she discovered the tick, there is nothing in the medical records, other than the letter report of Dr. Crist, which causally relates the Petitioner's symptoms to a tick bite. The Arbitrator finds the letter report of Dr. Crist to be unreliable and unpersuasive. First, the Arbitrator notes that the report appears to have been generated in anticipation of litigation. Next, Dr. Crist bases his opinion on the fact that the Petitioner was bitten by a tick. As noted above, it is not clear from the record that

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the Petitioner was actually bitten by a tick. Additionally, it is not clear form Dr. Christ's report that he was relating the Petitioner symptoms to the alleged tick bite on June 17, 2001, as opposed to any other tick bite the Petitioner may have suffered. Dr. Crist merely opined that there was a highly significant likelihood that the Petitioner's illness was caused by an infection from "a tick bite." Finally, and most importantly, Dr. Crist opined that "there is a highly significant likelihood" that the Petitioner's illness was caused by a tick bite. A "highly significant likelihood" does not rise to the level of the required standard of "a reasonable degree of medical certainty". Thus, the Arbitrator finds Dr. Crist's opinions to be of insufficient probative value to satisfy the Petitioner's burden of proof.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner failed to prove that an accident occurred which arose out of and in the course of her employment with the Respondent. The Arbitrator further finds that the Petitioner failed to prove any condition of ill-being which is causally related to the alleged work injury of June 17, 2001.

Having found that the Petitioner failed to meet her burden of proof with regard to the issues of accident and causation, determination of the remaining disputed issues is moot.

The Petitioner's claim for compensation is denied. No benefits are awarded herein.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

☒ Affirm and adopt (no changes)	☒ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Arkadzi Karabeinikau,

Petitioner,

vs. NO: 06 WC 28067

16IWCC0200

Flyvision Dmitry Paev & Dan Rutherford
Illinois State Treasurer As Ex-Officio Of
The Injured Workers' Benefit Fund,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, benefit rates, employment, jurisdiction, medical expenses, notice, occupational disease, penalties, fees, permanent partial disability, temporary total disability, notice of decision and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 28, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondents shall pay Petitioner permanent partial disability benefits of $540.00/week for 63.25 weeks, as provided in Section 8(d)2 of the Act, because the physical injuries sustained cause the 12.65% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondents shall pay Petitioner temporary total disability benefits of $600.00/week for the period of 18 1/7 weeks, from June 6, 2006 through October 10, 2006 pursuant to Section 8(b) of the Act.

16IWCC0200

IT IS FURTHER ORDERED BY THE COMMISSION THAT Respondent Injured Workers' Benefit Fund shall pay Petitioner an amount equal to the total of the medically necessary and reasonable medical bills that are currently outstanding in this case, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

The Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefits Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefits Fund.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $45.000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 18 2016
o022516
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

CONFIDENTIAL

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KARABEINIKAU, ARKADZI
Employee/Petitioner

Case# 06WC028067

16IWCC0200

FLYVISION DMITRY PAEV & DAN RUTHERFORD
ILLINOIS STATE TREASURER AS EX-OFFICIO
OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 5/28/2015, 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 0.08% 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:

0125 COJN LAMBERT RYAN & SCHNEIDER
PATRICK J RYAN
500 W MADISON ST SUITE 2300
CHICAGO, IL 60661-2593

0000 FLYVISION DMITRY PAEV
10001 N LOMBARD RD
LOMBARD, IL 660148

5204 ASSISTANT ATTORNEY GENERAL
CHRISTOPHER FLETCHER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

16IWCC0200

STATE OF ILLINOIS)
)SS.
COUNTY OF Dupage)

☒ 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

Arkadzi Karabeinikau,
Employee/Petitioner

Case # 06 WC 28067

v.

Chicago, IL

Flyvision, Dmitry Paev, & Dan Rutherford, Illinois State Treasurer, as *ex-officio* custodian of the Injured Workers' Benefit Fund,
Employers/Respondents

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 **Brian Cronin**, Arbitrator of the Commission, in the city of **Wheaton**, on **12/12/14**. 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 **6/5/2006**, 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 an average weekly wage of $**900.00**.

On the date of accident, Petitioner was **41** years of age, ***single*** with **1** dependent child. (AX 1)

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

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

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

ORDER

Respondents shall pay Petitioner permanent partial disability benefits of $**540.00**/week for **63.25 weeks**, as provided in Section 8(d)2 of the Act, because the physical injuries sustained caused the **12.65%** loss of use of the person as a whole.

Respondents shall pay Petitioner temporary total disability benefits of $**600.00**/week for the period of **18-1/7** weeks, from June 6, 2006 through October 10, pursuant to Section 8(b) of the Act.

Respondent Injured Workers' Benefit Fund shall pay Petitioner an amount equal to the total of the medically necessary and reasonable medical bills that are currently outstanding in this case, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

The Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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.

Signature of Arbitrator

May 26, 2015
Date

MAY 28 2015

Petitioner testified that he has trouble lifting heavy things, and that his arm is not 100%. Petitioner has worked at least two jobs since he was released to return to work. Petitioner has returned to the occupation of driving across the country, albeit in a van that hauls a single vehicle on a trailer. Petitioner testified that he does not drive bobtails and tractor-trailers because it is too difficult for him.

Based on the foregoing, the Arbitrator finds that as a result of his accident of June 5, 2006, Petitioner has sustained a loss of use, man as a whole, to the extent of 12.65%, pursuant to Section 8(d)2 of the Act.

n. Is Respondent due any credit?

No evidence was presented by Respondent as to payments made.

Arbitrator Brian Cronin

May 26, 2015
Date

16IWCC0200

STATE OF ILLINOIS)
)
COUNTY OF Cook)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Arkadzi Karabeinikau,
Employee/Petitioner

Case # 06 WC 28067

v.

Chicago, IL

Flyvision, Dmitry Paev, & Dan Rutherford, Illinois State Treasurer, as *ex-officio* custodian of the Injured Workers' Benefit Fund,
Employers/Respondents

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

I. FINDINGS OF FACT

This action was pursued under the Illinois Workers' Compensation Act ("the Act") by the Petitioner and sought relief from Respondent-employer Flyvision, Dmitry Paev, and the Injured Workers' Benefit Fund regarding Petitioner's work-related accident on June 5, 2006. Petitioner subpoenaed Dmitry Paev for the hearing on December 12, 2014. Mr. Paev was also previously informed in open Court that his presence was required at trial on December 12, 2014, and that if he did not appear the trial would proceed without him. On the day of trial, no one appeared on his behalf or on the behalf of Flyvision. That trial was held before Arbitrator Brian Cronin in Wheaton, Illinois. The Illinois Attorney General filed an appearance on behalf of the Illinois State Treasurer, as *ex-officio* custodian of the Injured Workers' Benefit Fund. Petitioner's Exhibits 1 – 14 were admitted into evidence.

Petitioner testified that he lives at 2354 West Rice Street, Chicago, Illinois. Petitioner testified that he met Mr. Paev when he was hired by Flyvision, which is a company located in Lombard, Illinois. Petitioner first met Mr. Paev in April 2006. Petitioner was hired right away

by Mr. Paev to drive a bobtail truck, which is a truck that transfers large loads of up to 45,000 pounds, all over America. Petitioner testified that Flyvision had an office and warehouse together. Petitioner testified that electricity was used in the warehouse. Petitioner was to drive over all the states for Flyvision. Petitioner started driving for Flyvision immediately after being hired. Petitioner testified that the company was telling him that Mr. Paev also acted as a dispatch for Flyvision. Petitioner testified that he had an agreement in which he was to be paid a minimum of $900.00 per week. Petitioner testified that Respondent employer paid him by the mile, that is, they paid him in accordance with the length of his trips. Petitioner testified that Flyvision is a Russian-speaking company but that some at the company, like Mr. Paev, speak English. Petitioner testified that Flyvision has 15 or 16 trucks.

Petitioner testified that on June 1, 2006, he picked up a load with his truck in Clinton, North Carolina. Petitioner's Exhibit 3 is a Bill of Lading for that particular job. Petitioner's Group Exhibit 4 shows the miles covered by Petitioner and how much Petitioner was paid. Petitioner documented every run he did for Flyvision in this fashion.

Petitioner's Group Exhibit 4 shows a "run sheet" for June 5, 2006. The sheet shows that Petitioner made the drop off in Itasca, Illinois on that date.

Later that same day, Petitioner drove his bobtail and trailer into Respondent's parking lot in Lombard, Illinois. Petitioner testified that he disconnected an electrical line from the bobtail and the tractor. Petitioner testified that after he disconnected the lines, he fell down the steps and lost consciousness. Petitioner testified he fell down 3 steps on his left side and left shoulder. Petitioner testified that he hit his shoulder pretty badly and he lost consciousness. He did not know how long he was unconscious. Petitioner believed he fell from the top of the ladder and did not know if he was descending the steps when he fell. Petitioner testified that he first called

his wife to tell her what had happened. Petitioner testified that he then called Mr. Paev and told him about his fall, to which Paev responded: "It's your problem."

Petitioner testified that at that time, he felt a sharp pain in his left shoulder. Petitioner testified that he was not able to squeeze his fingers. Petitioner did not work for Flyvision after that day. Petitioner went to the St. Elizabeth Hospital Emergency Room on the same day he was injured. Petitioner testified that he was treated in the emergency room and given "a sling and something like a band aid."

The records of St. Elizabeth Hospital were admitted into evidence as Petitioner's Exhibit 8, and the medical bills for such services were admitted into evidence as Petitioner's Exhibit 13.

Petitioner decided to go see another doctor, Dr. Gordin, because his shoulder was hurting him all the time. Petitioner was treated with physical therapy and muscle relaxants. Petitioner saw Dr. Gordin through June 28, 2006. Dr. Gordin treated Petitioner with numerous physical therapy modalities on each of his twelve visits and then referred him to Dr. Visotsky. Petitioner testified that Dr. Gordin kept him off work because he was not able to squeeze anything with his left arm.

The records of Gordin Medical Center, S.C, were admitted into evidence as Petitioner's Exhibit 9, and the medical bills for such services were admitted into evidence as Petitioner's Exhibit 5.

Petitioner had an MRI at Dr. Visotsky's office on June 7, 2006. Radiologist Eugene Pai, M.D., offered the following impression: (1) supraspinatus and infraspinatus tear with mild retraction (2) associated bursitis (3) Hill-Sachs lesion compatible with sequela of anterior dislocation injury and (4) no detectible labral tear. (PX 10)

On June 15, 2006, Petitioner underwent shoulder surgery at Golf Surgical Center. Dr. Visotsky performed the surgery, which consisted of a left arthroscopic subacromial decompression and left arthroscopic rotator cuff repair. His post-operative diagnosis was (1) left shoulder rotator tear (2) left shoulder synovitis (3) left shoulder degeneration and (4) left traumatic rotator cuff tear.

The records of Dr. Visotsky/Illinois Bone & Joint Institute were admitted into evidence as Petitioner's Exhibit 10, and the medical bills for such services were admitted into evidence as Petitioner's Exhibit 7.

The records of Golf Surgical Center were admitted into evidence as Petitioner's Exhibit 11, and the medical bills for such services were admitted into evidence as Petitioner's Exhibit 6.

Petitioner testified that Dr. Visotsky then referred him to Dr. Ivachenko for physical therapy.

Petitioner further testified that he also treated with Dr. Zarubinsky, an acupuncturist, from July 19, 2006 through November 2007. Petitioner is not seeking an award for Dr. Zarubinsky's outstanding charges. (PX 12) Dr. Zarubinsky was unable to provide treating records to support his charges.

Dr. Visotsky's November 24, 2006 progress note indicates the following impression/plan: "He has returned to work activity. He is capable of performing most tasks at work. He still has some pain with overhead activities and pain on forward flexion, but he is improving. He understands the therapy program as outlined. He will continue the aggressive stretch-and-hold and soft tissue mobilization. We will see him back in four weeks." (PX 10)

Petitioner testified that he saw no other doctors for his left shoulder, that Blue Cross/Blue Shield paid some of his medical bills, and that he and his family paid some of the medical bills.

Petitioner's Exhibit 6 is a statement from Golf Surgical Center that shows Petitioner made credit card payments that total $1,067.99. Petitioner's Exhibit 7 is a statement from Illinois Bone & Joint Institute that shows Petitioner made credit card payments that total $1,035.02

Petitioner testified that he found it hard to perform the first job he worked after the shoulder surgery and rehabilitation. Petitioner testified that he has worked since the accident, but that he does not drive bobtail trucks or semis any longer.

Petitioner testified that he now notices that he cannot pick up heavy things and that his arm is not 100%.

Petitioner testified that he does not remember the last time he saw a doctor for his arm. Petitioner testified that he treats his left arm with caution and does not put stress on it. Petitioner testified that he has not hurt his left arm at any other time. Petitioner testified that he has told this Arbitrator everything that he sees and feels about his arm.

On cross-examination, Petitioner testified that when he saw Mr. Paev in Court (workers' compensation commission) last month, it was the first time he had seen him since the accident. Petitioner testified that he did not call Mr. Paev to ask him to pay his medical bills because he did not have contact with Paev, Paev would not pick up the phone, and Paev kept his distance from Petitioner. Petitioner testified that Flyvision had its own dispatcher and that Mr. Paev was "running" the dispatcher.

Petitioner testified that he never sent a letter or placed a phone call to Mr. Paev in which he asked Paev if he could come back to work. Petitioner testified that Mr. Paev told him he could come back to work when he recovered. However, Petitioner testified, when Petitioner's belongings from work were delivered to him and they took away his keys, he realized that they did not want him to come back to work after 6 months of rehabilitation.

Petitioner testified that he now drives a van that has one trailer that can haul a single vehicle. Petitioner no longer has a CDL. Petitioner does have a regular driver's license, though. Petitioner now works for himself. He runs a company named Med-Trade. Med-Trade transfers a single car to destinations all over the country. Petitioner testified that he drove for Med-Trade one week before this trial. Petitioner also testified that after he returned to work following the left shoulder surgery/rehabilitation, but before he started Med-Trade, he drove a truck for a Lithuanian company.

II. CONCLUSIONS OF LAW

a. Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Disease Act?

Petitioner testified that he drove trucks across the country for Flyvision. Petitioner has proven that Flyvision is subject to §3(3) of the Act because Flyvision was engaged in carrying goods by land. (Carriage by land, water or aerial service and loading or unloading in connection therewith, including the distribution of any commodity by horse-drawn or motor vehicle where the employer employs more than 2 employees in the enterprise or business). Additionally, although not necessary for this finding, Flyvision is subject to §3 of the Workers' Compensation Act since they also operated a warehouse with electricity. Moreover, this Arbitrator can infer that Flyvision's trucks required gasoline, thereby making it mandatory that Flyvision obtain workers' compensation insurance, pursuant to Section 3(15).

b. Was there an employee-employer relationship?

Petitioner testified that he was hired by Mr. Paev to drive trucks. Flyvision and Mr. Paev gave Petitioner interstate driving assignments. (PX 3) There is no evidence that when Petitioner made runs for Respondent, he drove his own truck. It is clear that Petitioner

drove for the benefit, and at the direction, of Mr. Paev and Flyvision. This Arbitrator finds by a preponderance of the evidence that Petitioner worked for Flyvision as an employee under the Act.

c. Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

Petitioner was working as a driver for Flyvision on the day he was injured. Petitioner had just returned from an out-of-state driving job and was disconnecting lines from the tractor when he fell off the truck. Although the St. Elizabeth Hospital Emergency Room handwritten record of June 5, 2006 indicates that Petitioner fell and injured his *right* shoulder, Dr. Gordin's June 5, 2006 record indicates Petitioner presented to the office "for left shoulder pain after falling off a truck onto his left shoulder." Furthermore, Petitioner presented unrebutted testimony that he called Mr. Paev on the June 5, 2006 and told him that he had fallen from the truck and that Mr. Paev responded: "It's your problem." This Arbitrator finds that Petitioner has proven by a preponderance of the evidence that an accident arose out of and in the course of his employment at Flyvision.

d. What was the date of accident?

Petitioner's testimony and medical records establish a date of accident of June 5, 2006.

e. Was timely notice of the accident given to Respondent?

Petitioner testified that on the date of accident, he informed Mr. Paev that he fell from the truck and hurt himself. Petitioner informed Mr. Paev by telephone. Petitioner has proven timely notice of the accident to the Respondent.

f. Is Petitioner's current condition of ill-being causally related to the injury?

On June 5, 2006, Petitioner fell off his truck after disconnecting an electrical line from the trailer. Petitioner experienced immediate pain in his left shoulder and on his left side. Petitioner sought treatment from Dr. Gordin on June 5, 2006 and Dr. Gordin's records corroborate Petitioner's testimony with regard to mechanism of injury. Petitioner later required surgery for his left shoulder.

A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. International Harvester v. Indus. Comm'n, 93 Ill. 2d 63-64 (1982)

The Arbitrator finds that Petitioner has proven by a preponderance of the evidence that his current condition of ill-being is causally related to the accident.

g. What were Petitioner's earnings?

Petitioner provided unrebutted testimony that when he was hired in April 2006, he had an agreement with Respondent employer that he would be paid a minimum of $900.00 per week. Petitioner's Exhibit 4 consists of various paycheck stubs that support an average weekly wage of $900.00. Therefore, the Arbitrator finds that Petitioner's average weekly wage is $900.00.

h. What was Petitioner's age at the time of the accident?

Based on the evidence presented, the Arbitrator finds that at the time of the accident Petitioner was 41 years old.

i. What was Petitioner's marital status at the time of the accident?

Based upon the evidence presented, the Arbitrator finds that at the time of the accident Petitioner was married with one dependent child. (AX 1)

j. Were the medical services provided to the Petitioner reasonable and necessary, and has Respondent paid all appropriate charges for all reasonable and necessary medical services?

Petitioner has claimed outstanding balances to the following medical providers:

Dr. Gordin	$3,900.00
Dr. Visotsky of Illinois Bone and Joint Institute	$13,328.00
Golf Surgical Center	$10,757.00
Total	$27,985.00

Respondent contends that Dr. Visotsky billed for services totaling only $12,385.00.

The date of the statement for Gordin Medical Services, Inc., is September 12, 2008 (PX 5), while the dates of the statements for Dr. Visotsky of Illinois Bone and Joint Institute (PX 7) and Golf Surgical Center (PX 6) is August 11, 2014 and August 13, 2014, respectively.

Petitioner made out-of-pocket payments of $1,035.02 to Illinois Bone and Joint Institute and $1,067.99 to Golf Surgical Center.

Petitioner has a pending subrogation lien from Blue Cross/Blue Shield. (PX 14) Respondent employer did not present any evidence with regard to their right to an 8(j) credit.

Liability exists only for any current outstanding balances to the above providers.

The Arbitrator finds the medical services from the above providers to be reasonable and necessary.

Therefore, Respondent Injured Workers' Benefit Fund shall pay Petitioner an amount equal to the total of the medically necessary and reasonable medical bills that are currently outstanding in this case, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

k. What temporary benefits are in dispute? TTD.

Petitioner testified to lost time of at least six months. However, the records of Dr. Visotsky support lost time benefits from the date of accident, June 5, 2006, thru October 10, 2006. The Arbitrator finds this to be reasonable given the nature of Petitioner's surgery and the fact that Dr. Visotsky, as of Petitioner's July 11, 2006 visit, recommended continued aggressive therapy, soft tissue mobilization, scar management and to continue therapy 2-3 times per week. Therefore, the Arbitrator finds that Petitioner was temporarily totally disabled from June 6, 2006, the day after the accident, through October 10, 2006, which represents 18-1/7 weeks.

l. What is the nature and extent of the injury?

Petitioner had an MRI at Dr. Visotsky's office on June 7, 2006. Radiologist Eugene Pai, M.D., offered the following impression: (1) supraspinatus and infraspinatus tear with mild retraction (2) associated bursitis (3) Hill-Sachs lesion compatible with sequela of anterior dislocation injury and (4) no detectible labral tear. (PX 10)

On June 15, 2006, Petitioner underwent shoulder surgery at Golf Surgical Center. Dr. Visotsky performed the surgery, which consisted of a left arthroscopic subacromial decompression and left arthroscopic rotator cuff repair. His post-operative diagnosis was (1) left shoulder rotator tear (2) left shoulder synovitis (3) left shoulder degeneration and (4) left traumatic rotator cuff tear.

There is no evidence that following Petitioner's post-surgical rehabilitation, Dr. Visotsky or any other medical professional released Petitioner to return to work with restrictions.

Petitioner could not tell this Arbitrator the last time he treated with a doctor for his left shoulder.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LORENZA ACOSTA,

Petitioner,

16IWCC0193

vs.

Nos. 08 WC 11242 & 08 WC 19227

BBJ LINEN,

Respondent.

DECISION AND OPINION ON REVIEW

This matter comes before the Commission on Petitioner's Petition for Review of the Decision of Arbitrator Carlson refusing to reinstate Petitioner's Applications for Adjustment of Claims. A hearing was held in Chicago before Commissioner White on March 19, 2015. Both parties were represented by counsel and a record was taken. The only purpose for the hearing was to submit documents into the record.

Petitioner filed her claims on March 12, 2008, alleging aggravation of a degenerative lower back condition and possible herniation caused by accidents occurring on October 17, 2007 and February 22, 2008. Arbitrator Cronin initially dismissed the claims for want of prosecution on December 19, 2011. The claims were reinstated on February 21, 2012. Arbitrator Cronin last dismissed the claims for want of prosecution on June 13, 2014, noting at that time, Petitioner had failed to appear at a status call or trial date. On January 8, 2015, Arbitrator Carlson denied Petitioner's Petition to Reinstate without comment. This denial is the subject of the instant review which was filed on January 15, 2015.

Petitioner submitted into evidence a Power of Attorney specifying she empowered her lawyers to cash checks received in settlement of her claims. While the document is not executed, Petitioner's lawyer asserted, as an officer of the court, that he had an executed original copy. In the document Petitioner acknowledged that she would receive between $22,142.79 and $22,642.70, representing a total settlement of $31,603.37, less attorney fees and costs of bankruptcy, which would be filed to discharge medical bills totaling $128,614.11.

Petitioner also submitted into evidence an executed settlement contract signed by Respondent's lawyer on December 20, 2013, and by Petitioner on October 18, 2014, with the same settlement amount. Initially, the settlement was to expire on February 15, 2014, but after a discussion between the lawyers that date was stricken and a new date of April 14, 2014 was substituted.

Petitioner also submitted a brief in support of her Petition to Reinstate. In her brief, Petitioner asserts she attempted diligently to negotiate outstanding medical bills in excess of $70,000 to no avail and on October 18, 2014 retained a bankruptcy lawyer and signed the settlement contract. Petitioner then asserts her lawyer contacted Respondent's lawyer on October 20, 2014 seeking again to extend the expiration date of the settlement contract. At that time he was informed the claims had been dismissed on June 13, 2014. Petitioner's lawyer acknowledged that his firm received the notices of dismissal on June 14, 2015, "however, they were put directly into the file which was with the settlement department." Therefore, Petitioner's lawyer asserts he did not have actual knowledge of the dismissal until the October 20, 2015 conversation with Respondent's lawyer. Petitioner's lawyer also acknowledged the Petition to Reinstate was filed 99 days after the dismissal, more than 60 days after receipt of the notice of dismissal.

Petitioner argues the 60 day requirement to file a Petition to Reinstate is "jurisdictional in nature" but not "jurisdictional" *per se*. She cites *TTC Illinois Inc., v IWCC*, 396 Ill. App. 3d 344 (5th Dist. 2009) for that proposition. Therefore, she asserts, that the passage of 60 days after dismissal does not divest the Commission of subject matter jurisdiction. She also quotes the language of Commission rule 7020.90(d): "A cause shall be reinstated upon the stipulation of the parties filed with the Commission, which will docket the stipulation." She stresses that language does not include a time limit and if the parties can stipulate to reinstatement, the passage of time is not jurisdictional because parties cannot stipulate to subject matter jurisdiction. Finally, Petitioner asserts that the equities clearly are in favor of reinstatement so that the settlement contract can be put into effect.

In its brief, Respondent asserts that the failure of Petitioner to file her Petition to Reinstate within the specified 60-day period is indeed jurisdictional and the Commission does not have subject matter jurisdiction to reinstate the claims. Respondent also provides a timeline of the events regarding these claims. According to Respondent's reply, one of the claims was dismissed on May 29, 2012. Petitioner filed a Motion to Reinstate for the July 5, 2012 status call but did not appear to present the motion. Respondent also asserts that no action was taken on these claims between July 5, 2012, and June 4, 2013, at which time the claims "randomly appeared" on Arbitrator Cronin's status call for June 21, 2013. At that time Arbitrator Cronin set a trial date of September 23, 2013. Arbitrator Cronin last dismissed the claims for want of prosecution on June 13, 2014, noting Petitioner had failed to appear at a status call or trial date.

Also Respondent asserts, and submitted supporting documentation, that settlement had actually been reached by May 26, 2011, and it sent Petitioner's lawyer a settlement contract executed by Respondent's lawyer the next day. Respondent's lawyer sent a cover letter with that contract indicating that Petitioner's lawyer represented that the medical providers would likely settle for expenses for treatment certified by utilization reviews. However, that had not been

confirmed and Respondent's lawyer noted that pursuant to the terms of the settlement contract it would not be responsible for any medical expenses not paid prior to the contract, and that all such bills must be resolved prior to approval of the contract. Respondent also pointed out that the offer expired on August 1, 2011, after which it was null and void. Respondent submitted a second cover letter dated December 26, 2013, with another executed settlement contract in which its lawyer highlighted that the offer expired on February 15, 2014, and the contracts must be executed and approved by that date or the offer was null and void.

The case cited by Petitioner really does not support her argument. In *TTC Illinois*, the Appellate Court affirmed the Decision of the Commission reinstating claims where the Motion to Reinstate was timely filed but it failed to specify a date at which the motion would be heard. The Court found that the employer waived the notice requirement by basically representing that it had no objection to reinstatement. The Court reasoned "although the 60-day limit for filing a petition to reinstate a case after it has been dismissed by an arbitrator for want of prosecution is jurisdictional in nature, we do not believe that the same is true of the contents requirements of such a petition." 396 Ill. App. 3d 344, 354. The Court then explained "the decision to grant or deny a **timely** petition to reinstate is a matter which rests within the sound discretion of the Commission, and its determination will not be disturbed on review absent an abuse of that discretion" 396 Ill. App. 3d 344, 355 (emphasis added). Contrary to the argument of Petitioner, the above cited language would seem to suggest that while granting a timely filed motion to reinstate is discretionary, granting one that is not timely filed is not.

Petitioner is correct that the provision of the rule requiring reinstatement upon stipulation of the parties does not specify a time limit. Petitioner's interpretation that such an omission means that the 60-day limitation is not jurisdictional would appear to be contrary to the interpretation implied in *TTC Illinois*. The Commission concludes that a more reasonable interpretation is that the 60-day time limitation still applies but with a stipulation reinstatement is mandatory and a separate written motion is not necessary. Accordingly, the Commission finds that filing a Petition to Reinstate within the 60-day period is jurisdictional and affirms the denial of Petitioner's Petition to Reinstate.

THEREFORE, IT IS ORDERED BY THE COMMISSION, that the denial of Petitioner's Petition to Reinstate dated January 8, 2015 is hereby affirmed.

The party commencing the proceeding for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: MAR 16 2016

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-2/24/16
46

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LENA MARKS,

Petitioner,

vs.

NO: 08 WC 28921
09 WC 19490
09 WC 19491

VERIZON COMMUNICATIONS,

Respondent.

16IWCC0203

DECISION AND OPINION ON §19H/§8A PETITION

Petition for unpaid medical expenses under §8(a) of the Act having been filed by Petitioner's attorney herein and due notice given, this cause came before Commissioner White on November 4, 2015. The Commission having jurisdiction over the persons and subject matter, and after being advised in the premise, finds:

1. Petitioner suffered work-related accidents on October 6, 2006, May 6, 2008, and March 31, 2009. After treatment, the parties entered into a settlement contract agreement, which was approved in November of 2012.

2. Petitioner has been on prescription medication since the accident. These prescriptions were part of the settlement agreement, which stated that medical should remain open.

3. At the time of the hearing, Petitioner was taking Hydrocodone 10 three times daily, had a Fentanyl patch that she applied every 2 days, a prescription for Baclofen (taken 4 times daily), and one for Cyclobenzaprine (3 times daily).

4. These medications were on a 30 day cycle, but since 2013 Petitioner repeatedly had problems having her prescriptions filled in a timely fashion.

5. The majority of times Petitioner attempted to have her prescriptions filled, they were denied by the carrier. She was then forced to either call Sedgwick or write letters questioning the denial, or submit the prescriptions through her husbands' carrier, which included a co-pay.

6. When Petitioner complained to Sedgwick, there was usually a 2 to 4 day window during which her prescribed medications were unavailable to her.

7. In April 2014 Petitioner received a letter from Respondent stating that they were agreeing with all medications and had approved them for Petitioner. However, subsequent to that, Petitioner still had issues getting her prescriptions filled, almost on a monthly basis.

8. Petitioner also stated that there were medical bills from her original treatment that she was dealing with until just prior to the hearing. In January 2014 she began requesting payment for these bills from Respondent. Ultimately these bills were also paid through Petitioner's husband's insurance. There remained an outstanding balance post-insurance payment, which Respondent did not satisfy until a few days prior to the November 2015 hearing.

9. Respondent did not factually dispute any of Petitioner's allegations. However, Respondent did point out that Petitioner was given a prescription card in November 2013. At that time there were 2 narcotics and a muscle relaxer (Baclofen) on the prescription list. In 2014 additional non-narcotics (Lamictal and Cymbalta) were added to the list.

10. At that point Respondent requested an explanation for the need of these additional prescriptions. In May 2015 Petitioner's treating physician confirmed through letter that the need for the additional prescriptions was causally related to the accident. In June 2015 the prescriptions were covered by Respondent.

11. Respondent then initiated a utilization review, which questioned the long term use of the narcotics.

The matter was taken under consideration by the Commission on January 21, 2016.

The Commission notes that in May 2015 Petitioner's treating physician provided a letter to Respondent indicating that Lamictal, Cymbalta, Baclofen, Fentanyl, and Norco were all medically necessary for treatment of Petitioner's conditions.

Respondent stated at hearing that 2 narcotics and Baclofen had been prescribed in 2013. Based on the treating physicians May 2015 letter, the 2 narcotics were Norco, and Fentanyl.

Respondent indicated at trial that, due to the additional medications prescribed in 2014

16IWCC0203

(Lamictal and Cymbalta) a utilization review was initiated in June 2015. However, the utilization review did not find Lamictal or Cymbalta to be unnecessary, but rather the 2 narcotic medications.

Since the new medications were not found to be unnecessary, the Commission finds that Respondent's basis for disputing the new medications is moot. Furthermore, the Commission finds that the Utilization Review findings that the narcotics were medically unnecessary is not persuasive. The Utilization Review itself notes that Petitioner has been stable with her medications for over a year. This indicates to the Commission that the medications are appropriate and are necessary. This is especially true when combined with the fact that Respondent itself approved these same narcotics in April 2014.

With this in mind, the Commission finds that Respondent's routine refusal to provide Petitioner her medications in a timely fashion rises to the level of unreasonable and vexatious delay. Moreover, the fact that an agreement on payment of the outstanding medical bills was reached a mere 6 days prior to the November 2015 hearing date is of no merit, as Petitioner has unfortunately been dealing with these hiccups for years.

Accordingly, the Commission finds that Respondent is liable for penalties and fees. The awards are based on the aggregate amount of recently outstanding bills from Respondent's Exhibit #6 to Respondent's Exhibit #8 ($8,770.05), combined with all related co-pays found in Petitioner's Exhibit #4, which equal $60.00. Thus the total is $8,830.05.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent is liable for §16 attorney fees of $1,766.01, §19(k) penalties of $4,415.03 and §19(l) penalties of $10,000.00.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 2 2016
DLG/wde
Disc.: 1/21/16
45

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MARKS, LENA CHRISTINE
Employee/Petitioner

Case# **08WC028921**

09WC019490
09WC019491

VERIZON COMMUNICATIONS
Employer/Respondent

16IWCC0203

On 7/27/2012, 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 0.14% 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:

1167 WOMICK LAW FIRM CHTD
CASEY VANWINKLE
501 RUSHING DR
HERRIN, IL 62948

4866 KNELL & O'CONNOR PC
BRIAN P WOJCICKI
901 W JACKSON BLVD SUITE 301
CHICAGO, IL 60607

16IWCC0203

STATE OF ILLINOIS)
)SS.
COUNTY OF **Madison**)

- ☐ 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

Lena Christine Marks
Employee/Petitioner

v.

Verizon Communications
Employer/Respondent

Case # **08** WC **28921**

Consolidated cases: **09 wc 19490**
09 wc 19491

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 **Gerald Granada**, Arbitrator of the Commission, in the city of **Collinsville**, on **June 26, 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 **Mileage reimbursement pursuant to Section 8(a) of the Act**

FINDINGS

On **5/6/08, 10/6/06, 3/31/09**, 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 **$30,233.84**; the average weekly wage was **$581.42**.

On the date of accident, Petitioner was **44** years of age, ***married*** with **0** 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 **118 6/7 weeks ($387.61)** for TTD, **$0** for TPD, **36 5/7 weeks ($387.61)** for maintenance, and **$0** for other benefits, for a total credit of **$60,301.04**.

Respondent is entitled to a credit of **$7,775.78** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$387.61**/week for **160-2/7** weeks, commencing **9/10/08** through **10/6/11**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of **$387.61**/week for **37-5/7** weeks, commencing **10/7/11** through **6/26/12**, as provided in Section 8(a) of the Act.

Respondent shall pay related, reasonable and necessary medical expenses, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall reimburse Petitioner **$3,084.48** for her mileage at the rate of **$0.51** per mile for which she travelled 224 miles roundtrip for 27 visits to Dr. Robert Thompson in St. Louis, Missouri from her residence in Carbondale, IL, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$348.85**/week for **250** weeks, because the injuries sustained caused the **50%** loss of the person as a whole, as provided in Section 8(d)2 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.

Signature of Arbitrator

7/25/12
Date

JUL 27 2012

16IWCC0203

Findings of Fact

Petitioner began working for Respondent on June 21, 2004, and is claiming multiple repetitive trauma injuries either caused or aggravated by work activities. More specifically, Petitioner sat, answered phones, entered computer data, and occasionally wrote. Petitioner is claiming repetitive trauma injuries with manifestation dates of October 6, 2006, May, 6, 2008 and March 31, 2009. There is no dispute regarding the issues of accident or causation.

Petitioner testified that her job was repetitive and she suffered a bilateral carpal tunnel syndrome and ulnar nerve, and bilateral thoracic outlet injuries. She required surgery on wrists, elbows and thoracic areas. She further testified that due work injury that her treating doctor has permanent restrictions of no pushing, pulling or lifting over 10lbs and no repetitive use of either upper extremity. Based on those restrictions Respondent could not accommodate her at her normal employment. Petitioner testified that she still requires prescription drugs at times they render her incapable of functioning simple tasks that require cognitive reasoning.

Petitioner was first treated by Dr Marci Moore-Connelly. Dr Robert Miller performed a left thoracic surgery on December 20, 2006. She was referred to Dr Steven Young who diagnosed and did surgery on Bilateral Carpal Tunnel and bilateral ulnar nerve; these surgeries took place on July 9, 2008, August 20, 2008, September 10, 2008 and October 31, 2008. After surgery although Petitioner improved, she still had pain and loss of range of motion in her arms and hands. At that time Dr Connelly referred her to an expert in the St. Louis area, Dr Robert Thompson. Petitioner had to travel 224 miles roundtrip from her home in Carbondale, IL to see Dr. Thompson in St. Louis. Dr. Thompson's medical records indicate Petitioner attended 27 appointments. Dr Thompson ultimately performed surgery on both thoracics on August 7, 2009 and October 26, 2009, followed by a left sympathetic block and a redo surgery on left thoracic. Dr Thompson has now released Petitioner with restrictions of no pushing, pulling or lifting over 10lbs and no repetitive motion of upper extremity.

Petitioner started a job search on her own for a period of time October 2011 through December 2011. She was later provided with vocational rehabilitation assistance from Respondent. In later February 2012, professional vocational rehabilitation was conducted by Brenda Latham MS CRC CCM of Genex Services. Latham testified that she did first interview to review education, prior work experience, age and transferrable skills. She decided based on that interview and Dr Thompson's restrictions to start a job search basically in the field of light secretarial /reception type jobs. Latham testified that Petitioner was cooperative, did what she was requested of her and did a diligent job search. Latham's work with Petitioner and her job search until the date of hearing. The job search was unsuccessful. Latham testified that she did not do a labor market survey, but based on her unique knowledge of the Southern Illinois Area and the years of experience felt that the Labor market Survey was not necessary. At trial both Petitioner and Brenda Latham testified to Petitioner's three and one-half month vocational rehabilitation and job search, with Petitioner confirming that she filed for SSDI before even beginning vocational rehabilitation and in fact, not wanting to return to work at all. Despite Petitioner's intentions, Brenda Latham testified to vocational rehabilitation resulting in "fairly good success," with no expected job search changes if not for its termination by Petitioner. Brenda Latham also testified to a potential average earning capacity of $9.17 in a field of work similar to Petitioner's employment prior to her injury.

STATE OF ILLINOIS)
) SS
COUNTY OF WILL)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Akossiwa Dansouvi Agbedey,

Petitioner,

No. 10 WC 14110

Tyson Foods, Inc.,

Respondent.

ORDER

Petition's to compel Respondent to pay related medical bills and Penalties and Attorney fees under §19(k), §19(l), & §16, having been filed by Petitioner's attorney herein and due notice given, this cause came before Commissioner Gore on November 21, 2014, in Ottawa, Illinois. The Commission having jurisdiction over the persons and subject matter and after being advised in the premise finds:

- This matter was properly filed by Petitioner's original attorney April 13, 2010 regarding an accident date of August 11, 2008 alleging repetitive trauma and injury involving Petitioner's neck, left shoulder and arm, and right hand and arm.

- The matter was settled (with Petitioner's initial attorney) and approved by Arbitrator Pulia January 3, 2013 for 42.4% loss of Petitioner's person as a whole ($56,907.72). The face of the settlement contract indicated that not all medical bills were paid and to see the terms of settlement. The terms of settlement state, in pertinent part, "Petitioner is solely responsible for payment of all outstanding medical bills. Respondent specifically denies responsibility under Workers' Compensation for authorization for payment for a C4-5 surgical fusion, based on lack of causal connection. Respondent is responsible for payment of all medical bills, for reasonable and necessary medical treatment that is related to this accident and occurred prior to the approval date of this settlement contract, limited to fee schedule charges."

- Petitioner's original counsel initially filed a motion to compel payment of medical bills and penalties and attorney fees under §19(k), §19(l), and §16 April 16, 2013. Petitioner's current attorney subsequently refiled the motion regarding the bills April 14, 2014 for the May 9, 2014 Review call. The motion was first presented May 9, 2014 and continued. On November 21, 2014 the matter was heard and taken under advisement.

- Petitioner's counsel noted and presented into evidence bills that remained unpaid from Michigan Avenue Clinic/Gold Coast Clinic for cervical epidural injections and other cervical treatment and related expenses from December 2011 and into February and March 2012. Petitioner's counsel acknowledged the approved settlement contract; however, argued that while the settlement contract provided that Respondent was not responsible for the cervical surgery, the contract did not state Respondent would not pay for treatment work-up to the date of surgery. Petitioner's counsel argued that the contract was specific and there was no mention of nonpayment for that treatment, only as to the nonpayment regarding the surgery. Petitioner further argued for penalties and attorney fees due to the nonpayment of the bills. Petitioner argued there was nothing in the settlement contract stating Respondent was not going to pay the outstanding medical bills for that treatment.

- Respondent stated the accident was August 11, 2008 and Petitioner did not treat for some complaints until 2009. Respondent stated the bills in question began November 2011 and Petitioner had surgery, subject to the settlement contract language, March 7, 2012. Respondent argued the settlement contract has four governing provisions regarding medical bill obligations. Respondent noted first that the front page of the settlement contract indicated the Respondent had not paid all medical expenses, "see terms of the settlement". Respondent noted the terms of settlement stated, "Petitioner is solely responsible for payment of all outstanding medical bills." Respondent's attorney noted the terms further stated, "The Respondent specifically denies responsibility under Workers' Compensation for authorization for payment for a C4-5 surgery fusion, based on lack of causal relationship." Respondent stated that second sentence defined causal relationship for the purpose of the settlement contract. Respondent further noted the terms of the contract stated, "Respondent is responsible for payment of all medical bills, for necessary medical treatment that is related to this accident and that occurred prior to approval of this settlement contract, limited to the fee schedule charges." Respondent's counsel argued that the language of the settlement contract clearly stated that the C4-5 surgical fusion is not causally related to the accident in this case and implicit in that the language is that if the surgery itself was not related to the accident, neither would be the workup and post-surgical treatment. Respondent's counsel noted Petitioner's prior attorney's letter of August 2, 2012, six months prior to the final settlement, regarding payment of the bills. Respondent's counsel argued that that letter clearly indicated the former attorney's knowledge of those bills and his signature on the settlement contract acknowledged a resolution of that liability in a way he understood. Further Petitioner's prior attorney had agreed to the terms by signing the settlement

contract and obtaining approval from the Commission. Respondent's counsel stated he did not believe any evidence beyond the exhibits and settlement contract needed to be considered to interpret the clear intent and outcome in the terms of the settlement contract regarding the cervical condition and those associated medical bills. Respondent stated it does not believe it has any underlying liability for the bills and therefore no liability for payment of penalties and attorney fees for any lack of good faith defense to payment of the bills in question.

- Petitioner's counsel argued the letter has no relevance and should not be brought into the terms of the settlement contract. Petitioner argued the settlement contract is the issue and it is not clear as to payment of treatment, work-up prior to approval of the settlement contract. Petitioner argued Respondent did not say they were not liable for that treatment; it was only not liable for the surgery. Petitioner argued that there was nothing on the contract to state Respondent would specifically not pay for that treatment. Petitioner's counsel argued if Petitioner was responsible for those bills, after fees and paying the bills, Petitioner would receive less than $10,000 of the $56,000 contract amount and he did not think any reasonable person would have agreed to that contract (speculation). Petitioner's counsel again argued the contract did not specifically state that Respondent would not pay for that treatment. Petitioner's counsel argued they believe Respondent is liable for the work-up treatment (prior to surgery) before the settlement agreement was approved and requested the Commission direct Respondent to pay the outstanding medical bills as well as penalties and attorney fees for the delayed payment.

- The matter came before Commission Gore in Ottawa, Illinois on November 21, 2014 and taken under consideration. Of note, neither party submitted any briefs regarding this matter.

The Commission finds the terms of the contract pretty specific as to responsibility for the outstanding medical bills. Per the terms of the approved settlement contract:

> 1. "Petitioner is solely responsible for payment of all outstanding medical bills."
>
> 2. "The Respondent specifically denies responsibility under Workers' Compensation for authorization for payment for a C4-5 surgery fusion, based on lack of causal relationship."
>
> 3. "Respondent is responsible for payment of all medical bills, for necessary medical treatment that is related to this accident and that occurred prior to approval of this settlement contract, limited to the fee schedule charges."

This accident occurred in 2008 and the bills in question arose for treatment in 2011 and 2012. The Respondent clearly denied any causal relationship to Petitioner's need for cervical surgery; it is equally implicitly clear, and logically, by that language, that any

treatment leading up to the cervical surgery was denied for the same reason, lack of causal relationship. Respondent accepted liability only for medical bills that were reasonable, necessary and causally related to the 2008 accident. Petitioner and his former attorney also signed the settlement contract specifically noting the language that "Petitioner is solely responsible for payment of all outstanding medical bills." albeit somewhat conflicting terms with Respondent accepting liability on causally related medical expenses. Further, the Commission notes that Petitioner's attorney presented no evidence from the medical providers to even suggest that those bills were causally related to the 2008 accident; Petitioner's only argument being that the bills in question were not specifically denied for not being causally related as the cervical surgery was. The Commission finds that, based on the specific language of the settlement contract and with Petitioner failing to evidence a causal relationship, that Respondent is not liable for the medical bills in question and likewise not liable for any penalties or attorney fees. Petitioner failed to meet the burden of proving entitlement to the outstanding medical bills, as well as, penalties and attorney fees as Petitioner failed to prove Respondent acted in an unreasonable or vexatious manner. Therefore, the Commission, herein, denies and dismisses Petitioner's petition and motion for relief.

THEREFORE IT IS ORDERED BY THE COMMISSION that Petitioner's Petition to compel payment of the medical bills in question, and for penalties and attorney fees under §19(k), §19(l), and §16 of the Act is hereby denied and the motion dismissed.

DATED: OCT 0 8 2015

DLG/jsf
11/21/14
045

David L. Gore

Stephen Mathis

Mario Basurto

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
X ON REMAND FROM CIRCUIT COURT, MADISON COUNTY	☐ PTD/Fatal denied
X Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Edward Kolkovich,

Petitioner,

vs.

NO: 11 WC 01296

16IWCC0199

Basler Electric Co.,

Respondent.

DECISION AND ORDER ON REMAND FROM THE CIRCUIT COURT

This matter had previously been heard and the Decision of Arbitrator Luskin had been filed November 5, 2013. The Arbitrator found that Petitioner established a causal connection-(in part, Left leg only—[no causal connection as to right leg/knee]) between these accidental work related injuries and his condition of ill-being. The Arbitrator found no credible evidence of inability to work beyond February 15, 2011; all temporary total disability had been paid through then. The Arbitrator found that Petitioner was entitled to an award of $211.65 for reasonable and necessary medical expenses under §8(a) of the Act and that Petitioner was entitled to an award of 20% loss of use of Petitioner's LEFT LEG under §8(e)(12) of the Act (43 weeks at $370.08 per week for $15,913.44 total PPD). The Arbitrator awarded nothing as to RIGHT LEG as no causal connection was found. The matter was presented on Petitioner's Review and the Commission modified the decision of the Arbitrator, increasing the permanent partial disability of the left leg to 25%, and otherwise affirming and again finding no causal connection regarding Petitioner's right leg. Thereafter, Petitioner went before the Circuit Court of Madison County who reversed the decision, in part, finding also a causal connection regarding Petitioner's right leg and remanded the case back to the Commission for decision and award regarding Petitioner's right leg permanent partial disability and to award temporary total disability benefits given their causal connection finding.

16IWCC0199

- The parties had stipulated to the permanency award regarding the left leg as found by the Commission on Review and affirmed by the Circuit Court of Madison County.

- Petitioner's accident occurred May 11, 2010. Treating records then indicated only left leg complaints, but x-rays were also done of the right knee May 12, 2010 that indicated no fractures, mild spurring, moderate decrease in medial joint space with osteophyte, mild lateral and patellofemoral joint space degenerative change with the patella intact, mild patellofemoral degenerative change and small joint effusion. Petitioner treated only regarding the left knee through to November 2010 when he appeared for Respondent examination. Petitioner testified at prior hearing of the events at the §12 exam with Dr. Gross on November 11, 2010. Petitioner testified that they had gone for the exam and he had filled out some papers and the receptionist went over things with them. Petitioner stated he met the doctor and shook hands and Petitioner stated the doctor stated that he hoped he did not hurt Petitioner and Petitioner stated that he just kind of laughed and Petitioner told the doctor he hoped the doctor did not hurt Petitioner either. Petitioner indicated then he had gone through enough already. Petitioner stated they went into the exam room and the doctor had Petitioner get on the table. Petitioner testified that all then other doctors had treated his knee with care. Petitioner testified that after he got on the table, the doctor kind of grabbed Petitioner's foot and heel with both hands. Petitioner stated the doctor was nicer with his left leg first and then the doctor actually got 'violent' with Petitioner's right leg. Petitioner testified as the doctor was performing the exam on the right, it hurt and then all of a sudden, Petitioner stated that his right knee popped out and Petitioner stated that the doctor said, 'look, I can even pop this knee out'. Petitioner stated that it popped out twice and Petitioner did not know what he said. Petitioner stated that he had hollered awe a couple of times and Petitioner stated that the doctor said he had to do the evaluation. Petitioner stated the doctor popped it out again and then some more push and pull and then the doctor popped it out two more times. Petitioner testified that his wife was there sitting about four or six feet away from Petitioner at the time and Petitioner stated that there was a therapist that stood overhead also. Petitioner testified after the examination was completed the doctor showed Petitioner the x-rays. Petitioner testified he walked towards the room and his right leg hurt. After they were shown the x-rays, Petitioner indicated the therapist took him in a room and said she was going to tell Petitioner what kinds of exercises he could do to help his leg now and he said the therapist said she could say nothing. Petitioner testified after the exam the doctor walked them out towards the elevator. Petitioner stated after he walked out and got into the car his right leg was hurting and Petitioner stated that he almost rolled into a car at a stop sign because it was giving away again. Petitioner stated that he told his wife that if he could not drive with his left foot on the brake then she would have to drive. Petitioner's wife testified of the same event by the examining doctor.

- On November 12, 2010, Petitioner saw Dr. Poirot-(Mt. Olive Family Practice) who noted, Petitioner presented with knee pain; Occasional popping and swelling; left and right knee. Pain sharp occasionally and achy. It was noted Petitioner saw Dr. Gross yesterday and patient told that he had arthritis and there was left knee damage from old work injury. Knee injections were discussed, pending Workers' Compensation

authorization. (Nothing was noted there regarding Dr. Gross hurting Petitioner's right knee). Petitioner then saw Dr. Ungacta-(Midwest Bone & Joint), who noted November 17, 2010, that Petitioner saw the workers compensation doctor who really worked his knee over; A lot of pain at that time and Petitioner did not think he could work at that time. Dr. Ungacta further noted post-operative DVT-(left leg); Moderate pain left knee precluding him from working full duty. Again the doctor noted that Petitioner had been recently evaluated by Dr. Gross, §12 examiner, regarding potential injections, who had agreed with the injections. Again, only left knee complaints were noted. Then on November 24, 2010, Dr. Ungacta noted, Petitioner still had left knee complaints, and at that time also noted right knee since Dr. Gross pulled and tugged on it; It was also noted there that Petitioner stated that he had right knee popping since that visit. Dr. Ungacta noted that Petitioner may be candidate for Hyalgan injections to consider in near future. From then on Petitioner complained of bilateral knee problems.

The Commission notes that per the remand from the Circuit Court of Madison County, wherein, they found causal connection resulted from the §12 examination by Dr. Gross in November 2010 due to the 'violent' nature of the examination immediately after, and no other incidents or explanation for the onset of pain at that time, and the chronology, and two other doctors indicated that could have caused injury to the right knee. Petitioner clearly had degenerative changes noted in the right knee. There is no real evidenced treatment or diagnosis regarding the right knee other than the degenerative changes and Petitioner was offered to have the right knee scoped in November 2011 after an MRI then noted moderate tricompartmental osteoarthritis with knee joint effusion, Baker's cyst and posterior medial ganglion cyst, and chronic anterior ligament tear. Whether the exam caused the noted 'chronic' ligament tear seems somewhat speculative given the little treatment and then discharge in February 2011, albeit, there may have been some aggravation of the underlying degenerative osteoarthritic changes in the knee with the Dr. Gross examination for a causal connection as found by the Circuit Court, even though there was really no clear acute diagnosis or finding from November 2010 to February 2011 or even clear treatment at that point to find more than a limited causal connection to March 1, 2011 when Petitioner stopped treating altogether. Per the Circuit Court, the Commission, therefore, vacates its prior decision, in part, and based on the Circuit Court's remand order finding of a causal connection to Petitioner's right leg also, and further finds that Petitioner is entitled to an award regarding the right leg/knee, of a 2.5% loss of use (5.375 weeks at $370.08 weeks- for $1,989.18 total PPD regarding right leg) and temporary total disability benefits February 15, 2011 through March 1, 2011 (2 weeks at $411.20 per week- for total TTD due of $822.39). All else is affirmed as to prior awarded medical expenses and left leg permanent partial disability.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $411.20 per week for a period of **2 weeks**-(February 15, 2011 through March 1, 2011---$822.39 total TTD due), that being the period of temporary total incapacity for work under §8(b) of the Act. (Prior TTD periods had been paid with Respondent entitled to credit for those payments.)

16IWCC0199

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $370.08 per week for a period of 59.125 total weeks, as provided in §8(e)(12) of the Act, for the reason that the injuries sustained caused the 25% loss of Petitioner's left leg-(53.75 weeks), and the 2.5% loss of Petitioner's **Right Leg**-(5.375 weeks). ($21,880.98 total PPD)

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner for any reasonable and necessary unpaid medical expenses under §8(a) of the Act. Respondent shall receive credit of $211.54 for medical benefits paid and Respondent shall hold Petitioner harmless from any claims by any providers of services for which Respondent is receiving credit.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $23,100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 17 2016
d-2/11/16
DLG/jsf
045

David Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

KOLKOVICH, EDWARD
Employee/Petitioner

Case# **11WC001296**

16IWCC0199

BASLER ELECTRIC
Employer/Respondent

On 11/5/2013, 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 0.08% 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:

1580 BECKER SCHROADER & CHAPMAN PC
TODD J SCHROADER
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

0180 EVANS & DIXON LLC
JAMES M GALLEN
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

16IWCC0199

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

☐ 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

Edward Kolkovich
Employee/Petitioner

Case # **11** WC **001296**

v.

Consolidated cases:

Basler Electric
Employer/Respondent

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 **Joshua Luskin**, Arbitrator of the Commission, in the city of **Collinsville**, on **August 29, 2013**. 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

RECONSIDER

FINDINGS

On **5-11-10**, 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 in part*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$3,081.60**; the average weekly wage was **$616.60**.

On the date of accident, Petitioner was **62** years of age, married with **0** 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 **$3,801.60** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of **$3,801.60**.

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

ORDER

The respondent shall satisfy the outstanding balance of $111.65 to Dr. Ungacta within the limits of Section 8.2 of the Act.

The respondent shall pay the petitioner is entitled to receive the sum of $370.08 for a period of 43 weeks because his injuries caused 20% permanent loss to his left leg pursuant to 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.

/s/ Arbitrator Joshua Luskin

November 5 /2013
Date

NOV - 5 2013

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

EDWARD KOLKOVICH,	)	
	)	
Petitioner,	)	
	)	
vs.	)	No. 11 WC 01296
	)	
BASLER ELECTRIC,	)	
	)	
Respondent.	)	

ADDENDUM TO ARBITRATION DECISION

STATEMENT OF FACTS

The petitioner worked in the respondent's machine shop. On May 11, 2010, he stepped up on a chair to retrieve something from a tall cabinet and injured his left knee. Accident was not disputed.

The petitioner sought care with Dr. Fulton, who prescribed an MRI of the left knee. The petitioner underwent the MRI scan on May 24, 2010, which revealed a tear of the medial meniscus with a cartilage flap and a MCL sprain. PX3, PX9.

The petitioner was referred to Dr. Ungacta, who recommended arthroscopy. The petitioner underwent left knee arthroscopy on June 8, 2010. Substantial patellar arthritis was debrided and meniscectomy was performed to repair the meniscal tear. PX3.

Post-operatively the petitioner was originally discharged without complications, but thereafter went to the emergency room and was admitted for DVT and pulmonary embolism treatment which were determined to be complications from the surgery. He was hospitalized and treated with blood thinners. See PX1, PX3, PX4, PX12-13. He was discharged on June 21, 2010. PX2. The petitioner remained on Coumadin until March 2011, at which time he ceased blood thinners. PX5.

The petitioner underwent postoperative physical therapy. On October 15, 2010, he reported to the therapist that he had been laid off from work. PX3. On October 20, he reported ongoing pain to Dr. Ungacta, who recommended Hyalgan injections due to the petitioner's underlying arthritis. PX3.

The petitioner underwent an IME with Dr. Gross on November 11, 2010. Dr. Gross noted that the injury was causally related to the treatment incurred but believed further treatment would be due to non-work-related factors and that he was at MMI. The petitioner asserted that during the course of this examination, Dr. Gross manhandled the

petitioner's right knee, injuring it and causing persistent pain and weakness in the right knee. Dr. Gross testified in deposition that he did nothing out of the ordinary course of evaluations when he saw the petitioner, and that while examinations can produce discomfort, nothing was done in the examination that could have produced a lasting injury of the kind described by the claimant. He further testified that the claimant reported no such complaints at the time to him. See RX2.

The petitioner saw Dr. Ungacta on November 17 and November 24. On November 17, the petitioner reported that he did not feel he could complete a full shift even on light duty, and Dr. Ungacta prescribed part time employment. On November 24, the petitioner complained of right knee pain. Dr. Ungacta prescribed full duty without restrictions at that time. PX3.

On December 13, 2010, the petitioner reported to Dr. Ungacta that he was doing somewhat better. Dr. Ungacta noted full range of motion of both knees with minimal tenderness. He maintained full duty and prescribed Ultram. PX3.

On January 10, 2011, the petitioner saw Dr. Ungacta. He had fallen about a week before, and stated his right knee had given out. The petitioner asserted that his right knee had been giving out since he was evaluated by another orthopedist. Examination of the right knee noted full range of motion with no effusion and 5/5 strength. Dr. Ungacta maintained full duty work. On January 27, 2011, the petitioner told Dr. Ungacta that he twisted his right knee at work. He asserted weakness in the knees. Following examination, Dr. Ungacta noted full extension with some tenderness and assessed the petitioner with chronic knee pain, likely related to osteoarthritis. Dr. Ungacta maintained full duty without restrictions. PX3.

On February 14, 2011, the petitioner saw Dr. Ungacta and complained of bilateral knee pain. Dr. Ungacta noted "I think that most of his pain at this point is coming from osteoarthritis and the patient does not feel that he is able to return to work secondary to this." The petitioner reported "he would prefer not to go to work" and Dr. Ungacta prescribed him off work for two weeks. PX3.

The petitioner testified that he voluntarily retired on March 1, 2011.

On March 31, 2011, Dr. Ungacta testified in deposition. See PX31. Dr. Ungacta related the history of injury and the medical condition of the left knee and the postoperative DVT and opined the work injury had caused the meniscal tear and the need for surgery, which in turn led to the postoperative complications. Dr. Ungacta opined with regard to the arthritis, it was "very unlikely" the injury had caused or aggravated that condition. See PX31 p.15. He was asked about the petitioner's unsteadiness on his feet and whether he could explain it: "Not really. I don't think I can." He hypothesized that it might be due to someone walking stiff-legged. See PX31 p.21. Lastly, he was asked about the right knee condition and its relationship to the Section 12 examination. Dr. Ungacta testified "I wasn't there. All I can tell you is what I have in my note and that's what he told me. I don't know if that's really possible, you know, to injure somebody's

knee in an exam, but that's what he – a patient can subjectively feel that and – I don't know. I can't say with significant certainty that that's what caused his [right] knee problem." See PX31 pp. 22-23. Dr. Ungacta confirmed that right knee treatment was not related to the work injury or sequela of the examination. PX31 p.24.

On April 20, 2011, the petitioner presented to Dr. Ungacta's office "to discuss the deposition that was done for his case." The petitioner "is not happy secondary to the fact that the deposition was not in his favor." Dr. Ungacta advised him that the opinions he related in the deposition remained his opinions, and noted the petitioner would be seen on an as needed basis only. PX3.

On October 19, 2011, the petitioner saw Dr. Craig Beyer. See PX6. He reported right knee and left shoulder pain following a fall and noted a pop on October 16, 2011. Dr. Beyer noted a bicep tendon rupture after what appeared to be a minor incident. An MRI suggested chronic meniscal pathology and Dr. Beyer noted "an old chronic ACL deficient knee." He noted the petitioner reported pain in the knee following Dr. Gross' examination, but did not opine whether there was a causal connection.

On July 12, 2012, Dr. Ungacta testified in deposition for a second time. He stated that he had not had available certain notes from his assistant at the time of the first deposition, and now opined that Dr. Gross' examination had aggravated the petitioner's symptoms given the pre-existing arthritic condition. On cross-examination, he admitted that it would be "uncommon" for a knee to be injured in the course of an evaluation. PX32 p.43. He noted nothing in Dr. Gross' examination that was out of the routine course of orthopedic examinations and that "the likelihood of it causing pain in the knee is low" although some of the maneuvers to test knees can involve force. PX32 p.44. He admitted that something that was not aggressive in the mind of a physician could be aggressive in the mind of a patient. PX32 p.45.

The respondent commissioned a second Section 12 examination, with Dr. Frank Petkovich. This examination took place on January 21, 2013. Dr. Petkovich testified in deposition on June 3, 2013. See generally RX1. Dr. Petkovich noted that a normal orthopedic examination could provoke symptoms but would not injure a knee. Dr. Petkovich opined the petitioner's right knee was not injured during the physical examination performed by Dr. Gross and that the petitioner had degenerative arthritis in his right knee based on x-rays taken both before Dr. Gross' examination and on the date of Dr. Petkovich's examination.

OPINION AND ORDER

Causal Relationship to the Injury

The parties did not dispute the left knee surgery being related to the initial injury, and the Arbitrator finds the work-related accident resulted in the meniscal tear which

prompted the surgery. For obvious reasons, the postoperative DVT and pulmonary emboli are similarly related to the original injury.

Relative to the right knee, the credible medical evidence does not support a causal connection to any current condition of ill-being. All the physicians are in accord that while a normal orthopedic examination can provoke symptoms, it would not injure the examinee. Moreover, all physicians are in accord that the examination performed by Dr. Gross was consistent with usual and expected orthopedic examination technique. Dr. Ungacta's latter deposition demonstrates patient advocacy, but his earlier skepticism weighs more heavily on the Arbitrator's mind. Moreover, even were one to discount Dr. Gross' testimony, Dr. Ungacta's first deposition is corroborated by the opinions of Dr. Petkovich and the fact that later objective examinations showed only longstanding and chronic findings, consistent with the claimant's age and health. The right to recover benefits cannot rest upon speculation or conjecture. *County of Cook v. Industrial Commission*, 68 Ill.2d 24 (1977). The claimant may well be sincere in his belief that Dr. Gross injured him, but substantive evidence does not support this conclusion.

Relative to the shoulder treatment with Dr. Beyer, no compelling evidence was presented suggesting a causal connection between the original injury and that condition, and the Arbitrator does not find any relationship to have been established.

Medical Services

As it appears the medical bill to Dr. Ungacta with remaining balance of $111.65 is related to that treatment that was causally related to the injury, the respondent shall satisfy it within the limits of Section 8.2 of the Act. If that amount is overage following reductions per the fee schedule cap, then it shall be reduced to zero and dismissed pursuant to Section 8.2 of the Act. Respondent shall receive credit for any and all amounts previously paid but shall hold the petitioner harmless, pursuant to 8(j) of the Act, for any group health carrier reimbursement requests for such payments.

Temporary Total Disability

The parties stipulated all appropriate TTD was paid up until February 15, 2011. At that time Dr. Ungacta prescribed the claimant off work for two weeks for subjective symptoms. In light of the above findings as to causal connection, coupled with the earlier findings that the claimant was physically capable of full duty work, the Arbitrator finds a lack of credible evidence substantiating medical inability to work during that period.

Nature and Extent of the Injury

The petitioner's work-related accident was causally related to the left knee meniscal tear, which was corrected surgically. Following his rehabilitation, the petitioner

was released to full duty by his treating physician. The petitioner having reached maximum medical improvement, respondent shall pay the petitioner the sum of $370.08 per week for 43 weeks, as provided in Section 8(e) of the Act, as the injuries sustained caused the permanent loss of use the petitioner's left leg to the extent of 20% thereof.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lydia Granda,
Petitioner,
vs.
Joliet Public Schools District 86,
Respondent,

NO: 12 WC 05416

16IWCC0201

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, causal connection, temporary total disability, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 20, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 22 2016

MB/mam
o:2/25/16
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GRANDA, LYDIA
Employee/Petitioner

Case# **12WC005416**

16IWCC0201

JOLIET PUBLIC SCHOOLS DISTRICT 86
Employer/Respondent

On 3/20/2015, 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 0.14% 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:

0412 RIDGE & DOWNES
AMYLEE HOGAN SIMONOVICH
101 N WACKER DR SUITE 200
CHICAGO, IL 60606

1109 GAROFALO SCHREIBER & STORM
LAURA D HRUBEC
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

16IWCC0201

STATE OF ILLINOIS)
)SS.
COUNTY OF **WILL**)

- ☐ 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

Lydia Granda,
Employee/Petitioner

v.

Joliet Public Schools District 86,
Employer/Respondent

Case # **12** WC **5416**

Consolidated cases: **none**

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 **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **New Lenox**, on **2/10/15**. 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 _____

16IWCC0201

FINDINGS

On **2/9/12**, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**24,480.56**; the average weekly wage was $**470.78**.

On the date of accident, Petitioner was **59** 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 $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**0.00**.

Respondent is entitled to a credit of $**25,635.36** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that while Petitioner sustained accidental injuries arising out of and in the course of her employment on 2/9/12, Petitioner failed to prove by a preponderance of the credible evidence that her current condition of ill-being relative to her right arm/shoulder is causally related to said accident. Accordingly, her claim for compensation is hereby denied.

No benefits are awarded.

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.

Signature of Arbitrator

3/13/15
Date

ICArbDec p. 2

MAR 20 2015

STATEMENT OF FACTS: 16IWCC0201

Petitioner, a 59 year old paraprofessional, testified that on February 9, 2012 she was on hallway duty. She indicated that on that date an angry 8 year old student ran out of the lunchroom and slammed into her shoulder. She testified that she flew back but did not fall. Petitioner is 4'10" tall. The student was given a three-day suspension and was made to apologize to Petitioner. She testified that she was stunned but as the day progressed her pain worsened and she could not lift her arm.

Melissa Badger testified that she was a clerical aide and was on hallway duty with Petitioner on February 9, 2012. She noted that on that date she saw a student running, push a garbage can out of the way and push into Petitioner. She indicated that she saw Petitioner's right arm fly back.

Petitioner had injured her right shoulder and received treatment for same prior to the incident in question. Petitioner testified that in October of 2011 she was rolling a boat up to a trailer and something clicked in her shoulder. She began treatment with Dr. Hurbanek at Hinsdale Orthopedics on October 27, 2011. On that date she presented with a chief complaint of right shoulder pain. She was a 58-year-old female teacher's aide who reported that approximately 3 weeks ago while tightening the straps on her boat she was moving her right shoulder and felt a pop. A doctor had not previously evaluated her for this condition. She had no therapy or injections. She reported her pain was located over the top and lateral aspect of the shoulder and the quality of the pain was burning in nature. The pain was constant. It was aggravated with activities such as lying on her side, internal and external rotation. Overhead activities bothered her as well. Forward flexion was to 180 degrees, abduction was to 180 degrees, external rotation was to 60 degrees, internal rotation was to L1. Pain occurred with flexion, abduction and external rotation. She was diagnosed with right shoulder rotator cuff tendinitis and impingement. Conservative treatment was recommended to include a formalized dedicated therapy program. (RX2).

On November 1, 2011, Petitioner presented to ATI for an initial evaluation regarding her right shoulder. She had a primary complaint of right shoulder/upper trap pain with radicular symptoms to the right elbow and right lateral neck pain. The condition began when she was cranking a ratchet on a boat when she felt a snap in her right shoulder. She reported difficulty getting dressed, reaching to the side and up her back. (RX4).

On November 7, 2011, Petitioner reported that her shoulder was killing her. She had increased tenderness and spasm. On November 17, 2011, Petitioner reported right shoulder pain with reaching behind her back, wearing her purse and sleep disruption. The therapist noted severe pain with palpation of the scalene and pec. She had pain with end range of passive flexion. She would benefit from rotator cuff strengthening. (RX4).

On November 23, 2011, Petitioner returned for therapy reporting soreness of her shoulder. On December 1, 2011, Petitioner returned to ATI and had an evaluation. She reported minimal improvement in pain. She could actively abduct to 140 and internally rotate to L4. She could passively rotate to 50 degrees. Hawkins and Neer signs were positive. On December 5 and 7, 2011, Petitioner reported to her therapist that her shoulder was killing her. Between December 9 and 16 Petitioner continued to report soreness. (RX4).

On December 19, 2011, Petitioner reported that she was not getting any better. She could abduct to 100 with pain and 60 degrees internal rotation. (RX4). The progress note reported that she had limitations getting on pants, a shirt, carrying groceries, lifting waist to shoulder and overhead reaching. She could abduct to 100 degrees and internally rotate to 50 degrees. The assessment stated that she continued to have a painful arc with 110-120 degrees of flexion. She made some strength gains but continued to have high subjective pain complaints. (RX4).

On December 20, 2011, Petitioner returned to Dr. Hurbanek for her right shoulder. She was in therapy at ATI. She was no better despite 17 therapy visits. Forward flexion was limited to 170. External [sic] rotation is limited down to approximately L2. Internal [sic] rotation is to 30. She had 4/5 external rotation forward flexion strength and 5/5 internal rotation strength. Her impingement signs were positive. She was diagnosed with persistent right shoulder rotator cuff tendonitis. It was possible that she might have a tear and an MRI was recommended. They were going to hold therapy for now as well. (RX2).

On December 27, 2011, Petitioner underwent an MRI of the right shoulder prescribed by Dr. Hurbanek that revealed a rotator cuff tear versus tendonitis. (RX2). The impression was as follows: 1) Full thickness tear of the anterior and central supraspinatus tendon with 1.6 mm retraction and no significant atrophy; 2) Fraying of the superior labrum but no actual labral tears. (RX2).

On December 29, 2011, Petitioner visited ATI and reported continued right shoulder pain, worse with reaching behind her back and to the side. She reported minimal improvements in pain. The progress note reported that she had limitations getting on pants, a shirt, carrying groceries, lifting waist to shoulder and overhead reaching. She could abduct to 100 degrees and internally rotate to 50 degrees. (RX4).

On December 29, 2011, Petitioner presented to Dr. Hurbanek. She was there to discuss her MRI results. She had a large full thickness tear in the supraspinatus tendon with approximately 1.6 cm of retraction. There did not appear to be atrophy. The doctor stated that "I do think it is traumatic and so far there is no atrophy; therefore I would recommend surgical fixation. She had failed physical therapy. I discussed the importance of being relatively prompt with this but she would like to think about it and see how it fits into her schedule and will let me know." Upon further discussion she stated she wanted to proceed with surgery. The preoperative paperwork was completed. (RX3).

Petitioner testified that she did not schedule surgery because she did not have enough sick days. She testified that she intended to proceed forward in June. She testified that between October 2011 and February of 2012 there were things that she could not do, but that she functioned fine. She testified that after the accident she was unable to lift her arm up at all anymore and that he pain level was much higher.

Respondent's assistant superintendent for human resources, Cheryl Clendening Woods, testified that she spoke to Petitioner about the latter's request for time off work prior to the surgery set for January 11, 2012. Ms. Clendening Woods indicated that she informed Petitioner that she did not have any more sick time left, and that Ms. Granda told her she was going to contact her union to see what options she had to have the surgery now.

On February 13, 2012, or following the accident in dispute, Petitioner returned to Dr. Hurbanek at Hinsdale Orthopedics stating that she had an injury on February 9, 2012 at school. She reported that a student ran into her shoulder. She described the pain as 7 out of 10. She claimed the pain was dull in nature but could be sharp and that lifting aggravated or increased her pain. Dr. Hurbanek believed her injury inflamed her shoulder and that she was a good candidate for a rotator cuff repair. She would have surgery. She was released to left-handed work only. (RX2).

Petitioner returned to ATI on February 14, 2012 and reported that she was hurt when a student slammed into her right shoulder causing increasing pain. Her active ROM for flexion was 85, passive was 125. Shoulder abduction was 85 actively, 110 passively. She could not internally rotate but passively reached 45 degrees and could externally rotate passively to 60 degrees. Her previous limitations included lifting from floor, overhead and waist to shoulder and opening and closing lids. Her current limitations were noted to be difficulty with carrying groceries, lifting waist to shoulder pulling objects and overhead work. (RX4).

On February 24, 2012, Petitioner reported that her shoulder hurt like hell. On February 28, 2012, Petitioner reported that her shoulder was really sore. On March 1, 2012 she reported that her shoulder was killing her. On March 5, 2012 she reported that her shoulder still "hurts like hell." On March 7, 2012 she had an evaluation. She continued to report pain but passive range of motion improved. She had difficulty performing work tasks. (RX4).

On March 22, 2012, Petitioner underwent an MRI at Hoffman estates MRI that revealed the following: abnormal signal and appearance to the rotator cuff tendon compatible with a discrete full thickness tear supraspinatus; patchy tendinosis more diffusely also was noted; findings were stable since the prior study; there was no fracture, bone bruise or any other adverse change; there was fluid in the shoulder joint as well as subdeltoid and subacromial bursa. (RX3).

On March 22, 2012, Petitioner returned to Dr. Hurbanek in follow up of her right shoulder. She was still having trouble reaching out to the side or behind her back and was scheduled for a right shoulder arthroscopy RTC repair on 3/30/12. They would address the biceps with a subacromial decompression depending on the intraoperative findings. (RX3).

On March 26, 2012, Dr. Hurbanek performed (1) arthroscopic right shoulder rotator cuff repair; (2) subacromial decompression; and (3) limited debridement glenohumeral joint. She was authorized to remain off work following surgery. (RX3).

On August 13, 2012, Petitioner returned to Dr. Hurbanek in follow up for her right shoulder five months post right shoulder scope, rotator cuff repair on March 26, 2012. She said her pain increased after being startled by the dog and turning abruptly. She was not taking any medication. She was progressing in therapy at ATI in Joliet and had one visit remaining prior to discharge. Dr. Hurbanek said it would be unlikely that she re-tore her rotator cuff with a sudden turn, but may have just ripped some scar tissue. No imaging was necessary and she would return back to work full duty as of August 16, 2012. (RX3). Petitioner did in fact return to work for Respondent at the start of the 2012-2013 School Year. She indicated that she worked one (1) full school year and then retired as of September 1, 2013.

On September 20, 2012, Petitioner returned to Dr. Hurbanek with complaints of some lateral shoulder pain with abduction when doing her home exercises. She had been back to work without difficulty. Dr. Hurbanek believed some of her pain was related to muscular fatigue. She was to continue with home exercises and placed at MMI. She was released to return to work without restrictions as of September 21, 2012. (RX3).

At the request of the Respondent, Petitioner visited Dr. Mark Levin for purposes of a §12 examination. Dr. Levin testified that Petitioner had a preexisting massive rotator cuff tear before the accident, and that there were no findings that the accident caused or aggravated any additional pathology. (RX1, p.15). Dr. Levin also noted that if Petitioner did in fact have trauma from being hit in the front of her shoulder there would have been changes in the soft tissues of her shoulder. (RX1, p.16). Instead, Dr. Levin noted that there were no changes on the MRI and that the rotator cuff was exactly as retracted as it was before without any inflammation or changes to the soft tissues. (Id.)

Petitioner testified that she currently experiences an achy pain in her shoulder on a daily basis that she described as localized and which sometimes goes up her neck. She indicated that she has difficulty with hair straightening and reaching up for things. She also noted that she has had to downsize to smaller purses because the big ones are too heavy. She finds it painful to reach up and she has to do this all the time because she is so short. Precipitation affects her shoulder symptoms, and when it rains or snows she takes Tylenol as directed.

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

An employee's injury is compensable under the Act only if it arises out of and in the course of his or her employment. 820 ILCS 305/2 (West 2008). The phrase "in the course of" refers to the time, place and circumstances under which the accident occurred. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483, 546 N.E.2d 603, 137 Ill. Dec. 658 (1989). The words "arising out of" refer to the origin or cause of the accident and presuppose a causal connection between the employment and the accidental injury. *Illinois Bell Telephone Co.*, 131 Ill. 2d at 483. Both elements must be present at the time of the claimant's injury in order to justify compensation. *Illinois Bell Telephone Co.*, 131 Ill. 2d at 483.

Petitioner testified that on February 9, 2012 she was on hallway duty outside the lunchroom when a second grade student slammed into her right shoulder. She noted that the student was stomping and very angry and was between walking and running when he ran into her. Petitioner, who is 4'10" tall, testified that she felt nauseated and saw stars following the incident, but that she did not fall to the ground. She also noted that she felt stunned at first, but then the pain got worse and worse and she could not even lift her right arm. Petitioner testified that she reported the incident to her supervisor and was told to fill out a report and write a statement.

Melissa Badger testified that she was working as an aide for Respondent on the date of the alleged accident. She noted that she and Petitioner were on hallway duty and that they turned to look at some commotion in the lunchroom when a student pushed a garbage can and exited the lunchroom angrily. She indicated that she was about five feet to Petitioner's left when the student pushed into Petitioner on her right side. Ms. Badger testified that she saw Petitioner's arm move backwards at the time of the incident, and that she was in quite a bit of pain thereafter.

On February 13, 2012, Petitioner visited Dr. Hurbanek at Hinsdale Orthopedics and gave a history of suffering an injury at school on February 9, 2012 when a student ran into her shoulder. (RX2).

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner sustained accidental injuries arising out of and in the course of her employment on February 9, 2012. Both Petitioner and Ms. Badger credibly testified that an unruly student slammed into Ms. Granda on his way out of the lunchroom on the date in question. Petitioner also testified that she felt increased pain following the incident. Furthermore, the history recorded by Dr. Hurbanek four days later likewise references an incident whereby Petitioner was run into by a student. Therefore, the Arbitrator finds that Petitioner proved by a preponderance of the credible evidence that she sustained accidental injuries arising out of and in the course of her employment on February 9, 2012.

The ultimate issue is whether Petitioner's current condition of ill-being is causally related to said accident.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

It has long been recognized that, in preexisting condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been causally-connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 204-206, 797 N.E.2d 665, ___, 278 Ill.Dec. 70, ___ (2003); citing *Caterpillar*

Tractor Co. v. Industrial Commission, 92 Ill. 2d 30, 36-37, 65 Ill. Dec. 6, 440 N.E.2d 861 (1982); Caradco Window & Door v. Industrial Comm'n, 86 Ill. 2d 92, 99, 56 Ill. Dec. 1, 427 N.E.2d 81 (1981); Azzarelli Construction Co. v. Industrial Comm'n, 84 Ill. 2d 262, 266, 49 Ill. Dec. 702, 418 N.E.2d 722 (1981); Fitrro v. Industrial Comm'n, 377 Ill. 532, 537, 37 N.E.2d 161 (1941).

The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. Hansel & Gretel Day Care v. Industrial Commission, 158 Ill.Dec. 851, 858, 574 N.E.2d 1244, 1251 (Ill.App. 3 Dist. 1991); citing Board of Education v. Industrial Commission, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969). Although a preexisting condition does not prevent recovery of benefits if that condition was aggravated or accelerated by claimant's employment, recovery is denied where the claimant's health has so deteriorated that any normal activity engaged in presents risks no greater than those to which the general public is exposed. Hansel & Gretel Day Care, 574 N.E.2d at 1250; citing Caterpillar Tractor v. Industrial Commission, 92 Ill.2d 30, 36, 65 Ill.Dec. 6, 440 N.E.2d 861 (1982). In Hansel & Gretel Day Care, supra, the claimant was a teacher who injured her knee while getting out of a children's desk. Id., at 1246. The court noted that the claimant had had previous problems with her knee, including difficulty with her leg during the period leading up to the date of the alleged injury, and that while there was no way to tell how long the meniscal tear had existed, the medical evidence showed that the claimant's knee "... could have locked or gone out while she was walking, turning, getting out of bed or, in short, performing the activities of everyday life." Id., at 1246-1251. As a result, the court ruled that the claimant had not established that she was exposed to a risk not common to the general public, and reversed the Commission's finding that the incident aggravated the claimant's pre-existing condition. Id., at 1251.

In the present case, there is no dispute that Petitioner suffered from a pre-existing condition relative to her right shoulder, having injured herself tightening straps on her boat in October of 2011. Furthermore, there is no question that Petitioner had been diagnosed with a full thickness tear of her right rotator cuff prior to the incident on February 9, 2012. Along these lines, the record shows that Petitioner underwent an MRI on December 27, 2011, or a mere six (6) weeks before the accident in question, which revealed a full thickness tear of the anterior and central supraspinatus tendon with 16 mm of retraction and no significant atrophy as well as fraying of the superior labrum but no actual labral tears. (RX2, p.48). Following the accident, Petitioner underwent a subsequent MRI on March 22, 2012 which likewise revealed a discrete full thickness supraspinatus tear as well as patchy tendinosis, findings which the interpreting physician noted were "... stable since prior study." (RX3, p.88). Indeed, both the treating physician, Dr. Hurbanek, and examining physician, Dr. Levin, agree that Petitioner's MRI from March 22, 2012 did not change as compared to the December 2011 MRI. (PX3, p.17; RX1, pp.13-14).

Furthermore, it is equally clear that Dr. Hurbanek had recommended surgery to repair the full thickness tear prior to the accident, and that Petitioner had agreed to go forward and had initially scheduled same before the incident, only to be forced to delay the procedure until the summer break given that she was out of sick days. And while Petitioner claimed that the incident resulted in increased symptoms, the Arbitrator is not convinced that the simple act of being bumped in the manner described had an appreciable effect on a shoulder that had already been shown to exhibit a full thickness tear. As a result, the Arbitrator finds the opinion of Respondent's §12 examining physician, Dr. Levin, to the effect that the incident neither caused nor aggravated any additional pathology (RX1, p.15), to be more persuasive than the opinion of Dr. Hurbanek. Indeed, as in the case of Hansel & Gretel, supra, it would appear that Petitioner's condition was so far gone that any activity could have resulted in the increased symptoms that Ms. Granda experienced on February 9, 2012. And unlike the claimant in Hansel & Gretel, there was actually a before and after MRI, evidencing the exact same pathology, as well as

a recommendation for surgery that pre-dated the accident to support a finding that the incident did not sufficiently aggravate or accelerate the disease process.

Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner failed to prove by a preponderance of the credible evidence that her current condition of ill-being is causally related to the accident on February 9, 2012.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

In light of the Arbitrator's determination as to accident and causation (issues "C" & "F", supra), the Arbitrator finds that Petitioner failed to prove her entitlement to medical expenses. Accordingly, Petitioner's claim for same is hereby denied.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, THE ARBITRATOR FINDS AS FOLLOWS:

In light of the Arbitrator's determination as to accident and causation (issues "C" & "F", supra), the Arbitrator finds that Petitioner failed to prove her entitlement to temporary total disability benefits. Accordingly, Petitioner's claim for same is hereby denied.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

In light of the Arbitrator's determination as to accident and causation (issues "C", "D" & "F", supra), the Arbitrator finds that Petitioner failed to prove her entitlement to an award for permanent partial disability. Accordingly, Petitioner's claim for same is hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tshoma Pugh,
Petitioner,

vs.
City of Chicago (Dept. of Streets and San),
Respondent,

NO: 12 WC 11108

16IWCC0202

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 29, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 2 2016

MB/mam
o:2/25/16
43

Mario Basurto

David L. Gore

Stephen Mathis

CONFIDENTIAL

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PUGH, TSHOMA
Employee/Petitioner

Case# **12WC011108**

16IWCC0202

CITY OF CHICAGO (DEPT OF STREETS AND SAN)
Employer/Respondent

On 6/29/2015, 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 0.08% 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:

0154 KROL BONGIORNO & GIVEN LTD
MIKE BRANDENBERG
120 N LASALLE ST SUITE 1150
CHICAGO, IL 60603

0113 CITY OF CHICAGO
MICHELLE BRYANT
30 N LASALLE ST 8TH FL
CHICAGO, IL 60602

16IWCC0202

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐	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

Tshoma Pugh
Employee/Petitioner

v.

City of Chicago (Dept. of Streets and San.)
Employer/Respondent

Case # **12** WC **11108**

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 **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **June 9, 2015.** 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 _____

16IWCC0202

FINDINGS

On **March 20, 2012**, 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 $**66,367.60**; the average weekly wage was $**1,276.30**.

On the date of accident, Petitioner was **40** years of age, ***married*** with **4** dependent children.

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

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

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 **$850.87/week** for **2/7 weeks** commencing **3/21/2012** through **3/25/2012**, as provided in §8(b) of the Act and after taking into account the three working day waiting period as required by §8(b).

Respondent shall pay Petitioner disfigurement benefits of **$695.78/week** for **15 weeks** in accordance with §8(c) 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.

Signature of Arbitrator

June 25, 2015
Date

JUN 29 2015

16IWCC0202

FINDINGS OF FACT

At the time of accident Tshoma Pugh ("Petitioner") was a 40-year-old laborer employed by the City of Chicago, Streets and Sanitation Department, ("Respondent") since 1997. Petitioner testified that on March 20, 2012 he was emptying garbage bins into the Respondent garbage truck when one of the garbage bags tore open and splashed a liquid on his face and hands. As a result, he immediately felt pain, burning, and itching on his face and hands, and he had several holes burned into his shirt.

On the date of the accident, Petitioner received emergency treatment at Trinity Hospital. On March 21, 2012, Petitioner was referred to MercyWorks Occupational Medicine by Respondent, where he treated with Dr. Jayant Sheth. Dr. Sheth noted first and second degrees burns and discolorations on Petitioner's face. He recommended that Petitioner remain off of work from March 21, 2012 through March 25, 2012. (PX1)

Petitioner testified that he did not work from March 21, 2012 through March 25, 2012. He returned to work at full duty on March 26, 2012.

Petitioner followed up with Dr. Sheth on March 28, 2012. Dr. Sheth observed healed burns and multiple 2cm to 5cm discolorations on Petitioner's face. Petitioner was discharged from care and has received no further medical care for his injuries. (PX1)

At the time of hearing, the Arbitrator viewed Petitioner's face and hands from a distance of approximately six feet or more. Petitioner had a blemish on his forehead just above between the eyebrows, another blemish just above the right eyebrow, and his right cheek had a difference in texture than the left cheek. Petitioner had some blemishes on each hand.

Petitioner testified that he is an actor and a recording artist. He uses make-up and wears a hat to cover the blemishes on his face when he performs. Petitioner testified that none of the blemishes were present on his skin prior to the accident on March 20, 2012.

Petitioner continues to work for Respondent.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE? TTD

The Petitioner claims that he is entitled to TTD benefits for the period between March 21, 2012 and March 25, 2014, a period representing 5/7 weeks. Respondent claims that it does not owe any TTD benefits.

Dr. Sheth recommended that Petitioner remain off of work completely from March 21, 2012 through March 25, 2012. PX1. Petitioner testified that he did not work during that time.

Based upon Petitioner's testimony, the records of MercyWorks and the Work Status Report, the Arbitrator finds that Petitioner was temporarily and totally disabled from work as a result of the injury from March 21, 2012 through March 25, 2012, a period of 5/7 weeks. There is a 3 working day waiting period required under §8(b), therefore Petitioner is entitled to 2/7 weeks TTD.

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

The Arbitrator finds that the injuries caused 15 weeks of disfigurement to Petitioner's face and hands, as provided in §8(c) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ronnie D. Smith,
Petitioner,

vs.
St. of IL-Dept of Transportation,
Respondent,

NO: 12 WC 15820

16IWCC0195

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability, causal connection, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 20, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

No bond or summons for State of Illinois cases.

DATED: MAR 16 2016

MB/mam
o:2/11/16
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SMITH, RONNIE D
Employee/Petitioner

Case# **12WC015820**

16IWCC0195

ST OF IL-DEPT OF TRANSPORTATION
Employer/Respondent

On 7/20/2015, 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 0.10% 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 BRESNEY
CHARLES N EDMISTON
129 S CONGRESS
RUSHVILLE, IL 62681

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

5260 ASSISTANT ATTORNEY GENERAL
KRISTINA ECHOLS
500 S SECOND ST
SPRINGFIELD, IL 62706

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

1430 CENTAL MGMGT SERVICES
WORKERS' COMP MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

JUL 20 2015

RONALD A.HASCIA, Acting Secretary
Illinois Workers' Compensation Commission

16IWCC0195

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

Reconsidered

☐ 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

Ronnie D. Smith
Employee/Petitioner

v.

State of Illinois - Dept. of Transportation
Employer/Respondent

Case # 12 WC 15820

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 William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on May 21, 2015. 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 February 24, 2012, 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 not causally related to the accident.

In the year preceding the injury, Petitioner earned $65,783.00; the average weekly wage was $1,265.06.

On the date of accident, Petitioner was 50 years of age, married with 0 dependent child(ren).

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 $65,280.97 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $65,280.97.

Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 6, from February 28, 2012, through April 25, 2012, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall pay Petitioner temporary total disability benefits of $843.37 per week for 91 2/7 weeks commencing April 4, 2012, through January 2, 2014, as provided in Section 8(b) of the Act.

Based upon the Arbitrator's conclusions of law attached hereto, claim for permanency is denied.

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.

William R. Gallagher, Arbitrator

July 14, 2015
Date

JUL 20 2015

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on February 24, 2012. According to the Application, Petitioner was lifting a trash can and sustained an injury to the Back/Lower Extremities (Arbitrator's Exhibit 2). The parties stipulated that Petitioner sustained a work-related accident; however, Respondent disputed liability on the basis of causal relationship. Further, Petitioner claimed that he was entitled to temporary total disability benefits of 132 6/7 weeks commencing April 4, 2012, through October 21, 2014. Respondent disputed liability for temporary total disability benefits for this period of time and claimed that the period of time Petitioner was entitled to temporary total disability benefits was 77 3/7 weeks, commencing July 10, 2012, through January 2, 2014 (Arbitrator's Exhibit 1).

Petitioner testified that he worked for Respondent as a janitor and, on February 24, 2012, he was lifting/emptying a garbage can when he heard something "pop" in his right lower back. Petitioner estimated that the garbage can weighed 70 to 80 pounds.

Petitioner testified that he previously injured his back in 2003 while serving in the Army in Iraq. At that time, Petitioner was a paramedic and he was required to repetitively lift wounded and deceased soldiers. Petitioner stated that because of his back injury and post traumatic stress disorder (PTSD) he was awarded a 90% disability from the VA in April, 2012.

Petitioner also testified that he sustained a work-related back injury in 2010 that was caused by lifting garbage cans. Petitioner stated that he was treated by Dr. VanFleet and was released to return to work in April, 2011. That case was settled in November 2011. There were no medical records regarding that prior back injury tendered into evidence when this case was tried. Petitioner stated that he was able to return to work to his regular job and had no further problems or difficulties performing his job duties up until the accident of February 24, 2012.

Petitioner sought treatment from Dr. Christopher Leone, a chiropractor, on June 6, 2011. At that time, Petitioner complained of low back and right leg pain. Dr. Leone's record of that date noted both Petitioner's prior military service and work-related back injuries. Dr. Leone prescribed a 12 month "wellness" program with office visits that were to gradually decrease over time (Petitioner's Exhibit 2; p 4).

Prior to the accident of February 24, 2012, Petitioner was treated by Dr. Leone on a regular basis as part of the "wellness" program. Petitioner was seen by Dr. Leone on February 23, 2012 (the day before the accident) and, in regard to Petitioner's low back symptoms, Dr. Leone's record stated "LBP SX'S" (Petitioner's Exhibit 2; p 16).

Prior to the accident of February 24, 2012, Petitioner was treated at the VA where he was seen by various physicians and other medical providers. The earliest VA record was for a visit of August 29, 2011. At that time, Petitioner advised that he was in severe pain over his back and had been treated by a chiropractor who had succeeded in bringing his constant pain down to a six or seven. The record stated that "Veteran continues to be frustrated at his unresolved back pain." (Respondent's Exhibit 4; p 261).

The records indicated Petitioner was seen at the VA on September 24, 2011. At that time, he reported back pain of 9/10 and he believed his depression was secondary to his chronic back pain (Respondent's Exhibit 4; pp 254-257).

On November 28, 2011, Petitioner was evaluated at the VA by Dr. Diane Bontke. At that time, Petitioner stated that he had back pain since 2004 and was having problems lifting 200 small wastebaskets a day. Petitioner advised that he was being treated by a chiropractor and taking pain medication. Petitioner reported a pain level of five which had been present since 2004 (Respondent's Exhibit 4; pp 236-239).

On December 16, 2011, Petitioner was interviewed by Notasha Gavins, a social worker with the VA. At that time, Petitioner advised her that he had been working as a janitor for Respondent but was seeking employment in another area because of significant back pain which he rated as 7/10 (Respondent's Exhibit 4; p 232).

On January 10, 2012, Petitioner was seen at the VA by Dr. Donald Owens, a chiropractor. At that time, Petitioner complained of low back pain which he rated as 8/10 which was constant and had been present for the preceding seven years. Dr. Owens administered acupuncture and manual manipulation of the spine. Dr. Owens subsequently saw Petitioner on January 17, 2012 and Petitioner advised that his pain was 6/10, a moderate decrease since the last visit (Respondent's Exhibit 4; pp 226-229).

Petitioner was again seen by Dr. Owens on January 24, 2012, and Petitioner advised that his low back pain was 5/10; however, he stated there had been no change/improvement since the last visit. Dr. Owens administered acupuncture to the low back but he concluded that Petitioner had not shown significant gains that would justify further treatment (Respondent's Exhibit 4; p 225).

Subsequent to the accident of February 24, 2012, Petitioner sought treatment from Dr. Leone who saw him on February 28, 2012. Counsels for both Petitioner and Respondent tendered into evidence copies of Dr. Leone's treatment records. The copy tendered by Respondent was printed on June 4, 2012, and the copy tendered by Petitioner was printed on August 15, 2012 (Respondent's Exhibit 8; Petitioner's Exhibit 2).

In the copy of Dr. Leone's record tendered by Respondent, the entry of February 28, 2012, in reference to Petitioner's low back condition states "LBP SX'S" and is identical to the prior record of February 23, 2012. There was no reference to Petitioner's work-related accident (Respondent's Exhibit 8; p 13). However, in the copy of Dr. Leone's records tendered by Petitioner, the entry of February 28, 2012, makes a specific reference to Petitioner's accident of February 24, 2012, that Petitioner was lifting garbage cans at work that weighed approximately 300 pounds and that Petitioner sustained immediate low back pain and sciatica on the right side at the time of the injury (Petitioner's Exhibit 2; p 16).

Petitioner was subsequently seen at the VA by Dr. Bontke on March 6, 2012. Her record of that date stated Petitioner was being seen for "service connected issues" which included low back pain. There was no reference to Petitioner's work-related accident (Respondent's Exhibit 4; p 212).

Dr. Bontke also prepared two letters both dated March 6, 2012, addressed to Petitioner. One of the letters stated that Petitioner had chronic low back pain due to strain and arthritis and should be restricted to light duty. The other letter stated that Petitioner was complaining of acute pain from work-related injury on February 24, 2012, and that light duty was recommended (Petitioner's Exhibit 1; pp 122-123).

Petitioner was later seen at the VA by Dr. S. Raju on March 27, 2012. Dr. Raju's record of that date noted that Petitioner had chronic low back pain for the past few years which was getting worse. Petitioner rated the pain as being 6 to 7/10. Dr. Raju ordered an MRI scan. The record of that date did not contain any reference to Petitioner's work-related accident (Respondent's Exhibit 4; p 211).

On April 9, 2012, Dr. Leone wrote a letter addressed "To Whom It May Concern" which stated that he had been treating Petitioner for approximately one year for chronic low back pain. He recommended Petitioner not lift heavy garbage cans and imposed a 15 pound lifting restriction. He opined that continuing chiropractic care was appropriate. There was no reference to Petitioner's work-related accident (Respondent's Exhibit 3).

The MRI was performed on April 16, 2012. On May 7, 2012, Petitioner called the VA and spoke to Dr. Bontke regarding completion of a form that had been requested by CMS. Dr. Bontke reviewed the MRI and completed the form (Respondent's Exhibit 4; p 184). In the form submitted to CMS, Dr. Bontke stated that Petitioner had back pain and was unable to perform the lifting requirements of his janitorial job. She did not make any reference to Petitioner's work-related accident (Petitioner's Exhibit 1; pp 120-121).

Petitioner was again seen by Dr. Raju on May 29, 2012. At that time, Dr. Raju noted that the MRI was negative for both disc herniations and stenosis but did reveal minimal degenerative changes at L4-L5 and L5-S1. Petitioner stated that his back pain was 5/10. Dr. Raju ordered a series of epidural steroid injections (Respondent's Exhibit 4; p 179).

Petitioner contacted the VA by telephone on June 1, 2012, and advised that he had been awarded a service connection of 100% and unemployability status. Petitioner stated that this was a big relief for him and that he had been working on this for years. Petitioner was later seen at the VA by Dr. Basanti Mukerji on July 1, 2012. Dr. Mukerji noted that the MRI was normal and that Petitioner's care was transferred to Dr. Bontke (Respondent's Exhibit 4; pp 164, 178).

Petitioner was seen by Dr. Bontke on July 9, 2012, and the record of that date noted that Petitioner had injured his back while lifting on February 24, 2012. Dr. Bontke ordered a functional capacity evaluation (FCE) which was performed on July 17, 2012. When the FCE was performed, Petitioner stated his low back pain was 5/10 but had been 6/10 over the preceding 48 hours. While the examiner stated that Petitioner demonstrated maximum effort during the evaluation, it was noted that Petitioner's perception of his abilities were less than what he was able to objectively demonstrate on that date (Respondent's Exhibit 4; p 155; Petitioner's Exhibit 1, p 129).

Petitioner was seen by Dr. Bontke on July 26, 2012, and she reviewed the FCE at that time. She noted that Petitioner had a good functional capacity but he had a perception of not being able to do things. Her record of that date also noted that Petitioner informed her that his attorney wanted a narrative regarding her March 6th evaluation of him. Dr. Bontke noted that "There was no note from a nurse about an injury at work." (Respondent's Exhibit 4; p 144).

Dr. Bontke subsequently prepared two reports for CMS both dated August 15, 2012, wherein she stated that Petitioner had sustained an acute injury due to lifting of "300#" on February 24, 2012 (Petitioner's Exhibit 1; pp 124-126).

Petitioner continued to be treated at the VA and Opti Care. During that time, he received pool therapy, acupuncture and chiropractic treatment (Petitioner's Exhibit 1; pp 44-85).

Petitioner saw Dr. Bontke again on December 5, 2012. At that time, he advised her that his chiropractor (Dr. Leone) opined that he could not return to work as a janitor and she agreed (Respondent's Exhibit 4; p 51).

During the aforementioned periods of time, Petitioner also continued to be treated by Dr. Leone. Dr. Leone treated Petitioner through May, 2014 (Respondent's Exhibit 4 - updated portion printed May 21, 2014).

Dr. Leone referred Petitioner to Dr. Gary Western, a physician with Springfield Clinic, who examined Petitioner on February 15, 2013. Petitioner provided Dr. Western with a detailed history which included the work-related accident of February 24, 2012; however, Dr. Western's findings on examination were rather benign and he wanted to review the MRI and FCE. The only recommendation he made was possible work hardening (Petitioner's Exhibit 3; pp 6-7).

Petitioner was again seen at the VA by Dr. Raju on May 21, 2013, and, because Petitioner had experienced some relief after undergoing epidural steroid injections, he indicated that he wanted to undergo additional injections. Dr. Raju referred Petitioner to the Indianapolis VA Clinic for a series of epidural injections; however, the VA subsequently refused to provide any further treatment for Petitioner's back conditions until the workers' compensation case was resolved (Petitioner's Exhibit 1; pp 28-30).

At the direction of Respondent, Petitioner was examined by Dr. Thomas Lee, an orthopedic surgeon, on October 10, 2013. In connection with his examination of Petitioner, Dr. Lee reviewed medical records and the MRI which had been provided by Respondent. Dr. Lee opined that Petitioner sustained a lumbar sprain as a result of the accident of February 24, 2012. He further noted that Petitioner had a significant pre-existing condition but that Petitioner had no objective findings attributable to the accident. Dr. Lee did opine that Petitioner had a 10 pound lifting restriction; however, he did not attribute it to the February 24th accident, but to the degenerative condition of the spine. Dr. Lee further opined that Petitioner was at MMI as related to the February 24, 2012, sprain (Respondent's Exhibit 2).

Dr. Lee was deposed on August 21, 2014, and his deposition testimony was received into evidence at trial. Dr. Lee's testimony was consistent with his medical report and he reaffirmed

the opinions contained therein. Dr. Lee stated that Petitioner's back symptoms prior to the accident of February 24, 2012, were curtailing his activities and, that after sustaining the accident, they would be curtailed further but for a temporary period of time. In regard to the garbage can weighing 300 pounds, Dr. Lee stated that he did not see how it could possibly weigh that much (Respondent's Exhibit 1; pp 9-11).

Dr. Leone was deposed on June 9, 2014, and his deposition testimony was received into evidence at trial. Dr. Leone testified he began treating Petitioner in June, 2011, but that after 90 days Petitioner had improved to where he provided "wellness" care. When Petitioner saw Dr. Leone on February 28, 2012, he informed him that he had injured his back after lifting 300 pounds worth of trash cans and that he immediately sustained severe back pain. In comparing Petitioner's pre and post accident condition, Dr. Leone stated "Yes, it was a completely different person. We're talking about a wellness person with no symptoms," (Petitioner's Exhibit 4; pp 6-9).

In regard to causality, Dr. Leone opined that there was an aggravation and that "In my opinion he was completely well prior to the work accident." On cross-examination, Dr. Leone found Petitioner's statement that a trash can weighed up to 300 pounds to be credible (Petitioner's Exhibit 4; pp 11, 33).

At the direction of his attorney, Petitioner was examined by Dr. Michael Watson, an orthopedic surgeon, on October 21, 2014. Dr. Watson was deposed on April 8, 2015, and his deposition testimony was received into evidence at trial. Dr. Watson testified that Petitioner gave him a history of his back condition as well as the treatment he had received. Dr. Watson also reviewed medical records provided to him by Petitioner's counsel and the deposition transcript of Dr. Leone's testimony. Dr. Watson's diagnosis was an acute lumbar sprain with chronic low back pain secondary to degenerative spine disease. In regard to causality, Dr. Watson opined that Petitioner had a long history of low back pain and pre-existing degenerative disc disease which was either aggravated or accelerated by the injury at work. He further opined that Petitioner was capable of performing sedentary work only and subject to a 10 pound lifting restriction (Petitioner's Exhibit 5; pp 7-11).

On cross-examination, Dr. Watson agreed that the reasonable period of treatment for a lumbar sprain would be six to eight weeks. In regard to Petitioner's worsening of symptoms subsequent to the accident of February 24, 2012, Dr. Watson agreed that this was "...not reflected in Dr. Leone's records." (Petitioner's Exhibit 5; pp 16-17, 28).

At trial, Petitioner testified that he continued to work following the accident until April 4, 2012, when Respondent would not honor his light duty restrictions. Petitioner has continued to be treated by Dr. Leone and he intends to return to the VA for further treatment. He stated that he received a 90% disability from the VA and that his PTSD is part of the reason for it. Petitioner's activities of daily living are limited and he stated that it is difficult for him to climb stairs, sit for too long or walk in excess of one-half hour. Petitioner's level of pain is usually five or six out of ten.

Conclusions of Law

In regard to disputed issue (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner's current condition of ill-being is not related to the accident of February 24, 2012.

In support of this conclusion the Arbitrator notes the following:

Petitioner had significant low back symptoms that pre-existed the accident of February 24, 2012, for which Petitioner received extensive medical treatment from both the VA and Dr. Leone.

As is noted in the findings of fact, the VA medical records indicated that from September 24, 2011, through January 24, 2012, Petitioner's rating of his low back pain ranged from 9/10 to 5/10.

Dr. Leone is neither believable nor credible. As is noted in the findings of fact, there was a discrepancy in Dr. Leone's treatment records for Petitioner's first visit subsequent to the accident. The record printed on June 4, 2012, contained no reference to the accident of February 24, 2012, and was identical to the preceding entry of February 23, 2012. However, the record printed on August 15, 2012, made specific reference to the accident of February 24, 2012, and that Petitioner had an immediate onset of severe low back pain at that time. Obviously, Dr. Leone altered his treatment records sometime between June 4 and August 15, 2012.

Dr. Leone's testimony that Petitioner was "completely well" prior to the accident of February 24, 2012, is contrary to Petitioner's treatment records, specifically, the records from the VA.

Dr. Leone's records and testimony that Petitioner was lifting a garbage can that weighed 300 pounds at the time of the accident is contrary to Petitioner's testimony at trial and also defies common sense.

The VA records contained no reference to Petitioner's work-related accident until Dr. Bontke's record of July 9, 2012. However, Dr. Bontke submitted letters and a report to CMS dated March 6, 2012, which specifically referenced the work-related accident. Additionally, the VA record of Petitioner's evaluation by Dr. Bontke on July 26, 2012, noted that in regard to the March 6, 2012, visit there was not a note from a nurse which described a work-related accident. There was no explanation for these discrepancies.

Respondent's Section 12 examiner, Dr. Lee, credibly testified that Petitioner sustained a lumbar sprain and temporary aggravation of his pre-existing back condition.

Petitioner's Section 12 examiner, Dr. Watson, agreed that Petitioner's worsening of symptoms subsequent to the accident of February 24, 2012, was not reflected in Dr. Leone's treatment records.

In regard to disputed issue (J) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that the medical treatment provided to Petitioner from February 28, 2012, through April 25, 2012, was reasonable and necessary and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 6 for medical services provided to Petitioner from February 28, 2012, through April 25, 2012, as provided in Sections 8(a) and 8.2 of the Act subject to the fee schedule.

In support of this conclusion the Arbitrator notes the following:

Petitioner sustained a lumbar sprain as a result of the accident of February 24, 2012. Petitioner's Section 12 examiner, Dr. Watson, opined that treatment for six to eight weeks following the accident was reasonable.

In regard to disputed issue (K) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 91 2/7 weeks commencing April 4, 2012, through January 2, 2014.

In support of this conclusion the Arbitrator notes the following:

Petitioner was on light duty restrictions on April 4, 2012, and was still receiving medical treatment related to the accident of February 24, 2012. At that time, Respondent was unable to accommodate those restrictions.

Respondent commenced payment of temporary total disability benefits to Petitioner effective July 10, 2012; however, the basis for the benefits beginning on that date cannot be determined from the record.

While Respondent's Section 12 examiner, Dr. Lee, opined that Petitioner was at MMI at the time he examined Petitioner on October 10, 2013, Respondent stipulated that Petitioner was temporarily totally disabled from July 10, 2012 through January 2, 2014.

In regard to disputed issue (L) the Arbitrator makes the following conclusion of law:

Based upon the Arbitrator's conclusion of law in disputed issue (F) the Arbitrator concludes Petitioner sustained no permanent disability causally related to the accident of February 24, 2012.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Alfred Motybel,
Petitioner,
vs.

16IWCC0188

NO: 12 WC 16625

Walter Jedeluk WL Construction Mark Hickman& Dan Rutherford IL St treasurer as Ex-officio of the Injury Workers' Benefit Fund,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of accident and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 28, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

DATED: MAR 16 2016
KWL/vf
O-3/7/16
42

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

8010301

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0188

MOTYBEL, ALFRED
Employee/Petitioner

Case# 12WC016625

WALTER JEDELUK WL CONSTRUCTION MARK HICKMAN & DAN RUTHERFORD ILLINOIS STATE TREASURER AS EX-OFFICIO OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 5/28/2015, 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 0.08% 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.

0293 KATZ FRIEDMAN EAGLE ET AL
DAVID BARISH
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

2291 BELLAS & WACHOWSKI
PETER C WACHOWSKI
15 N NORTHWEST HWY
PARK RIDGE, IL 60068

0000 MARK HICKMAN HOMES
417 W 2ND ST
HINSDALE, IL 60521

5204 ASSISTANT ATTORNEY GENERAL
CHRISTOPHER FLETCHER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF **COOK**)

☒ 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

16IWCC0188

Alfred Motybel
Employee/Petitioner

Case # **12** WC **16625**

v.

Consolidated cases: **N/A**

Walter Jedeluk, WL Construction, Mark Hickman, & Dan Rutherford, Illinois State Treasurer, as *ex-officio* custodian of the Injured Workers' Benefit Fund
Employer/Respondent

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 **Brian Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **November 3, 2014**. 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

16IWCC0188

FINDINGS

On **November 2, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

ORDER

The Arbitrator finds that on November 2, 2011, due his intoxication, Petitioner was not acting within the course and scope of his employment.

Compensation is hereby denied. All other issues are moot.

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.

Signature of Arbitrator

May 27, 2015
Date

MAY 28 2015

STATE OF ILLINOIS)
)
COUNTY OF Cook)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

16IWCC0188

Case # 12 WC 16625

Alfred Motybel,
Employee/Petitioner

v.

Chicago, IL

Walter Jedeluk, WL Construction, Mark Hickman,
& Dan Rutherford, Illinois State Treasurer,
as *ex-officio* custodian of the Injured Workers' Benefit Fund,
Employers/Respondents

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

I. FINDINGS OF FACT

This action was pursued under the Illinois Workers' Compensation Act ("the Act") by Petitioner and sought relief from Respondent-Employer Walter Jedeluk, WL Construction, Mark Hickman, and the Illinois State Treasurer, as *ex-officio* custodian of the Injured Workers' Benefit Fund, regarding Petitioner's alleged work-related injury on November 2, 2011. Respondent-Employer Jedeluk and Respondent Mark Hickman and the State Treasurer participated in the proceedings. On November 3, 2014, a hearing was held before Arbitrator Brian Cronin in Chicago, Illinois. The Illinois Attorney General filed an appearance on behalf of the State Treasurer, as *ex-officio* custodian of the Injured Workers' Benefit Fund. Petitioner's Exhibits 1 through 5 were admitted into evidence and Respondent Jedeluk's Exhibit 1 was admitted into evidence. All issues are in dispute in this case.

Petitioner testified, through a qualified interpreter, that he lives in Chicago, Illinois, and was born on February 10, 1952. Petitioner worked for Respondent-Jedeluk for around three years. When he worked for Respondent-Jedeluk, he did not work for anyone else. Petitioner

testified that his son also worked for Respondent-Jedeluk. Respondent-Jedeluk was in the business of building new homes and doing carpentry work.

Petitioner was paid $10.00 an hour, worked 40 or 50 hours per week, and was paid by check. Petitioner's total hours of work per week was dependent on the weather and on the type of work needed. Respondent Walter Jedeluk made the decisions on how the work would be done. On a typical workday, Mr. Jedeluk would be present unless he was traveling to Poland. Mr. Jedeluk would sometimes help on the job.

Petitioner used his own tools on his tool belt, which included a hammer, a square, and tape. Mr. Jedeluk provided a generator, a table saw, a handsaw, a plane, and ladders. Mr. Jedeluk provided all power tools. Petitioner did not supervise anyone. He did not hire or fire anyone and he did not talk to customers. Customers talked to Mr. Jedeluk.

On November 2, 2011, Petitioner worked on a house at 211 Washington in Hinsdale, Illinois. Petitioner testified that he did not have any problems with his left thumb or left index finger before that date. Mark Hickman was the general contractor on the job and Mr. Jedeluk was a sub-contractor on the job. Petitioner made an in-Court identification of Respondent-Mark Hickman. Petitioner has worked on other projects in which Respondent Mark Hickman has been involved before. Petitioner did not communicate with Respondent Hickman at the job site other than to say "hello".

On November 2, 2011, Petitioner was remodeling a basement. At 8:00 a.m., he started cutting board. The injury to his left hand happened quickly. He attempted to cut out a piece from a 2 x 4 board with an electric saw. He applied pressure to the saw as he tried to cut the piece of wood. However, the saw "backed up" and he cut off part of his left thumb and injured his left index finger. After he was cut, he grabbed his left hand, ran to the car and found

something to wrap around his hand. Mr. Jedeluk was present when the injury occurred. One of the workers drove Petitioner to the hospital. Petitioner testified that it took them an hour to get to Rush University Medical Center ("Rush"). They had intended to seek treatment at nearby Stroger Cook County Hospital. Petitioner testified that Mr. Jedeluk made the decision as to who would take him to the hospital.

Petitioner was treated at Rush. An ethanol blood test was ordered at 1006 hours on November 2, 2011. Petitioner's ethanol level was found to be 84 mg/dL, which is equal to 0.084 g/dL. Petitioner was flagged for alcohol abuse ("AA"). Dr. Jeff was notified. (PX 3)

Petitioner underwent surgery at Rush. Dr. Cohen performed a left thumb replantation with retained implant and left index finger debridement. Hardware was installed. Petitioner testified that his hand was in a cast after the surgery. Petitioner underwent a second surgery on January 3, 2012, at which time the hardware was removed. (PX 3) Petitioner used a sling to prevent his hand from moving around when he was healing.

Petitioner had physical therapy after his second surgery. At the end of 2012 and the January, February, and March of 2013 he was not working and was only at home. His hand felt cold or cool. He did not really leave the house during the winter of 2012. At the time of the injury, Petitioner was married with a daughter in Poland and two sons in the U.S. Petitioner's youngest child was born in May 1988.

On June 14, 2012, Petitioner's physician proposed more rehabilitation. Yet, Petitioner did not receive any medical care after June 14, 2012, as he could not pay for it. At that time his medical providers were not prohibiting him from returning to work. No one paid him for his time off work and no one paid his medical bills. When he was off work, his son helped him out

financially. Petitioner is right-handed. Petitioner is currently working as an electrician, which is his trade.

With regard to his current symptoms, Petitioner testified that he notices that his left hand is not what it used to be. He experiences "no feeling" and it is "stiff". Petitioner showed the Arbitrator his hand and testified that he experiences no feeling on the distal part of his thumb on the palmar side. At night, he has a sharp feeling near the base of his thumb. Petitioner testified as to a lack of strength in his left hand. Petitioner testified that sometimes he is afraid of taking something in this hand because he is afraid he might drop it. Petitioner has not had any new injuries to his left hand after the accident. His medical bills, which have not been paid, are contained in Petitioner's Exhibit 5.

On cross-examination, Petitioner was challenged repeatedly about his alcohol use on the morning of November 2, 2011. Petitioner testified on cross-examination that he had no alcohol before the accident. Petitioner also testified that he did not know if he would know the difference between alcohol and tea that morning. Petitioner denied in Court that he drank on the morning of the injury. Petitioner testified that he does drink sometimes, but denied that he drinks in the morning.

Petitioner testified that Rush provided him with a Polish interpreter so that he could communicate. On cross-examination, Petitioner denied that he told the hospital he had liquor and he specifically denied telling the hospital he had a history of using alcohol. Petitioner did not recall if he had told the hospital he had a significant history of smoking. Petitioner testified that he told the hospital he was right-hand dominant and that he answered that question through the interpreter.

On further cross-examination, Petitioner testified that he did tell the hospital staff that he had a significant history of alcohol use. Petitioner testified that he had bad weeks and good weeks with regard to the number of hours he worked. Sometimes he would work shorter hours and other times he would work longer hours.

Petitioner could not recall if there were weeks in which he worked as few as 30 hours. Petitioner testified that the accident happened between 8:00 a.m. and 9:00 a.m.

Petitioner testified that he is a trained electrician. Petitioner testified that he helped Mr. Ruduta with some electrical work at his home near Bloomingdale, Illinois. Petitioner could not recall if he was doing electrical work for Mr. Ruduta in May 2012. With regard to this electrical work, Petitioner testified that he would show Mr. Ruduta what to do and he did it himself.

Petitioner testified that he could not recall telling Dr. Cohen that he picked up additional electrical work. A medical note of February 27, 2012 states:

> Through interpreter, reports previously performed electrical construction work. Picked up carpentry work to supplement decrease in available electrical work. Feels stiff in thumb either shortly after working HEP or upon waking. Lack of normal sensation and hypersensitivity continue to be issues. Spoke with boss this weekend regarding work status.

Petitioner testified that he did not doubt what the doctor wrote down. Petitioner denied going back to work in February 2012 and claimed that he did not return to work for that whole year. Petitioner testified that in March 2012, he sustained a detached retina and that this occurred during the time he was participating in physical therapy.

On re-direct examination, Petitioner testified that he did not have any alcohol to drink from the time he got hurt until the time he arrived at the hospital. Michael, a co-worker, did not go into the hospital with him. Petitioner denied that he told the hospital staff he had alcohol in the morning. Petitioner again testified that he had no alcohol to drink before the accident.

Petitioner testified that he had no difficulty performing his duties from the time he started work that morning and the time when he sustained the injury.

In Respondent-IWBF's case-in-chief, Respondent-Mark Hickman was called as an adverse witness. Respondent-Hickman testified that he believed WL Construction Company is Walter Jedeluk's incorporated business. He testified that he used Mr. Jedeluk once or twice since 1998. Respondent-Hickman testified that Mark Hickman Homes is an Illinois corporation. Respondent-Hickman testified that he had a signed contract with WL Construction Company.

Walter Jedeluk was called as a witness in his case-in-chief. Mr. Jedeluk testified he owns WL Construction Company, which is an Illinois corporation, and that the WL stands for Walter and Lucy. Respondent-Jedeluk was president of the company and the company had a registered address on West Monticello in Chicago, Illinois.

Mr. Jedeluk testified that at that time, he was working at that Hinsdale construction site and Mr. Motybel was working for WL. Mr. Jedeluk testified that he treated Mr. Motybel as a subcontractor and did not take out money for taxes. Mr. Jedeluk testified that he paid Mr. Motybel $10.00 an hour and would cut him checks from WL Construction Company. Mr. Jedeluk testified that Mr. Motybel's hours varied. Respondent-Jedeluk's Exhibit 1 shows the checks that were written to Mr. Motybel. Respondent-Jedeluk testified that he believed Mr. Motybel's average weekly wage was $352.00 and used Respondent-Jedeluk's Exhibit 1 as the basis for computing such figure.

Respondent Jedeluk also testified that he saw Petitioner working after November 2, 2011 in Glendale Heights, at Stone Gate 36, which was a private home. This was the home of Andje Ruduta. Respondent-Jedeluk testified that he was in the same neighborhood in Glendale Heights on May 24th or 25th of 2012. Respondent-Jedeluk testified that he was there for one day and he

saw Mr. Motybel at that time doing electrical work at that Stone Gate Drive home. Mr. Jedeluk was there because his employees were putting up drywall at the home.

On cross-examination Mr. Jedeluk testified that anyone who was doing business with WL should talk to him, and that he hired and fired people. Mr. Jedeluk testified that he hired Petitioner, who worked for him for approximately three years. Mr. Motybel has not worked with Mr. Jedeluk since the injury at bar. Mr. Jedeluk testified that he paid Mr. Motybel as a subcontractor. Mr. Jedeluk testified that he stopped paying for the workers' compensation policy since he already had a problem with the IRS, which is where his financial problems began. Mr. Jedeluk testified that the problems he has with the IRS concern both himself and his company, WL Construction.

After trial testimony concluded, Petitioner made an oral Motion to Amend the Application for Adjustment of Claim to add WL Construction Company as a party, which was granted over Respondent-Jedeluk's objection.

II. CONCLUSIONS OF LAW

With regard to (C) "Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?", the Arbitrator finds the following:

Section 11 of the Act, as amended, states, in pertinent part, the following:

Intoxication

If at the time of the accidental injuries, there was 0.08% or more by weight of alcohol in the employee's blood, breath or urine *** then there shall be a rebut-table presumption that the employee was intoxicated and that the intoxication was the proximate cause of the employee's injury ***

The changes to this Section made by Public Act 97-18 apply only to accidental injuries that occur on or after September 1, 2011.

Petitioner testified that on November 2, 2011, he started cutting board at 8:00 a.m. and that the injury happened quickly. He later testified that the injury occurred sometime between 8:00 a.m. and 9:00 a.m. He testified that he arrived at Rush at approximately 9:00 a.m.

At 10:06 a.m. at Rush, Teresa E. Davis, MD, ordered an ethanol blood test. Petitioner's ethanol level was found to be at 84 mg/dL, which is equal to 0.084 g/dL. Petitioner was flagged for alcohol abuse ("AA"). Dr. Jeff was notified.

On cross-examination, Petitioner denied that he consumed any alcohol on the morning of the accident. Petitioner testified that he would not have been able to tell the difference between the taste of alcohol and the taste of tea on the morning of the accident.

The Arbitrator finds this statement incredible considering Petitioner has a long history of alcohol use as documented in Petitioner's medical records, and Petitioner eventually testified that he told the hospital staff he had a history of significant alcohol use.

Petitioner was asked many things on many subjects by the hospital staff through a Polish interpreter. None of the other questions asked by the hospital staff, such as "Which hand is your dominant hand?", confused Petitioner.

The Arbitrator cannot reasonably believe the hospital staff got it wrong when they noted Petitioner's history of alcohol use. This Arbitrator also cannot reasonably believe the hospital staff simply made up the fact that Petitioner told them he had been drinking in the morning. In fact, the hospital staff was specific, and not generic, in noting that it was hard liquor Petitioner had been drinking. (PX 3, PX 7) The records indicate that Petitioner told the hospital staff that

he had the shot of hard liquor at the time of the accident. At trial, Petitioner was adamant that he did not have any alcohol on the morning of the accident. That Petitioner flatly denied any of this conversation with the hospital staff is in direct contradiction with the medical records and further disparages Petitioner's testimony at trial.

In Petitioner's own re-direct examination, Petitioner testified that he did not have any alcohol from the time he got hurt to the time he got to the hospital, which is inconsistent with his statement to the hospital staff that he had a shot of hard liquor at the time of the accident.

Most important to assessing Petitioner's credibility, Petitioner flatly denied he told the hospital staff that he had a significant history of alcohol use and then, upon further cross-examination, admitted that he had, in fact, told them that.

The Arbitrator concludes that Petitioner is simply not credible. Moreover, his blood alcohol level, which was taken approximately 2 hours after his left hand injury, was found to exceed 0.08%.

Therefore, the Arbitrator denies accident and finds that intoxication was the proximate cause of Petitioner's injury.

Brian T. Cronin

5-27-15

Brian Cronin
Arbitrator

Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sherry Janus,
Petitioner,

vs. NO: 13 WC 26602

City of Chicago, Office of the City Clerk,
Respondent.

16IWCC0196

DECISION AND OPINION ON REVIEW

Petitioner appeals the decision of Arbitrator Fruth finding Petitioner failed to prove she sustained an accidental injury arising out of and in the course of her employment on February 8, 2013. The issues on Review are whether Petitioner proved she sustained an accidental injury arising out of her employment on February 8, 2013, whether Petitioner provided Respondent with proper notice of the alleged February 8, 2013 accident, whether there is a causal relationship between the alleged February 8, 2013 accident and Petitioner's present condition of ill-being, and if so, whether Petitioner is entitled to prospective medical treatment under Section 8(a) of the Illinois Workers' Compensation Act. The Commission, after reviewing the entire record, reverses the Arbitrator and finds Petitioner proved she sustained an accidental injury arising out of her employment on February 8, 2013. Petitioner provided proper notice of the February 8, 2013 accident to the Respondent and Respondent is ordered to pay reasonable and necessary medical expenses related to the recommended right carpal tunnel surgery, for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner testified that prior to 1996 she worked as a part-time cashier for 1 to 1-1/2 years at Venture. The cash registers had buttons she had to push as opposed to being computerized cash registers. After that, she worked as a customer service representative for a drug company. Her duties included being on the telephone a lot. She was outfitted

with a headset and there was very little computer use. She was responsible for checking on orders that were shipped and for billing problems. She started working for the City in 1996.

2. From 1996 to 1999 Petitioner testified she worked for the City as a legislative assistant. Her job consisted of taking minutes for a section of the city council meetings. The typist typed the minutes up. Copies were then made and she and her co-workers had to proof read the minutes.

3. Petitioner testified that she has worked as a payment service representative (PSR) for Respondent for the last 16 years. She is right-handed and she predominantly uses her right hand to perform her job. Her job duties consist of selling city stickers, residential zone parking passes and visitor passes. For the first nine years, they did not have to print the city stickers. The stickers came in a pile that looked like playing cards. They put little labels on them. There were handwritten receipts. The customer would write out if they got the renewal forms and they would put a little sticker on the renewal form that matched the number of the city sticker. There was no printing, ripping or typing. Either the clerk or customer hand wrote the paperwork or the customer had his or her renewal form. The time period in which to obtain the city stickers spanned from June to July until two years ago and then they changed to issuing them monthly. Prior to the change the busy time was in June and July. They tried to get everyone a city sticker in that eight week period. They were also doing other things such as passports, which they do not do anymore.

4. Petitioner identified Respondent's RX2 as being a job description for a PSR. She said it was prepared in 1998. Petitioner opined that it does not accurately reflect what she does now in that it does not address the computer, printer or scanner. She reports that there was not any typing at that time and there was not much writing either. All of her work was directly in front of her on the counter. She used her hands less back then. The system was more manual and she spent more time with the customer back then. Petitioner testified that Respondent has had computers for the last 8 years in their office. She further testified that the way in which they performed their jobs changed about five years ago when the office switched from more manual work to more computer work. In order to perform her job over the last five years, she has had to use a computer with a keyboard, a printer, a 10 ounce hand held scanner, a credit card machine and a receipt printer. She works 7 hours a day, 5 days a week. She has two 20 minute breaks and an hour for lunch. She has to lift/carry 2 cases weighing 10-15 pounds every other week of stickers/ residential zone parking passes. She has to take sticker packages weighing 1-1/2 to 2 pounds out of the boxes and put them in the cabinet so that they can later be loaded into the printer. She has to reach up to get the stickers out of the printer, to get the scanner and to get the stapler. She performs lots of typing. She has to type in the customer's information-name, address, make/model/vin number of car, date of purchase, month the plate expires, and, if they want that put into the system, the zone. When a customer first

comes in she verifies what type of transaction they need. She types the information in and uses her mouse to move from field to field. She asks the customer if they want a one year or two year sticker. If they want a visitor pass, she has to open up a new program and re-enter their name, address, etc. Once the pass is established she has to ask them if they want one or two books and then give them the price. She clicks again on the payment site and then on the other side to print. She takes their payment by placing the money in the drawer or swiping their credit card and having them sign the receipt. She gives them a receipt, reaches up to get the City sticker, flips it over, picks up the scanner with her right hand, scans the top, folds them and gives them to the customer.

5. Her work station is set up with the counter and her keyboard in front of her. On her right side are the monitor, the mouse, the printer and the phone, which has to be answered. On her left side are the stapler and the register receipt.

6. Petitioner testified that she is one of the top three sellers of city stickers. While there is no counter that tracks how many customers come in, her estimate of her output is based on the number of sales she has a day. She would estimate that she services between 100-200 people a day. The first of the month, the 15th of the month and the end of the month are the busiest times. The requests range from city stickers, to visitors passes to dog tags. On a slow day she services 50 people a day. She would estimate she spends between 1-5 minutes with each customer. She would estimate that she spends 50-55% of her day typing, 10-15% of her time talking to the customers and 5-10% of the time processing the order. In between typing, she is handling the scanner, the phone and the printer. The remainder of the time is spent printing and explaining things to the customers. She is not using her hands when she does not have any customers. She performs approximately the same procedure for every customer. She spends her time moving, talking and typing.

7. During her leisure time, she uses a Kindle online. Her son has a laptop that she uses once in a blue moon. She has a smart phone that is connected to the Internet and it allows her to text, access Facebook and pay her bills online. She estimates that she goes online with her phone once or twice a day for 30-35 minutes at a time. She smokes. She has been using Chantix for the last 2 weeks and she is now down to 5 cigarettes a day. She has high blood pressure and takes medication for this condition.

8. Petitioner testified she had symptoms in her right hand/carpal tunnel syndrome in October of 1999. The symptoms went away after she gave birth to her son. On October 28, 1999, Petitioner saw Dr. Shaw who noted that Petitioner was complaining of right wrist pain getting worse. She also reported that she did not have any injury. Dr. Shaw noted that Petitioner maybe has carpal tunnel syndrome. Petitioner reported she had no medical treatment for her right wrist between 1999 and 2011.Petitioner testified that in 2011 she started experiencing symptoms in her hand again. She asked her doctor about the tingling; he said it is probably carpal tunnel syndrome and he recommended she start using a brace, which she did for a little while. Petitioner also said she has been wearing

an elastic brace on her right wrist consistently since 2011. It just kept getting worse instead of better. When she saw Dr. Shaw, her primary care physician, between 2001 and 2013 it was for regular physical exams. With the exception of the brace, he did not prescribe anything for her wrist. Her doctor did not recommend any medical treatment until 2013.

9. Petitioner testified that on February 8, 2013 they were short-handed and she was extremely busy. She would estimate she waited on 200-300 people that day. Normally there are 5 people and a supervisor. Usually, there are three sellers working on average. That day there were only two people working. She reported her problem to Lisa Marie, her supervisor, and she then completed a form with her. She had a copy of the accident report that was given to her by Ms. Miller a couple of days later.

10. On March 9, 2013, Petitioner was evaluated by Dr. Stewart for right wrist numbness and pain. Dr. Stewart noted that Petitioner reported approximately two years ago she started developing pins and needles at night while in bed. She reported that the numbness affects the entire right hand and it came on gradually. She reports she saw her personal doctor two years ago, who diagnosed her with right carpal tunnel syndrome and he placed her in a cock-up wrist splint. She was told to initially wear the splint at night but she states it was very uncomfortable and kept waking her so she decided to just wear it while at work. She reports she has been intermittently wearing the splint at work over the past two years and on a regular basis during the busy season. She reports over the past few weeks her right wrist numbness and tingling has worsened. She notices worsening with counting money and doing any repetitive activity at work. While she reports they are in the slow season at work, they are also understaffed, which means she has to move very fast and this has worsened the symptoms. She reports she went back to her personal doctor a few weeks ago and he recommended surgery due to the fact that she is still having symptoms after two years. She was told by her doctor that physical therapy would not help her. She has tried Ibuprofen intermittently over the past two years and had taken it on a more regular basis recently without any improvement. She reported that the only thing that seems to improve her symptoms is rest. She reports she has problems picking up a gallon of milk. She had a past history of hypothyroidism, which has been linked to carpal tunnel syndrome. She is 5'2 and 298 pounds. On physical examination, he noted that Petitioner has mild tenderness over the extensor pollicis longus and abductor pollicis brevis tendons of the right wrist only. The Tinel's sign elicits a right third finger paresthesias but carpal compression test is negative bilaterally. The Finkelstein maneuver elicits mild pain and Phalen's test for median nerve compression is mildly positive for numbness over the first, second and third fingers on the right side only. Dr. Stewart diagnosed Petitioner has having paresthesias of right hand and possible carpal tunnel syndrome. He released Petitioner to regular work without any restrictions, told her to continue wearing the splint, use the medication, ice her wrist and participate in occupational therapy. He told her he would recheck her condition on March 14, 2013.

11. On April 4, 2013 Petitioner followed up with Dr. Stewart. At that time she reported that she continues to experience right wrist pain over base of her thumb that extends to the tip of her thumb. His diagnosis stayed the same. He did note that she has right wrist pain due to an unknown etiology and he ordered a right wrist MRI.

12. The April 8, 2013 right wrist MRI showed a thinning of the triangular fibrocartilage at the ulnar/lunate articulation with no evidence of triangular fibrocartilage tear or rupture, mild bowing of the flexor retinaculum in a volar direction. The radiologist stated that the median nerve appears enlarged with increased signal, which are findings that may be seen with carpal tunnel syndrome. However, there are neither sensitive nor specifics for this diagnosis. As such, clinical correlation is required.

13. During the April 9, 2013 follow up with Dr. Stewart he noted that the MRI showed a thickening of median nerve and the carpal tunnel. His diagnosis was status quo and he ordered an EMG.

14. On April 26, 2013 an Injury Report was made in which the incident date was noted to be February 8, 2013. Petitioner says she had carpal tunnel syndrome. Her main job duty consists of entering vehicle sticker information into the city's cashiering system. Petitioner's supervisor, Lisa Marie Miller, first notified us of the claim on February 8, 2013.

15. On June 6, 2013, Petitioner saw Dr. Shaw for a flare up of her right carpal tunnel syndrome. He noted that he has been following her care for a year or two and has been managing it conservatively. She has reported this problem at work now and she reports she is on the computer all day long. She also reported that she is being evaluated by doctor at work and that an EMG is planned. Dr. Shaw examined the Petitioner and noted that she has a positive Tinel and Phelan tests on the right. He diagnosed her with carpal tunnel syndrome and hypertension. He advised her to remember to use her splint at night.

16. On June 7, 2013, Petitioner was evaluated by Dr. Cohen. The doctor noted that Petitioner is a 45 year old right-handed female who works as a PSR for the City of Chicago. She has been working in this capacity for approximately 15 years. In preparation for this evaluation, he reviewed her prior medical records and job description. The first medical record is from March 9, 2013 and it indicates that Petitioner has had right wrist pain and numbness for approximately two years. She had been diagnosed by her primary care physician with right carpal tunnel syndrome. She was diagnosed with hand paresthesias and possible carpal tunnel syndrome and conservative measures were initiated. She denies any specific injury. She reports she developed a slow and progressive tinging and numbness in her digits with nocturnal awakening. This began approximately two years ago. Initially, her symptoms were improved with a brace. However, today she reports her symptoms are worse with the right wrist being much worse than the left wrist. She reports she experiences on and off tingling and numbness with pain and she states the

pain is worse with use. Dr. Cohen stated that he did spend some time in the office today with Petitioner in which they discussed her work activities. She informed him she performs data entry. In addition to typing, she regularly counts money. She reaches for stickers, scans the stickers and hands these off to the customer. Dr. Cohen stated that he reviewed her job description as well. He noted that Petitioner's medical history is significant for hypothyroidism. He examined the Petitioner and noted that she is 300 pounds and is 5'2" tall, which places her in the super obese category. Her right wrist exam was quite benign. She had no pain to palpation. He noted her right wrist showed no warmth, swelling, crepitation or instability. Of note, she had some soreness during a median nerve compression test on the right side. However, she denied any tingling or numbness during this provocative maneuver. Her Phalen's test led to some volar right wrist discomfort. It did not reproduce any tingling or numbness in her hands. In summary, Dr. Cohen noted that Petitioner appears to have signs and symptoms consistent, most likely, with right greater than left carpal tunnel syndrome. He noted that carpal tunnel syndrome is a chronic, compressive neuropathy of the median nerve at the wrist and palm. In the vast majority of cases, it is idiopathic in nature. This condition can be seen with certain medical conditions including obesity and hypothyroidism. He believes carpal tunnel syndrome is associated with tobacco use as well. Currently it is clear, using evidence based medicine that, carpal tunnel syndrome is not caused by or specifically associated with the simple repetitive use of one's hands and this includes data entry activities as well. Thus, Dr. Cohen opined that he does not believe that that the evidence supports an association and/or causal relationship between Petitioner's carpal tunnel syndrome and her job activities.

17. On September 18, 2013 Petitioner saw Dr. Iftikhar. The doctor noted that Petitioner is 5'2" tall and 285 pounds, smokes one pack of cigarettes a day and has a two year history of carpal tunnel syndrome. She sells city stickers for City of Chicago and has been typing for 17 years. In addition to typing, she has to scan stickers use her wrists on both sides and has to constantly rotate, flex and extend her wrist performing these activities. The Petitioner reports she is experiencing numbness and tingling in right and left wrists, with her right wrist being more symptomatic. She related symptoms to her work activities and said they have been progressively getting worse. She said she has tried conservative treatment but did not get any better. She has a medical history of hypothyroidism which she has had for approximately four years. She reports smoking a pack of cigarettes a day. On physical examination she has very early thenar atrophy on the right side. There is diminished sensation on the volar aspect of the right thumb as well as the middle and index fingers. Her sensations are impaired to pin prick and superficial palpation. On carpal compression her Tinel sign and Phalen's test are positive. The left hand shows similar findings, but they are less intense. She also seems to have some volar synovitis of both wrists. Dr. Iftikhar diagnosed Petitioner with bilateral carpal tunnel syndrome, which he classified as moderately severe on a clinical basis on the right side. He also diagnosed volar synovitis of the wrist. He ordered an EMG/NCV. He noted that according to the description the patient gave of scanning, he would opined that this

activity requires constant flexion and extension of the wrist on a regular basis and this activity may be a precipitating factor in her condition.

18. Petitioner underwent a EMG on September 25, 2013. The doctor noted that the patient for the past 2-1/2 years has been having intermittent problems with numbness and tingling in the fingers of her right hand. This originally was especially at nighttime, and it was awakening her. She tried wearing a brace for carpal tunnel syndrome and states there was definite improvement at least at first. Recently, she does not feel that she is getting benefit from the brace. She is having somewhat different symptoms. She states over the last few months she has been having significant sharp pain in the wrist at the base of the thumb upon using her hand. There is also significant swelling over the radial aspect of the wrist at the base of the thumb and thenar region frequently. She is right-handed. She is also treating for hypothyroidism and recently was placed on a pill for slightly high blood pressure. The doctor noted that Petitioner's work involves repetitive reaching and grabbing and bending activities with her hand. On physical examination, she is prominently obese. He opined that it is certainly likely that the patient's recurrent tingling and numbness and nocturnal paresthesias are related to the very mild median neuropathy. It is far more likely that the sharp pain in the wrist and base of the thumb and swelling and are musculoskeletal based.

19. On October 23, 2013 Petitioner followed up with Dr. Iftikhar who noted that the EMG demonstrated mild carpal tunnel syndrome of the right side and that the left side was unremarkable. He noted that Petitioner does not seem to be getting better with conservative treatment. He gave her a local steroid injection, advised her to use non-steroidal anti-inflammatory medication and wrist brace and to recheck in four weeks.

20. On January 20, 2014, Dr. Iftikhar noted that Petitioner has responded well to injection for about two months. However, now her symptoms are getting worse. This is especially the case for her right hand.

21. On May 9, 2014 Dr. Iftikhar noted that Petitioner's reports her symptoms have been returning. She is waking up at night constantly despite use of wrist braces. He noted that since surgery has been cleared, an injection can be given. He further noted that if the symptoms re-occur after the injection then he thinks Petitioner is a surgical candidate for right carpal tunnel release surgery.

22. Petitioner testified that currently she does not experience any more pins or needles. Now, it is straight, right-sided pain. She gets a lot of swelling in her thumb and lower hand area. Every once in a while the pain shoots up to her shoulder or neck area. She is using Ibuprofen and a heating pad for the pain.

Based on Petitioner's testimony, Petitioner's accident report and Petitioner's treating records, the Commission finds that Petitioner established that over the last five years her job required constant and repetitive motion of her right dominant hand. The Petitioner further established the date the condition manifested itself can be attached to the alleged February 8, 2013 work date. Additionally, the evidence demonstrates Petitioner provided proper notice of the manifestation date to the Respondent. Moreover, the Commission finds that the chain of events supports a finding of a causal relationship between the February 8, 2013 manifestation date and Petitioner's present condition of ill-being and/or need for reasonable and necessary medical treatment including the proposed right carpal tunnel release surgery. More specifically, the Commission notes that the Illinois Supreme and Appellate Courts have held that:

> "By their very nature, repetitive-trauma injuries may take years to develop to the point of severity precluding the employee from performing in the workplace. An employee who discovers the onset of symptoms and their relationship to the employment, but continues to work faithfully for a number of years without significant medical complications or lost working time, may well be prejudiced if the actual breakdown of the physical structure occurs beyond the period of limitation set by statute. Similarly, an employee is also clearly prejudiced in the giving of notice to the employer if he is required to inform the employer within 45 days of a definite diagnosis of the repetitive-traumatic condition and its connection to his job since it cannot be presumed the initial condition will necessarily degenerate to a point at which it impairs the employee's ability to perform the duties to which he is assigned. Requiring notice of only a potential disability is a useless act since it is not until the employee actually becomes disabled that the employer is adversely affected in the absence of notice of the accident." Oscar Mayer v. Industrial Commission, 176 Ill. App. 3d at 611. See also Durand v. Industrial Commission, 224 Ill. 2d 63 (2006).

The Commission finds Petitioner established that her job in the last five years required constant and repetitive motion and use of her right hand. She further established that the February 8, 2013 was the date Petitioner experienced a break down on her physical condition that warranted the need for the current medical treatment which consists among other things of the need for invasive surgery. The Commission finds Petitioner should not be penalized for continuing to work until her condition actually physical broke down and she sought treatment. With the exception of the wrist splints, Petitioner was not provided with any medical treatment for her hands in 2011. It was not until February 8, 2013 that Petitioner was aware of her condition and the need for her current medical treatment arose. Thus, the Commission finds that the manifestation date was February 8, 2013 and not in 2011. As noted above, the case law demonstrates that the manifestation date can be years after Petitioner first begins experiencing symptoms. The Commission finds Petitioner should not be penalized for continuing to work after her condition of ill-being is noted.

Based on Petitioner's testimony and Dr. Iftikhar's understanding of Petitioner's job duties, it appears that there was sufficient extension and flexion of Petitioner's right wrist continuously throughout the work day to warrant a finding of repetitive trauma to the same. While Petitioner did perform a variety of tasks, all of the tasks still required the use of Petitioner's right hand/wrist. Furthermore, while Petitioner has other health conditions that could be easily attributable to the condition, Petitioner's work duties need only be "a" cause of her condition of ill-being. As such, the Commission finds that Petitioner provided sufficient evidence via her testimony, the medical records of Dr. Shaw and the causation opinion of Dr. Iftikhar to find that Petitioner prove a causal relationship exists between her current condition and her work duties on February 8, 2013. As such the Commission finds that Respondent should pay for all of reasonable and necessary medical expenses related to the proposed right carpal tunnel surgery. Lastly, the Commission finds through the accident report that Petitioner provided Respondent with proper notice of said accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that the decision of the Arbitrator filed August 10, 2015 is hereby reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay all of reasonable and necessary medical expenses related to the proposed right carpal tunnel surgery.

IT IS FURTHER ORDERED BY THE COMMISSION that this case is remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: MAR 16 2016

MB/jm

O: 2/25/16

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Mario Basurto

David L. Gore

Stephen Mathis

STATE OF ILLINOIS)
) SS.
COUNTY OF ROCK ISLAND)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kelly Penn,

Petitioner,

vs.

NO: 13 WC 30310
14 WC 20975

Fresenius Medical Care,

Respondent.

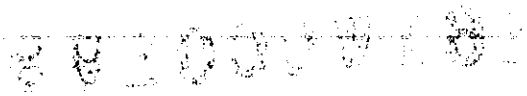
16IWCC0198

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of the causal connection, medical expenses, prospective medical care, and temporary total disability benefits and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

There is no question that Petitioner suffered aggravations of her preexisting degenerative disc disease on January 11, 2013 and January 16, 2013; however, it is clear to the Commission that by October 4, 2013, Petitioner had reached maximum medical improvement and was back to baseline, which included prescriptions of physical therapy and injections for her ongoing, chronic left low back pain. The Commission notes that Petitioner suffered another aggravation on July 15, 2014 at home that rendered her unable to move and required that she be taken to the hospital by ambulance. That same day, Petitioner underwent a new MRI that showed, as compared to the June 28, 2011 MRI, "no significant change since." (PX13) The January 11, 2013 & January 16, 2013 accidents were temporary aggravations of Petitioner's preexisting left low back condition, the same as the July 15, 2014 incident. As such, the Arbitrator's findings and award of medical expenses only through October 4, 2013 is affirmed.

Regarding Petitioner's claim for temporary total disability benefits, the Commission notes that Petitioner was still under light duty restrictions when she voluntarily left her employ. On October 4, 2013, Dr. Jhee noted that Dr. Woods had taken Petitioner off work, yet the evidence shows that Petitioner was not taken off work, but had left her employ. Therefore,



16IWCC0198

Petitioner is not entitled to temporary total disability benefits after July 30, 2014.

Finally, while the Commission agrees with the Arbitrator's award of medical expenses through October 4, 2013, it also hereby awards the recommended treatments from Dr. Jhee, namely physical therapy and a series of epidural steroid and sacroiliac joint injections. As noted by Dr. Jhee, Petitioner had undergone physical therapy and injections in the past, which led to improvement in Petitioner's condition. (PX11) Therefore, the Commission awards prospective medical care in the form of physical therapy and injections as prescribed by Dr. Jhee, and affirms the Arbitrator's award of prospective medical care in the form of Neurontin as prescribed by Dr. Rink.

So that the record is clear, and there is no mistake as to the intentions or actions of this Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical / legal perspective. Furthermore, we have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent. Finally, one should not and cannot presume that we have failed to review any of the record made below. Though our view of the record may or may not be different than the arbitrator's, it should not be presumed that we have failed to consider any evidence taken below. Our review of this material is statutorily mandated and we assert that this has been completed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on December 22, 2014 is modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses incurred through October 4, 2013, as provided under Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for physical therapy and up to three injections as prescribed by Dr. Jhee and Neurontin as prescribed by Dr. Rink.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under Section 19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

16IWCC0198

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $9,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 17 2016
MJB/ell
o-01/25/16
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Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

PENN, KELLY
Employee/Petitioner

Case# **13WC030310**

14WC020975

FRESENIUS MEDICAL CARE
Employer/Respondent

16IWCC0198

On 12/22/2014, 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 0.11% 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:

0564 WILLIAMS & SWEE LTD
STEVEN R WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

2904 HENNESSY & ROACH PC
EMILIE A MILLER
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

☐ 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
19(b)

Kelly Penn
Employee/Petitioner

v.

Fresenius Medical Care
Employer/Respondent

Case # **13 WC 30310**

Consolidated cases: **14 WC 20975**

16IWCC0198

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 **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Rock Island**, on **November 13, 2014**. 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

16IWCC0198

On the date of accident, **1/11/2013 & 1/16/2013**, 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 of 1/11/2013.

In the year preceding the injury, Petitioner earned $**21,109.40**; the average weekly wage was $**405.95**.

On the date of accident, Petitioner was **44** years of age, ***single*** with **1** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $ for TTD, $**3,686.49** for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

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

ORDER

Petitioner's conditions of ill-being of mild left radiculopathy and subjective lumbar pain are causally related to the accident of January 11, 2013, as explained in the Conclusions of Law.

Prospective medical prescribed by Dr. Jhee is denied as it is for conditions not causally related to the Petitioner's accident and not reasonably necessary treatment for her conditions which are related to said accident. The Neurontin recommended by Dr. Rink is reasonable under Section 8 (a) and is awarded.

Respondent shall pay reasonable and necessary medical services incurred through October 4, 2013, as provided in Sections 8(a) and 8.2 of the Act.

Claimed temporary total disability benefits are denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

D. Dylan McCarthy
Signature of Arbitrator

Dec. 19, 2014
Date

STATEMENT OF FACTS

Petitioner is 43-years old and employed by Respondent at McLean County Dialysis in Bloomington, Illinois as a Patient Care Technician. Petitioner has worked for Respondent since August 27, 2012. Petitioner was working on January 11, 2013 with another employee in the bicarbonate mixing room when she sustained injuries to her low back while lifting a 40 pound bag of bicarbonate powder to pour into the mixer while standing on a stepstool. Subsequent to returning to work Petitioner again aggravated her back lifting bicarbonate powder on January 16, 2013. Notice of Petitioner's accidents was timely provided to Respondent. Petitioner's accidents have been accepted as compensable; however, Petitioner's condition of ill-being and need for medical treatment after August 21, 2013 is disputed. It is noted that Petitioner has a history of problems with her low back predating her accidents.

Medical records from OSF St. Joseph's Medical Center confirm treatment related to Petitioner's low back beginning in February, 2011, prior to her work accidents. Petitioner was initially seen by her primary care physician, Dr. Michael Woods, and referred for physical therapy. Petitioner also underwent an MRI of her lumbar spine on June 28, 2011 that revealed degenerative disc disease and spondylosis but no significant spinal stenosis. In July, 2011 Petitioner was referred by Dr. Woods for treatment with Dr. Christopher Rink at OSF Medical Group. Upon present to Dr. Rink Petitioner reported a 17 year history of chronic back pain on her left side, which had worsened recently after shoveling snow.

The last documented treatment of Petitioner related to her pre-existing back problems is from August 5, 2011. At that time, Petitioner was released by Dr. Rink following resolution of her back pain. There is no indication that the Petitioner had any treatment for her lower back from then until her accident of January 11, 2013.

Following her accident on January 11, 2013 Petitioner did not seek treatment until January 18, 2013. On that day Petitioner presented to Dr. May Yee Chow at OSF Occupational Health. Dr. Yee Chow diagnosed Petitioner with a low back strain and placed her on light duty restrictions of sedentary work only and prescribed her Vicodin. Petitioner's light duty restrictions were accommodated by Respondent.

On January 23, 2013 Petitioner returned to Dr. Yee Chow with continued reports of back pain. Dr. Yee Chow recommended an MRI of Petitioner's lumbar spine. Dr. Yee Chow also continued Petitioner's sedentary work restrictions, but limited her work day to no more than four hours. Petitioner's light duty restrictions continued to be accommodated by Respondent and TPD paid due to Petitioner's reduced hours.

Petitioner's MRI was completed on February 1, 2013 and revealed mid low-grade degenerative changes at L3-4 and L4-5. The findings of Petitioner's MRI were compared to her prior MRI on June 28, 2011. Based on the comparison Petitioner's degenerative disc disease was noted to have slightly progressed particularly at the L3-4 level where a tiny right lateral annular tear of the disc with minimal encroachment upon the right neural foramen and exiting right L3 nerve root sleeve.

On February 8, 2013 Petitioner returned to Dr. Yee Chow. After reviewing the results of Petitioner's MRI, Dr. Yee Chow again diagnosed Petitioner with a low back strain and referred her for physical therapy. Dr. Yee Chow also revised Petitioner's work restrictions. While continuing to limit Petitioner to no more than four hours work per day and sitting and standing as tolerated, Dr. Yee Chow removed Petitioner's sedentary work restrictions and instead placed her on restrictions of no repetitive bending, stooping or twisting and no lifting more than 25 pounds.

Petitioner began physical therapy at OSF Fort Jesse Rehab Services on February 13, 2013. Petitioner continued in physical therapy through March 1, 2013. The records show the therapy was discontinued because the Petitioner was not progressing.

On February 22, 2013 Petitioner returned to Dr. Yee Chow. Despite reporting to Dr. Yee Chow that physical therapy had helped at first, Petitioner reported increased pain after turning repetitively to file at work. Dr. Yee Chow again diagnosed Petitioner with a low back strain and recommended that she continue in physical therapy. Dr. Yee Chow also revised Petitioner's work restrictions again to limit her lifting to no more than 15 pounds. The remainder of Petitioner's restrictions remained in place.

Petitioner was last seen by Dr. Yee Chow on March 4, 2013. After reporting no relief with physical therapy Dr. Yee Chow referred Petitioner to Dr. Rink. Dr. Yee Chow also continued Petitioner's work restrictions as revised on February 22, 2013.

Petitioner was first seen by Dr. Rink on April 1, 2013. Petitioner reported to Dr. Rink persistent left low back and buttock pain with radiating pain into her left leg since her accident. Dr. Rink noted that Petitioner's treatment had included primarily physical therapy focusing on lumbar extension. After reviewing the results of Petitioner's MRI, Dr. Rink diagnosed her with probable sacroiliac joint involvement/dysfunction. However, he noted other possibilities could include discogenic pain with an annular tear, but noted that Petitioner's annular tear was to the right side which did not correlate with her complaints of left-sided symptoms. As Petitioner continued to work within her restrictions as provided by Dr. Yee Chow, Dr. Rink continued Petitioner's restrictions. For treatment, Dr. Rink recommended a left sacroiliac joint injection. Petitioner's injection was approved and administered on April 18, 2013.

Petitioner followed up with Dr. Rink after her injection on May 23, 2013. After reporting no improvement with the injection, Dr. Rink recommended a left L4 transforaminal epidural steroid injection as her MRI showed an annular tear of a disc. It was administered the same day.

On June 20, 2013 Petitioner returned to Dr. Rink to discuss the results of her left L4 transforaminal epidural steroid injection. Again, Petitioner reported no improvement with the injection. Based on Petitioner's response to her injections and examination, Dr. Rink diagnosed probable discogenic pain. Dr. Rink explained to Petitioner that the results of her injections ruled out sacroiliac joint-related issues, as well as facet-mediated pain. For treatment Dr. Rink recommended a course of anti-inflammatory medications and prescribed Petitioner Celebrex. Dr. Rink also recommended another trial of epidural steroid injections, this time at the L3 level bilaterally as Petitioner's MRI demonstrated an annular tear on the right. Dr. Rink also placed Petitioner off work beginning June 21, 2013 but again released her to return to work with the restrictions as previously provided on June 24, 2013.

Petitioner's bilateral L3 transforaminal epidural steroid injections were approved and administered on July 18, 2013. Following her injections, Dr. Rink took Petitioner off work again on July 19, 2013 and July 20, 2013, but released her again to return to work with restrictions effective July 22, 2013.

Petitioner was next seen by Dr. Woods on August 6, 2013 related to her anxiety disorder. Despite having apparently been placed on BuSpar, Petitioner reported to Dr. Woods that she continued to have a lot of anxiety. Petitioner also reported that she continued to have a lot of back pain and was seeking a second opinion with Dr. Nardone. Petitioner also reported a terrible fear of flying due to terrorist threats and requested advice on how to get through a flight that she was planning to take to Las Vegas in September. Dr. Woods diagnosed Petitioner with anxiety disorder, fear of flying and back pain. Dr. Woods raised Petitioner's BuSpar and instructed her to continue with use of Clonazepam.

Petitioner was seen by Dr. Nardone related to a second opinion on August 20, 2013. Petitioner reported to Dr. Nardone continued low back and radiating left leg pain since her accident on January 11, 2013. Dr. Nardone noted that Petitioner had undergone both a sacroiliac joint injection, as well as epidural steroid injections with no relief. Upon reviewing the results of Petitioner's MRI from February 1, 2013, Dr. Nardone noted some bulging discs at L3-4 and L4-5, but no nerve entrapment. Dr. Nardone also noted that x-rays ordered by him showed no gross abnormality and a normal looking appearance of the sacroiliac joint. Dr. Nardone noted that despite not having much imaging to match her pain, Petitioner had not responded to either epidural steroid injections or sacroiliac joint injections. In order to better characterize Petitioner's condition, Dr. Nardone ordered an EMG/NCV of Petitioner's lower extremities, as well as a bone scan. Both the EMG/NCV and bone scan as recommended by Dr. Nardone were approved for Petitioner. Dr. Nardone did not take Petitioner off work. Therefore, Petitioner remained under the light duty restrictions imposed by Dr. Rink.

Petitioner next presented for an Independent Medical Examination with Dr. Timothy VanFleet at Respondent's request on August 21, 2013. After examining Petitioner, Dr. VanFleet placed her at maximum medical improvement and recommended no further treatment and return to work full duty. Dr. VanFleet noted that Petitioner had degenerative disc disease predating her work accidents with an abundance of symptom magnification and paucity of findings that would indicate a poor prognosis for any type of improvement with continued treatment, including a psychiatric evaluation.

Based on Dr. VanFleet's examination of Petitioner, no further treatment for Petitioner was approved. However, the results of Petitioner's EMG/NCV and bone scan remained pending.

On August 30, 2013, Dr. Woods authored an off work slip taking Petitioner off work.

Petitioner was seen again by Dr. Rink on September 5, 2013. Dr. Rink noted that Petitioner had been seen by Dr. Nardone; however, his report was unavailable. Dr. Rink also noted that Petitioner had undergone an updated MRI. Upon reviewing Petitioner's updated MRI of August 13, 2013 he noted no evidence of a prominent disc herniation or definite nerve root encroachment. Dr. Rink also noted that Dr. Nardone had recommended an EMG/NCV of Petitioner's lower extremities and a bone scan, which were pending. Dr. Rink noted that while he had previously had Petitioner on light duty restrictions, that Dr. Woods had taken her off work effective August 30, 2013 to see if a period of significant rest and avoidance of aggravating activities would improve her back condition. Petitioner reported that as of September 5, 2013 she had not seen much change in her condition despite being off work for a week. Dr. Rink noted that in his opinion Petitioner's symptoms were still most consistent with nerve mediated pain based on her most recent MRI findings and lack of improvement with epidural steroid injections. Dr. Rink agreed with Dr. Nardone's recommendation for an EMG/NCV and noted Petitioner would be seen back after obtaining the results of both her EMG/NCV and bone scan.

Petitioner's bone scan was completed on September 23, 2013 and was normal. Petitioner's EMG/NCV was completed the following day, September 24, 2013, and revealed mild left L5 radiculopathy, longstanding in nature, and mild left S1 radiculopathy, but no evidence of peripheral neuropathy.

Petitioner followed up regarding the results of her EMG/NCV and bone scan with Dr. Nardone on September 30, 2013. After reviewing the results of both, Dr. Nardone noted no imaging supporting any type of nerve root impingement and nothing to treat from a neurosurgical standpoint. Dr. Nardone noted that the fact that Petitioner had no nerve root impingement was also supported by her negative response to the epidural steroid injections. Dr. Nardone released Petitioner to the care of Dr. Wong Jhee for physiatrist to continue conservative treatment.

Petitioner first saw Dr. Jhee on October 4, 2013. Despite noting that Petitioner had already undergone physical therapy and injections with Dr. Rink, Dr. Jhee recommended additional physical therapy and epidural steroid injections. He also continued Petitioner off work.

The results of Petitioner's EMG/NCV and bone scan were submitted to Dr. VanFleet for his review. In a supplemental to his initial report Dr. VanFleet confirmed that neither the results of Petitioner's EMG/NCV nor bone scan changed his opinion that Petitioner had reached a point of maximum medical improvement related to her work injury and required no further treatment and was capable of full duty work.

Based on the opinions provided by Dr. VanFleet, authorization for Petitioner's treatment with Dr. Jhee was denied.

After October 4, 2013, Petitioner was seen by Dr. Woods on October 28, 2013 and November 25, 2013. On each day Dr. Woods continued Petitioner off work pending approval of her treatment with Dr. Jhee.

On April 15, 2014 Petitioner returned to Dr. Jhee. At that time Dr. Jhee reconfirmed his recommendation for additional physical therapy and injections for Petitioner.

After April 15, 2014 Petitioner continued to see Dr. Woods who continued her off work pending authorization of her treatment recommended by Dr. Jhee.

Then, on July 17, 2014 Petitioner presented to the emergency room via ambulance after waking up with severe shooting pain down her left leg. At the ER Petitioner underwent an updated MRI that showed no changes when compared to her June 28, 2011 MRI. Petitioner was discharged home with instructions to follow up with Dr. Woods, Dr. Rink and Dr. Jhee.

In August of 2014, Petitioner attended aquatic therapy at OSF Forte Jesse, but reported increased pain with any type of activity.

Petitioner was last seen by Dr. Jhee on August 12, 2014. Dr. Jhee's recommendations as of August 12th remained the same.

Petitioner was last seen by Dr. Woods on September 16, 2014. Dr. Woods again continued Petitioner off work.

Dr. Rink testified via deposition. Dr. Rink testified that his diagnosis for Petitioner is chemical radiculopathy at L5 due to fluid leaking from an annular tear at L3-4. However, Dr. Rink conceded that Petitioner's annular tear as revealed on her February 1, 2013 MRI of the lumbar spine showed an annular tear of the disc at L3-4 on the right side, which does not correlate to Petitioner's report of symptoms on her left side.

Dr. Rink also conceded upon reviewing the results of Petitioner's EMG/NCV from September 24, 2013, that he would not take Petitioner off work, but would limit her repetitive bending, stooping and twisting, and lifting to no more than 15 pounds.

Dr. VanFleet also testified via deposition. Dr. VanFleet testified that as a result of her work-related injury Petitioner sustained an aggravation of her underlying degenerative disc disease, but had reached maximum medical improvement by the time of his examination of her on August 21, 2013 and required no further treatment. In support of his opinions, Dr. VanFleet testified that upon examining Petitioner she had

significant symptom magnification and that her objective findings did not match with her subjective complaints of pain. Dr. VanFleet also noted that there was no difference in Petitioner's MRIs predating and postdating her accident and that both showed L3-4 and L4-5 disc protrusions without focal neurologic compression. Dr. VanFleet also confirmed his opinion that as of August 21, 2013 Petitioner could work full duty.

Dr. VanFleet testified that he disagrees "100%" with the opinion provided by Dr. Rink that Petitioner's problems are related to an annular tear or chemical radiculopathy at L5 due to fluid leaking from the annular tear at L3-4. Dr. VanFleet testified chemical radiculopathy is a condition that occurs as a result of a disc disruption (disc protrusion or hyperinensity zone of a disc) where there is some irritation to the nerve root; however, Petitioner had no evidence of a disruption on MRI. Dr. VanFleet also testified that he did not appreciate an annular tear in his interpretation of Petitioner's MRI, but noted that even if he did it is very unusual that an annular tear is the cause of people's symptomology. Dr. VanFleet testified that after one's teenage years annular tearing is a natural part of degradation that takes place in everyone, so there is no way to know if they are the specific cause of someone's back pain.

Neither Dr. Jhee nor Dr. Nardone were deposed or provided causation opinions.

Petitioner testified that she has not worked for Fresenius since July 30, 2013. Petitioner testified that she remains in significant pain related to her back and wishes to proceed with treatment as recommended by Dr. Jhee. Petitioner testified that she is mostly bed ridden and unable to do most activities of daily living, including attending her children's activities. Petitioner testified she cannot sit or stand for more than ten minutes at a time and when she sits she has to shift her weight off her left side with her left hand.

Petitioner's husband, Eric Penn, testified that Petitioner is in a lot of pain and cannot do the things she normally does and lays down a lot. He also testified that Petitioner is very emotional and depressed and does not sleep. He testified that Petitioner helps out around the house when she can but is very limited and usually does not feel well afterward.

Petitioner testified that that while employed with Fresenius she earned $12.38 per hour and generally worked four to five days a week, 40 hours a week.

CONCLUSIONS OF LAW

The main issues to be decided are causation, prospective medical and the date of maximum medical improvement which is when the Petitioner's right to temporary benefits would end. Wage was also placed in issue, and there are some unpaid bills.

The parties agree that the Petitioner had an accident on January 11, 2013 and that she injured her lower back. The Arbitrator believes the evidence shows that she also developed some radiating pain down the left leg as a result of that injury. The second accident of January 16, 2011 was just a manifestation of the symptoms related to her initial accident, and is not causally related to her current condition of ill being.

As to the first accident and causation, the Arbitrator first notes the history of prior symptoms and diagnostic findings. While she had prior treatment for the lower back with left leg symptoms, there is no evidence of any treatment from August 5, 2011 until the first accident referenced above. Dr. Rink testified that she responded well to the 2011 treatment. Clearly the accident of January 11, 2013 was at the very least an aggravation of some pre-existing degenerative disc disease.

The main question is what is the Petitioner left with in terms of a condition of ill being from this accident? She does not have an injury to the sacroiliac joint. Dr. Rink explained that the SI joint injection he performed in April 2013, which he described as the gold standard for diagnosing such a condition, was negative. (PX 1 at 11) She also does not have any foraminal stenosis which could produce radiating symptoms down the left leg. Dr. Nardone ruled that condition out based upon the Petitioner's negative neurological exam, her lack of positive response from an epidural steroid injection which he performed and his review of the initial MRI performed on February 1, 2013.

She does seem to have some chronic mild left radiculopathy arising at the L5-S1 level, based upon the nerve studies done on September 24, 2013 and interpreted by both Dr. Nardone and Dr. Rink. Dr. Rink went on to say that those tests caused him to conclude that something was causing an irritation to the nerve. (Id at 32) He concluded it was a chemical radiculopathy coming from her annular tear at L3-4, seen on the above referenced MRI. (Id) It should be noted that the tear was described as "tiny" by the performing radiologist and was on the side opposite of the Petitioner's symptomatic side. (PX 2) Nonetheless, Dr. Rink testified that it could be the cause of her symptoms and could have been caused by her accident. (PX 1 at 23, 32) The Arbitrator finds his opinions more persuasive that those of Dr. Van Fleet, who concluded without much explanation that her complaints did not follow a true dermatomal pattern, while also acknowledging that the Nerve study findings could be related to the chemicals coming from a torn disc. (RX 3 at 10, 20) She also seems to have some subjective findings of ongoing lumbar pain which she consistently reported to all of her treating doctors since her accident.

So with those findings, is the prescribed treatment by Dr. Jhee causally related and reasonable? First of all, Dr. Jhee has recommended treatment for two conditions which the Arbitrator has found either not present or not related to the Petitioner's accident. His prescribed injections would be for a suspected SI joint injury and a disc causing stenosis, and Drs. Rink and Nardone persuasively ruled those conditions out. He has also prescribed physical therapy for proper body mechanics and core strengthening. The Petitioner had physical therapy shortly after her accidents and it did not help. Dr. Rink testified that additional physical therapy was not indicated. (PX 1 at 34) Accordingly the Arbitrator does not believe the treatment requested by the Petitioner is either for conditions causally related to her accident or reasonably necessary. The Arbitrator does, however, feel the ongoing prescription for Neurontin is reasonable and connected to her mild radiculopathy, and orders the Respondent to provide it.

The Arbitrator further finds that the Petitioner reached a point of maximum medical improvement on or about October 4, 2013, when Dr. Nardone reviewed her diagnostics and made his findings. Though the Petitioner testified that she stopped work on July 30, the Respondent's records show payment of temporary partial through August 17. (RX 6) While she was given an off work slip by her family doctor on August 30, Dr. Rink, her treating doctor, said that he would have kept her working under restrictions.(PX 1 at 22) Dr. Rink, as the treater, is more persuasive than Dr. Woods, who was only seeing her to prescribe medications, on the issue of workability. Accordingly, the Arbitrator believes that the petitioner has received all of the temporary benefits to which she is entitled.

The Arbitrator awards all of the medical through October 4, 2013 as shown on Petitioner's Exhibit 8, subject to the Fee Schedule.

In regard to disputed issue (G), the Petitioner worked for the Respondent's for a total of 21 weeks. The Petitioner's earnings were $8,525.04. Averaging the Petitioner's earnings, excluding overtime over 21 weeks yields an average weekly wage of $405.95.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Perry F. Pearce,

Petitioner,

16IWCC0190

vs.

NO: 14 WC 06049

City of Chicago,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) of the Act having been filed by the Respondent herein and notice given to all parties, the Commission, after considering all of the issues and being advised of the facts and law, reverses the Decision of the Arbitrator for the reasons set forth below and finds that Petitioner failed to prove that he sustained an accidental injury arising out of his employment on July 17, 2014 because we find that the preponderance of the credible evidence shows that Petitioner was intoxicated and that any injury arose out of Petitioner's intoxication rather than his employment.

PROCEDURAL HISTORY

Petitioner, a 55-year-old truck driver, alleged that on February 17, 2014 both shoulders popped and he felt immediate pain while attempting to pull open the rear gate of his truck. The alleged injury occurred at approximately 10:45 AM and was witnessed by Petitioner's coworker, Mr. Sacramento. Petitioner reported the injury and sought treatment at MercyWorks, where breath alcohol testing (BrAC) indicated alcohol concentrations greater than .08 in two tests conducted fifteen minutes apart. Respondent denied workers' compensation benefits. Petitioner filed his Application for Adjustment of Claim with the Commission on February 24, 2014. Petitioner underwent conservative treatment for bilateral shoulder pain and ultimately came under the care of an orthopedic surgeon, Dr. Chudik. Petitioner brought this case for hearing before the arbitrator pursuant to §19(b) on March 26, 2015 seeking TTD, compensation for

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medical expenses and prospective medical care by Dr. Chudik.

At the §19(b) hearing Petitioner denied that he consumed any alcoholic beverages on the date of accident. However, Petitioner explained that he used a "peppermint breath freshener," unaware of its alcohol content, throughout the morning of February 17, 2014. Furthermore, he claimed that he swallowed a few sips of the mouthwash just prior to submitting to the alcohol screening tests at MercyWorks. He testified that due to his "constant" cigar smoking habit, he always kept a bottle of mouthwash in his pocket and used it as needed on a daily basis. The arbitrator examined a thirty milliliter bottle of peppermint breath freshener Petitioner produced during his testimony on direct examination. While not the same bottle he used on the date of accident, Petitioner testified that it was the same brand and size. Petitioner denied any knowledge that the mouthwash contained alcohol prior to BrAC testing; the arbitrator noted that the product label stated the alcohol content was 75%.

Al Sacramento testified on behalf of the Petitioner and claimed that he witnessed Petitioner's injury on February 17, 2014. Mr. Sacramento testified that he had the opportunity to closely observe Petitioner before and after the injury. He denied that Petitioner showed any sign of impairment or of having consumed alcohol. On cross-examination, Mr. Sacramento testified that he had never seen Petitioner use breath freshener.

Following the conclusion of testimony, Respondent asserted that the breath freshener explanation was a surprise. Potential bifurcation of the hearing was discussed, however Petitioner wished to conclude the hearing and close proofs. The arbitrator issued a decision dated April 24, 2015 finding in favor of Petitioner and awarding benefits under the Act. The arbitrator relied on Petitioner's testimony that he unknowingly used an alcohol-based breath freshener immediately prior to the breath alcohol screening, and found that the test data was therefore unreliable. Additionally, the arbitrator found no evidence that intoxication, and not employment, was the proximate cause of the accidental injury.

TESTIMONY OF PETITIONER PERRY PEARCE

The Petitioner testified that he worked for Respondent as a truck driver for twenty years. His job involved making deliveries to job sites. On February 17, 2014, he started work at 7:00 AM, beginning with a meeting with Mr. Sacramento and another employee. Petitioner testified that he and Mr. Sacramento worked together all morning, and they made several stops prior to the job site where he was injured; he could not recall the specific location of the accident. He testified that he struggled to open the rear swing gate of the truck because it stuck on the bed of the truck. He testified that he had to "snatch and snatch" at the gate four or five times, trying to pull it open from the left side, and "as I was snatching on the bottom – on that gate, I popped my shoulders."

Petitioner testified that he reported the accident to his foreman, "Glen Miller," and went to MercyWorks following the accident. We note there is no accident report in evidence. Petitioner testified that while waiting at MercyWorks, he stepped outside and smoked a cigar until his name was called for his examination; he testified that he had to wait nearly two hours. While following a staff member back inside the clinic and to the examination room, he took a

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few sips of an "essence of peppermint" breath freshener from a bottle in his pocket. Seeing nowhere to spit out the breath freshener, he swallowed it. Petitioner testified that he was then given a urine test and two breath tests, but no blood was drawn. Petitioner testified that the breath tests detected "some numbers" and he was questioned by the test administrator and the doctor. He denied consuming any alcoholic beverages, but testified that he explained to them about using the breath freshener.

On continued direct-examination, Petitioner was asked when he last consumed alcoholic beverages prior to the accident. Petitioner testified that the prior evening he had two beers and a shot of alcohol around 6:30 or 7:00 PM before going to bed at 8:30 PM. Petitioner testified that on the date of accident he woke up at 5:00 AM and left for work at 5:45 AM, and that he did not consume any alcoholic beverages. Petitioner produced a bottle of the peppermint breath freshener for the arbitrator to examine. Petitioner testified that the bottle was identical to the product he used daily as "constant" cigar smoker. The label indicated 75% alcohol; Petitioner testified that he first learned the product contained alcohol at MercyWorks.

On cross-examination, Petitioner testified that the alleged accident occurred at around 10:45 AM and he went straight to MercyWorks afterward. Petitioner was shown RX1, a BrAC test form dated February 17, 2014. Petitioner identified his own signature on the document. On further questioning by Respondent's attorney, Petitioner explained that his daily habit was to take several sips of the breath freshener each time he smoked a cigar, and then spit it out. Petitioner estimated that he finished one bottle every two days, and that on the morning of the accident he used mouthwash five or six times before swallowing several sips at MercyWorks.

TESTIMONY OF AL SACRAMENTO

Mr. Sacramento testified as a witness for Petitioner and was not present during Petitioner's testimony. Mr. Sacramento testified that in February of 2014 he was the foreman of construction laborers and his job involved placement of 200 laborers. Mr. Sacramento testified that he worked with Petitioner for five or six years. On the morning of February 17, 2014, they were assigned to deliver steel plates. He testified that he was standing with Petitioner at the back of the truck and recalled the following:

> *"He pulled on it. He went: Oh.*
> *And I said: What's wrong, Perry?*
> *He said: My shoulders popped. So we got the plate off with the machine. I shut the door.*
> *I said: Perry, go to the office; tell them you're going to go see the City doctor. Because he was in pain. He had tears coming out."* (T. 48)

Mr. Sacramento testified that Petitioner's face was extremely close to his own while they spoke because the surroundings were very noisy. He did not notice glassy eyes, slurred speech, or any smell of alcohol on Petitioner's breath. He testified that he observed Petitioner get into and out of the truck several times that morning did not notice any sign of impairment. Mr. Sacramento denied ever seeing Petitioner consume alcohol on the job or intoxicated at work.

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On cross-examination, Mr. Sacramento estimated that the accident occurred at 10:30 or 10:45 AM and that he subsequently advised Petitioner to report the injury. He estimated that they were approximately a seven minute drive from the office. Mr. Sacramento denied seeing Petitioner use breath freshener on February 17, 2014 or at any time in his association with Petitioner.

MEDICAL RECORDS

Petitioner offered the records of MercyWorks as Petitioner's exhibit 1 at arbitration. Notably, the MercyWorks records do not contain the breath or urine test results, although the attached bills list charges for each test on the date of accident. Petitioner was examined by Dr. Diadula and reported experiencing a pop in both shoulders while pulling down on a chain to open a gate. Petitioner was diagnosed with strains, and Dr. Diadula recommended anti-inflammatories, ice and heat, and no work until reexamination in three days. A "City of Chicago Work Status Report" contained in the records states that Petitioner arrived at MercyWorks at 11:40 AM and was discharged at 2:02 PM on February 17, 2014.

Respondent offered the "Alcohol Testing Form (Non-DOT)" as a separate exhibit, Respondent's exhibit 1. As Petitioner identified on cross-examination, the form bears his signature and the date of accident. In the "Remarks" section, the form indicates that *"Pt. instructed not to chew, eat, nor drink, & belch."* The form shows that the first breath test was completed at 12:22 PM and the results indicated an alcohol concentration of .102. The second test was completed at 12:38 PM and the results indicated an alcohol concentration of .099. The form indicates that the test was calibrated at 12:43 PM and returned a result of "OK." As stated above, the form is not contained in Petitioner's exhibit 1, nothing in the records of MercyWorks mentions the results of the BrAC or urine testing, and no medical opinions are in evidence.

Petitioner returned to Dr. Diadula on February 20, 2014 with complaints of right shoulder pain at a level of 8/10 and left shoulder pain at a level of 9/10. Dr. Diadula recommended Petitioner remain off of work pending an MRI. Petitioner returned to Dr. Diadula on March 6th and March 27th and reported no improvement. Petitioner testified that because treatment was not authorized by Respondent he went to his primary care provider, "Dr. Rupani," to obtain medication and a referral for a shoulder evaluation. We note that no records from Dr. Rupani's office are in evidence.

A left shoulder MRI was performed on May 14, 2014. The radiologist's report is contained in Petitioner's exhibit 2, the records of Holy Cross Hospital, and shows that the test was ordered by Dr. Rupani. Petitioner was subsequently examined by Dr. Schiappa on June 11, 2014. Dr. Schiappa noted that Petitioner was referred by Dr. Rupani and that Petitioner's left shoulder MRI showed arthritis with a labral tear. Dr. Schiappa recommended a right shoulder MRI as well. He noted, *"There is no history of true trauma. Degenerative arthritic condition is also present."* Dr. Schiappa performed a left shoulder injection six days later. The right shoulder MRI was completed on July 2, 2014. On July 10, 2014, Dr. Schiappa reviewed the right shoulder MRI and concluded that it was negative.

Petitioner returned to Dr. Schiappa on September 28, 2014 with continued complaints.

Dr. Schiappa included in his notes the history that Petitioner sustained an injury to both shoulders on "2/14/14[sic]" and was working with restrictions. Petitioner was given the option of left shoulder surgery if his shoulder pain persisted. The records show no further treatment with Dr. Schiappa after September 28, 2014. We note that there are no physical therapy records in evidence, despite Petitioner's testimony that he participated in physical therapy under the direction of Dr. Schiappa. Further, although Dr. Schiappa indicated that Petitioner was working as of September 28, 2014, the Request for Hearing claims entitlement to TTD from February 18, 2014 through October 20, 2014 and there is no clear evidence supporting Petitioner's claimed period of temporary total disability after he stopped treating at MercyWorks.

On February 9, 2015, over four months later, Petitioner was examined by Dr. Chudik at Hinsdale Orthopedics, purportedly on another referral from Dr. Rupani. Dr. Chudik noted that Petitioner gave a history of an injury to both shoulders from pulling a truck gate on "2/7/14[sic]." Petitioner complained of constant pain in his shoulders despite injections and medications; he also reported that physical therapy increased his pain. Dr. Chudik noted that he would need to obtain both MRI films and radiology reports prior to issuing recommendations for any further treatment. Petitioner reported that he was able to work regular duty and Dr. Chudik did not issue any restrictions.

DISCUSSION

In Illinois, for compensation to be denied on the basis of intoxication the evidence must show that the injury arose out of the intoxication rather than the employment, or that intoxication is of a sufficient degree to be viewed as an abandonment of or departure from employment. *Paganelis v. Industrial Comm'n,* 132 Ill. 2d 468 (Ill. 1989). The Commission exercises original jurisdiction in reviewing decisions of the arbitrator and is not bound by the arbitrator's findings. It is within the province of the Commission to judge the credibility of witnesses, to draw reasonable inferences from their testimony, and to determine what weight the testimony is to be given. Section 11 of the Act provides that if at the time of injury .08 or more by weight of alcohol is present in the employee's blood, breath, or urine then there shall be a rebuttable presumption that the employee was intoxicated and that the intoxication was the proximate cause of the employee's injury. Section 11 further provides that an employee may overcome the rebuttable presumption by the preponderance of the admissible evidence that the intoxication was not the proximate cause of the accidental injuries.

The accident occurred at approximately 10:45 AM according to the testimony of Petitioner and Mr. Sacramento. At 12:22 PM Petitioner's breath alcohol concentration was .102 and at 12:38 PM it was .099. Petitioner argued, and the arbitrator agreed, that Petitioner's consumption of breath freshener immediately preceding the tests rendered the results unreliable, despite a lack of any indication in the medical records that tests were improperly administered or rendered invalid results. Petitioner offered no credible medical opinions or testimony to explain or interpret the objective evidence in light of his claimed use of alcoholic mouthwash. Instead, Petitioner's argument relied only on his self-serving testimony. He strongly emphasized the ingrained nature of his daily habit of using breath freshener as circumstantial evidence that he was not intoxicated at the time of the accident. Based on Petitioner's testimony, it would be reasonable to expect that a frequent coworker would be aware of Petitioner's habit. Despite

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testifying to a longstanding work relationship with Petitioner, Mr. Sacramento had never seen Petitioner use breath freshener. In conclusion, we find that the arbitrator's decision is not supported by the preponderance of the evidence. The BrAC tests performed at MercyWorks following the alleged accident show that Petitioner was intoxicated, and we do not find the Petitioner's testimony alone sufficiently reliable or persuasive to rebut the objective evidence. In conclusion, we reverse the Arbitrator's decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 24, 2015 is hereby reversed.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 16 2016
RWW/plv
o-1/20/16
46

Ruth W. White

Joshua D. Luskin

Charles J. DeVriendt

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Debra M. Rechenberg,

Petitioner,

16IWCC0189

vs.

NO: 14 WC 06524

Centegra Memorial Medical Center,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) of the Act having been filed by the Respondent herein and notice given to all parties, the Commission, after considering all of the issues and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below and finds that Petitioner failed to prove she sustained an accident arising out of and in the course of her employment by Respondent on January 18, 2014 or that her current condition of ill being is causally related to her employment.

Petitioner, a 51-year-old registered nurse, was hired by Respondent on a part-time basis in February of 2006 and she continued to work in that capacity as of the alleged date of accident, January 18, 2014. She normally worked two or three days per week and every other weekend; her shifts were usually eight hours long but occasionally she worked twelve hour shifts. Petitioner testified that her work duties as a "floor nurse" were very physical. She was assigned to a medical and surgical unit where she was often required to assist patients who were disabled by injury or medical conditions and needed to be moved and repositioned. She explained that assistants and technicians were available for "the big moves," but that she performed readjustments or "boosting up" as needed to care for her patients.

Petitioner testified that in December of 2013 she fell at home while descending her basement steps. She testified that she fell straight down on her buttocks, and bumped her right shoulder against the wall. She did not recall the exact date of the fall, but she knew it occurred

before Christmas; on further questioning she agreed that the date of the fall would have been around December 18, 2013. She sought no immediate medical treatment, but she testified that she continued to experience some right shoulder soreness in the weeks after the fall. She testified that her son, a physical therapy student, urged her to go and have her shoulder examined. Petitioner testified that she made an appointment with Dr. Izquierdo at Crystal Lake Orthopedics for January 20, 2014. Dr. Izquierdo is a board certified orthopedic surgeon and a shoulder specialist; Petitioner testified that she was previously familiar with Dr. Izquierdo because her children had been seen by other doctors at Crystal Lake Orthopedics.

Between the December 2013 fall and the January 18, 2014 alleged injury, Petitioner testified that she continued working her regular duties and did not take any time off of work. On cross-examination, she testified that after the fall she worked approximately eight hour shifts on December 22, 25, and 28, and then a twelve-and-a-half-hour shift on January 18, 2014, the date of accident. Petitioner started her shift on January 18, 2014 at 7:00 AM. She testified that she was assigned to care for an obese patient in room 221 and that this patient required frequent repositioning in bed. Petitioner testified that sometime after lunch, while using her arms to "boost" the patient up in bed, she experienced a deep stabbing localized pain in her right shoulder. She testified that this was a sudden pain that occurred with one motion, and she thought to herself *"oh boy, oh boy, oh boy"* and *"what did I do to my arm?"* She testified that she continued her shift, performing her regular duties of moving and readjusting patients. She testified that the pain in her right shoulder continued as she performed her work activities, but that it was *"a different pain,"* not the sudden *"Oh, my gosh, pain"* that she experienced readjusting the patient in room 221. On cross-examination, she claimed that she was *"in tears"* due to pain as she continued her shift on January 18, 2014, yet she admitted she did not seek medical care at Employee Health or go to the emergency room. Petitioner acknowledged that she had an orthopedic evaluation previously scheduled for January 20, 2014.

The following day, Petitioner was also scheduled to work. She testified that she *"tried"* to call in sick, but she admitted that she went to work as scheduled and performed her regular duties rather than reporting to Employee Health or the emergency room on January 19, 2014. She testified that she had pain and throbbing in her right shoulder while working. Petitioner's accident report was admitted into evidence as Petitioner's exhibit 1 and Respondent's exhibit 1. Although Petitioner testified that she reported the injury on the date of accident, Petitioner's supervisor, "Karen Orlando," reported that she was notified of the injury on January 19, 2014 at 1:20 PM. Per the accident report, the injury occurred sometime in the midafternoon on January 18, 2014 as Petitioner was caring for her assigned patient in room 221: *"repetitively/frequently repositioning pt in bed to improve 02 sat/comfort turning in bed/diaper change."* The nature of the injury was described as right shoulder pain and biceps muscle spasms. The accident report does not indicate any specific event of sudden pain. Petitioner testified that she did not believe she could safely perform her job after January 19, 2014 due to her pain.

On January 20, 2014, Petitioner was examined by Alicia Hauser, a physician assistant at Crystal Lake Orthopedics (later Rockford Orthopedics). The "New Patient" portion of the history reads: *"a 51 year old right hand dominant female being seen for right shoulder pain that has been present since 12/2013 when the patient fell down the stairs in her home. The pain has been significantly worse since working as an RN for Centegra-Woodstock."* Petitioner complained of

pain at a level 2/10 at rest and 8/10 with activity, described as constant and dull or occasionally stabbing and located at the top of the shoulder. Symptoms increased brushing her teeth and reaching behind her, and she had been taking Ultram for pain which provided some relief. The "Work Injury" portion of the history read that Petitioner noted the date and time of the injury as *"1-18-14 – repetitive all day long"* and that Petitioner noted that the injury was witnessed and that the accident occurred *"repetitively moving a patient all day with the assistance of a tech"* and *"repetitively boosting a patient in bed with the assistance of a tech."* There was no mention of any specific injury or occurrence. On physical examination, Petitioner had no pain with palpation of the AC joint, cross body adduction or reaching for the belt loop but had positive impingement signs and pain with palpation of the biceps tendon. X-rays of Petitioner's right shoulder were taken and interpreted as negative. P.A. Hauser prescribed Vimovo, ordered an MRI *"due to the traumatic nature of the original injury,"* and restricted Petitioner to light duty work. Petitioner testified that restricted duty was not available.

Petitioner was seen in follow up by Dr. Izquierdo on February 3, 2014. The history states that Petitioner sustained an injury in *"December 2013 when she fell down the stairs at home."* Petitioner reported that she felt she was doing worse compared to her last visit. On examination, her range of motion had improved somewhat from January 20, 2014. A January 23, 2014 right shoulder MRI was interpreted by Dr. Izquierdo as showing a high grade partial thickness supraspinatus tear. Dr. Izquierdo recommended arthroscopic rotator cuff repair, subacromial decompression and anterior acromioplasty, and possible biceps tenodesis at Petitioner's earliest convenience. In the meantime, Dr. Izquierdo continued Petitioner's work restrictions and prescribed Ultram. The closing statement of Dr. Izquierdo's examination record reads: *"I do believe that all of their symptoms are directly related to the industrial injury they sustained on 1-18-14 while working for Centegra as a Nurse."*

Petitioner's claim was denied. She underwent surgery by Dr. Izquierdo on March 11, 2014. Dr. Izquierdo performed a right shoulder arthroscopic rotator cuff repair, mini open sub pectoral biceps tenodesis, extensive debridement of the glenohumeral joint, and subacromial decompression with anterior acromioplasty. Petitioner participated in post-operative physical therapy and follow up with Dr. Izquierdo.

On April 22, 2014 Petitioner was evaluated by Dr. Atluri at Respondent's request; his report was admitted into evidence as Respondent's exhibit 5. One day before, Dr. Izquierdo allowed Petitioner to discontinue use of the sling. However Petitioner testified that she remained in the sling at her examination by Dr. Atluri. Petitioner told Dr. Atluri that she fell on stairs at home in mid-December of 2013 and that she had right shoulder soreness aggravated each time she boosted a certain patient up in bed while she worked as a floor nurse on January 18, 2014. Dr. Atluri noted that Petitioner held her arms near her sides with her elbows flexed as she demonstrated boosting the patient up in bed. Petitioner did not describe any sudden injury or occurrence of pain at a specific moment in time. Dr. Atluri opined that Petitioner's diagnosis and treatment was reasonable but that Petitioner's rotator cuff tear was not related to her work activities on January 18, 2014. He reasoned that Petitioner's description of the mechanism of activity involved no sudden impact or load on the right shoulder, and he opined that a rotator cuff tear was more likely attributable to the incident when she fell on the staircase at home.

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Petitioner returned to Dr. Izquierdo on May 19, 2014 and June 9, 2014. He prescribed a CPM chair to improve Petitioner's range of motion and discussed glenohumeral injections for adhesive capsulitis. On July 14, 2014 Dr. Izquierdo injected Petitioner's right shoulder to treat her continued right shoulder stiffness. Petitioner returned to Dr. Izquierdo in further follow up on August 11, 2014 and September 15, 2014, before being released to full duty work on October 16, 2014. Petitioner testified that her job was terminated the first week of October, coinciding with the end of her FMLA period, and she subsequently obtained COBRA coverage for medical insurance. On cross-examination, Petitioner testified that she never went back to Respondent after October 16, 2014 with the full duty release in order to apply for a new job, although she agreed that under the circumstances she was in fact eligible to do so.

At Petitioner's request, Dr. Izquierdo issued a narrative letter dated October 27, 2014 and the letter is in evidence as Petitioner's exhibit 4 and Respondent's exhibit 7. Dr. Izquierdo stated that Petitioner initially contacted his office on January 15, 2014 and reported falling down stairs at home. When she was examined on January 20, 2014, Petitioner's fall down stairs was again documented, but Petitioner had also noticed her symptoms were worse after working a long shift and moving the same patient over and over on January 18, 2014. In response to Petitioner's attorney's request for a causal connection opinion between the "work injury" sustained on January 18, 2014 and the condition that required surgical intervention, Dr. Izquierdo opined that it was very difficult to confirm whether Petitioner would have required surgery regardless of aggravating her shoulder at work. He opined that it would be very difficult to repetitively cause biceps tendon pathology and a rotator cuff tear over the course of a twelve hour shift. He stated that a significant pre-existing partial tear could have, in theory, been completed boosting up the patient in bed. However, he believed that in that case Petitioner would have been able to delineate a moment in time where she experienced an acute onset of symptoms.

Dr. Izquierdo testified via deposition on November 11, 2014 with Petitioner in attendance. His deposition was admitted into evidence as Petitioner's exhibit 5. Dr. Izquierdo is board certified in orthopedic surgery, he completed a shoulder fellowship, and he is a member of the American Shoulder and Elbow Surgeons; shoulder treatment represents 85-90% of his practice. On direct-examination, Dr. Izquierdo testified that based on Petitioner's history that she fell at home in December 2013 and her symptoms became worse after working on January 18, 2014, it was his understanding that she sustained an aggravation of a pre-existing injury. He testified that she could have sustained the tear when she fell in December 2013, but a pre and post injury MRI would be needed to confirm. When Petitioner's attorney asked Dr. Izquierdo to give his causal opinion within a reasonable degree of medical certainty as to whether the alleged work accident caused or contributed to Petitioner's condition of ill-being, he answered: *"I can't answer that, all right, no – nobody knows."* He testified that when he examined Petitioner he accepted the history she gave that *"it was worse after working."* Therefore, he included the statement identified at the end of his examination record on February 3, 2014. He testified that he uses a template and chooses to include a causation statement if it is pertinent. Dr. Izquierdo testified that he relied on Petitioner's history at the time and reasoned that even if Petitioner had a pre-existing injury she was asymptomatic enough to be able to work before January 28, 2014, and after that she felt she could not work.

On cross-examination, Dr. Izquierdo testified that he did not know when Petitioner came

back to work after the mid-December 2013 fall or how much time she spent working prior to the January 18, 2014 alleged work accident. He agreed that the MRI could not prove whether the tear happened in December or January. On further questioning, Dr. Izquierdo testified that he believes it was incorrect to have used the word "all" in his causal statement (*"I do believe that all of her symptoms are directly related... ")* He testified that he would modify the statement to state that her symptoms were worse after the work injury; he agreed that this causal statement would have been based solely on Petitioner's history.

Dr. Izquierdo testified that in his opinion it would be difficult to cause a rotator cuff tear repetitively over a twelve hour shift. He believed it was possible that a pre-existing partial tear could have been completed during the course of the day's activities, but he testified that he still believed there would be *"a moment in time where she said, "Oh my god, at 2:15, I lifted this lady, and my arm hurt substantially more," some – "Now I can't pick up my arm," that's a different history, right, but I don't have that history."* Dr. Izquierdo further testified that in order for him to change his opinion, he would have to be confronted with a different history than what he obtained from Petitioner: *"Let's put it this way, if she – if there was a reported and documented moment or incident in time, the answer is yes, she could have made it [the tear] bigger."* Dr. Izquierdo testified that he thought *"there's a lot of gray here... [a] lot of gray as in what – in time as to where exactly in time did the tear occur."*

Dr. Izquierdo further testified that, a "pulling up" movement could possibly cause a rotator cuff tear. However, he believed that this mechanism of injury would normally involve lifting a heavy load and sudden symptoms: *"most people would recognize a moment in time when they went to lift something, and they would feel – they would feel a – a sharp pain or an immediate symptom."* He testified that in the history he obtained, Petitioner described *"a repetitive lifting issue,"* not a specific moment in time. Dr. Izquierdo could not state within a reasonable degree of medical certainty that lifting at work was the cause of the rotator cuff tear. On redirect examination, Dr. Izquierdo conceded that the work injury alleged "could or might have" aggravated a pre-existing tear but cautioned: *"[W]e're really splitting hairs here."*

Dr. Atluri testified via deposition on December 10, 2014 and the transcript was admitted into evidence as Respondent's exhibit 2. Dr. Atluri is a board certified orthopedic surgeon who exclusively treats upper extremity problems; he estimated that shoulder patients represent 30% of his practice. Dr. Atluri testified consistently with his §12 examination report in evidence as Respondent's exhibit 5. Dr. Atluri testified that following his physical examination and record review he diagnosed Petitioner as status post arthroscopic right rotator cuff repair but not yet at maximum medical improvement. He ultimately concluded that Petitioner's right shoulder rotator cuff tear was not related to her work activities. He based his conclusion on Petitioner's description of having sustained a traumatic injury at home with resultant shoulder pain, and then experiencing symptoms while repositioning a patient multiple times over a period of twelve hours on January 18, 2014. Dr. Atluri noted that Petitioner demonstrated the position of her upper extremities while performing that activity, as he noted in his report. At the April 22, 2014 §12 examination, Petitioner gave no history of a sudden impact or load on the right shoulder. Dr. Atluri testified that Petitioner's rotator cuff could not have been stressed to the point of causing full thickness tear in the performance of the job duties that she described. Furthermore, Dr. Atluri held the general opinion that lifting with the arms below shoulder level was not a plausible

mechanism of injury to the rotator cuff. He explained that the rotator cuff is only minimally affected by the force of lifting when the arm is below shoulder level. Dr. Atluri also denied that Petitioner could have completed a small rotator cuff tear by adjusting a patient in bed, again because of the mechanics of the activity described to him by the Petitioner.

On cross-examination, Dr. Atluri agreed that he did not have the opportunity to review Petitioner's operative report until before the deposition; however, he testified that viewing the report did not alter his opinions. Dr. Atluri testified that without the report he already knew that Petitioner had arthroscopic right rotator cuff surgery and he had radiographic images of the shoulder. He agreed that without an MRI taken between the December and January incidents he is unable to discern when the rotator cuff tear occurred. He again disagreed that a prior tear could have been completed on January 18, 2014 via the physical activity described by Petitioner. Dr. Atluri agreed that his opinion could change if the history was different.

After considering all of the evidence, we conclude that the credible record does not support a finding of a compensable accident on January 18, 2014 or causal connection between Petitioner's current condition of ill-being and her employment by Respondent. In this case, Petitioner's treating physician and Respondent's §12 examiner largely agree that the history and mechanism of injury described by Petitioner is not a reasonable or likely cause of the right shoulder condition surgically treated by Dr. Izquierdo. Both doctors acknowledged that the December 2013 fall at home was the only history of a *traumatic* event that Petitioner recounted; she described a repetitive-type injury occurring at work. Dr. Izquierdo relied on Petitioner's history that she was subjectively worse after January 18, 2014, however he could not opine within a reasonable degree of medical certainty that there was causal connection to the rotator cuff tear and surgery he ultimately performed.

We find that Petitioner's testimony at the §19(b) hearing lacks credibility regarding the nature of the December 2013 fall at home. Although Petitioner testified that she merely missed one step and fell straight down on her buttocks, no more than "bumping" her right shoulder against the wall, she nevertheless admitted that her right shoulder continued to bother her nearly a month later and that she made an appointment with an orthopedic surgeon specializing in shoulder treatment. We further note that the records of Dr. Izquierdo's office fail to corroborate Petitioner's testimony. The records do not reflect that Petitioner merely "missed a step" and landed directly on her buttocks, or that she only had slight "soreness" but was urged by her son in physical therapy school to have it checked out.

The evidence supports Dr. Atluri's belief that subsequent to the fall at home, Petitioner was mostly likely experiencing right shoulder symptoms outside of and unrelated to her work duties prior to January 18, 2014. On direct examination, Petitioner testified to only three days of work between the fall at home in mid-December 2013 and the January 18, 2014 alleged accident, which in fact occurred on her first day of work since the end of December. Despite working significantly less than her usual part-time schedule during the period between mid-December 2013 and January 18, 2014, Petitioner's shoulder symptoms apparently bothered her to the point of making an appointment with a shoulder specialist. Dr. Izquierdo testified that he relied on Petitioner's history that she was "worse" after repetitively adjusting a patient in bed on January 18, 2014, but he agreed that he did not know how many days Petitioner worked prior to the

alleged accident.

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Finally, nowhere in Petitioner's accident report or the medical histories did Petitioner delineate a specific episode of sudden or significant pain while lifting a particular patient on January 18, 2014. Instead, Petitioner reported a repetitive-type injury on January 18, 2014. Only at arbitration did Petitioner testify that she had a specific recollection of a moment in time where she felt a sharp stabbing pain while performing one movement at work. She further testified that at that moment she became unequivocally aware that she injured her right shoulder, and the pain she felt as she continued working the remainder of her shift and the following day was "different" and not like the sudden pain of the injury. As previously noted, Dr. Izquierdo testified that after considering all of the information available to him, including the objective evidence and Petitioner's history, he could not opine within a reasonable degree of medical certainty that the work activities on January 18, 2014 caused or permanently aggravated Petitioner's shoulder condition. He testified that he would modify the general causation statement in his examination record from February 3, 2014 when he was confronted at deposition with the known facts, including those from his own records. In Petitioner's presence, Dr. Izquierdo testified that if Petitioner's history was different in that she recalled a specific occurrence of sudden and severe pain with activity his opinion could change. Furthermore, Dr. Izquierdo agreed that the fall at home in December 2013 could have caused or completed a rotator cuff tear, and his testimony proves that he was unaware Petitioner had only worked three days in a month between mid-December and January 18, 2014. We find that Petitioner's subsequent testimony at arbitration gives a strong indication that an effort was made to closely conform to the doctors' reasoning in order show causation. We do not find Petitioner's testimony to be credible and it is not supported by the medical records or the expert opinions in this case.

In conclusion, we find that Petitioner failed to prove she sustained a compensable work accident on January 18, 2014 and failed to prove by the credible medical evidence that her right shoulder condition is causally related to the alleged work injury on that day. Therefore, we reverse the decision of the arbitrator and vacate the arbitrator's award of temporary total disability benefits and medical expenses.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 17, 2015 is hereby reversed.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 16 2016
RWW/plv
o-1/20/16
46

Ruth W. White

Joshua D. Luskin

Charles J. DeVriendt

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph Ward,
Petitioner,
vs.
Caterpillar,
Respondent,

NO: 14 WC 06833

16IWCC0194

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, medical expenses, prospective medical care and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 30, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $31,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 16 2016

MB/mam
o:2/11/16
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

WARD, JOSEPH
Employee/Petitioner

Case# **14WC006833**

16IWCC0194

CATERPILLAR
Employer/Respondent

On 7/30/2015, 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 0.14% 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:

1824 STRONG LAW OFFICES
HANIA SOHAIL
3100 N KNOXVILLE AVE
PEORIA, IL 61603

5035 CATERPILLAR INC
DARCY K GIBSON
100 NE ADAMS ST
PEORIA, IL 61629-4340

16 IWCC0194

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Joseph Ward
Employee/Petitioner

v.

Caterpillar
Employer/Respondent

Case # **14**WC **06833**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed out to each party. The matter was heard by the Honorable **GREGORY DOLLISON** Arbitrator of the Commission, in the city of **Peoria on June 17, 2015**. 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. [x] 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. [x] 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. [x] 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. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] 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. [x] Other **Prospective Medical**

FINDINGS

On or about **2/04/14**, 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 her employment.

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

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

Stipulated by the parties, Petitioner's average weekly wage at the time of the accident was $751.47.

On the date of accident, Petitioner was **26** years of age, ***married*** with **one** 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 **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and $0.00 for other benefits, for a total credit of $0.

Respondent is entitled to a credit of **$16,313.37** under Section 8(j) of the Act for nonoccupational indemnity disability benefits paid.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $500.98/week for 70 weeks, commencing February 12, 2014 to June 17, 2015. Pursuant to Section 8(j) of the Act, Respondent is entitled to a credit in the amount of $16,313.37 for short term disability paid.

Respondent shall pay reasonable and necessary medical services of **$12,359.61** as provided in Section 8(a) and 8.2 of the Act. Respondent shall further authorize the medical care and treatment as prescribed by Dr. Blair Rhode.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

Signature of Arbitrator

7/29/15
Date

ICArbDec p. 2

JUL 30 2015

Attachment to Arbitrator Decision
(14 WC 6833)

FINDINGS OF FACT:

16IWCC0194

Petitioner testified that he started working for Caterpillar on October 11, 2010, and worked for Caterpillar until on or about February 12, 2014. Petitioner testified that during this time he was not working and was off from May 2013, due to a compression fracture of his back and was shortly laid off and did not return back to Caterpillar until approximately October 2013.

Petitioner testified that when he started working for Caterpillar on October 11, 2010, he was working as a Core Specialist. Petitioner testified that as a Core Specialist he was to produce capsules and components which were poured into the next step of the process that included setting of machinery, sanding and filing sand components, painting sand components and inspecting finishing products. Petitioner testified that as a Core Specialist he was required to use tools that involved wrenches, screwdrivers, ratchets, hoists, hand sanders, hand files, paint brushes, pneumatic scribes, hand roller pieces, hot glue guns and paste bulbs. Petitioner testified that after approximately 6 to 8 months of working as a Core Specialist he was asked to perform job duties in the Finishing Department.

Petitioner testified that his job duties in the Finishing Department included loading and unloading pieces of iron. Petitioner testified that as part of the finishing process he was required to use pneumatically hand held tools. Petitioner provided that he was required to use a pneumatic air hammer, hoist, j-hooks and paint brushes. Petitioner testified that the air hammers used produced a significant amount of vibration. Petitioner also testified that essentially all of the tools he used in the Finishing Department required him to repetitively and forcefully use both hands.

Petitioner testified that while working in the Finishing Department, he was promoted to a Core Room Lead man where his job duties included both that of a Core Specialist and the job he was performing at the Finishing Department. Petitioner testified that after 3 months of working as a Core Room Lead man he started working at the Mapleton Foundry. Petitioner described his job duty at the Mapleton Foundry as "Shakeout." Petitioner testified that he was responsible for breaking open sand molds containing various Caterpillar products and using an air hammer to knock off various metal fins and sands out of the castings molds. Petitioner testified that the tools he used included sledge hammers, grinders, cup grinders, hoists, shovels, air hammers and pneumatic ratchets. Petitioner provided that the tools he used produced a significant amount of vibration and also required him to repetitively engage in forceful gripping and grasping. Petitioner testified that he worked at the Mapleton Foundry until May 2013 when he went on medical leave. He returned in June 2013 and was subsequently laid off.

Petitioner testified that he was recalled to work at Respondent sometime in October or November 2013. At that time he worked for a few weeks as a fork truck driver. In November 2013, as a result of bidding for a new job, Petitioner began his final job at Caterpillar as a Heat Treat Operator. Petitioner testified that his job as a Heat Treat Operator was to load and unload furnaces, gauge parts, perform set-ups as well as paint certain parts. Petitioner testified that as a Heat Treat Operator he used or work with tools such as wrenches, hoists, stick gauges, paint brushes, and lifting devices. Petitioner also provided that he used a computer for data entry and tracking. Petitioner testified that throughout his job at Respondent he was required to use tools that produced a significant amount of vibration and required repetitive forceful gripping and grasping with both of

his hands. At the time of arbitration a narrative job description completed by Petitioner was entered and admitted into evidence as Petitioner's Exhibit 4.

Petitioner testified that even though he is right-hand dominant he considers himself to be a left-handed individual meaning that he essentially performs all of the tasks with his left hand. Petitioner testified that in performance of his job duties he started to experience symptoms with both his right and left hand. Petitioner testified that the symptoms were significantly greater in his left than his right hand. Petitioner stated that he started experiencing mild symptoms sometime when he was working in the Finishing Department. Petitioner indicated that at that time he did not know as to what these symptoms were associated with and did not know whether those symptoms would become a problem. Petitioner stated that his symptoms were occasional and were not serious enough that he had to seek medical attention. He indicated that while on medical leave in May 2013, the symptoms resolved themselves. However, after he returned back to work and while working as a Heat Treat Operator, his symptoms again returned to the point where he started dropping things. Petitioner testified that there were two occasions where he dropped equipment and at that time he knew that he had to seek medical attention. Petitioner testified that the symptoms that he was experiencing with both of his hands were pins and needles, weakness in both hands, locking of both thumbs and overall weakness in both hands. Petitioner emphasized that the symptoms that he was experiencing in his left hand were more dominant than the symptoms that he was experiencing with his right hand.

Petitioner testified that in January 2014, his symptoms were severe enough that he advised his supervisor, Todd, about the problem that he was experiencing with his hand. Petitioner provided that he informed Todd that he was experiencing problems with his left hand, thumb, index and middle finger. Petitioner prepared an Incident Employee Statement Form on January 31, 2014. Petitioner described the incident as follows: "Was working back of 1st op of furnace. Was transferring parts to quench. My thumb, index and middle finger went numb with a dull pain present. Todd came over and I told him what I was feeling and [I] said I didn't want treatment just wanted him to know about it. Next day came in and told Todd it was still bothering me and that I wanted to be seen by medical." On this form, Petitioner also provided that he didn't know what caused the accident. (RX 2) At trial, Petitioner explained that he "wrote don't know because [I] didn't know what condition I had [and I] wasn't comfortable saying work caused it because [I] didn't know..."

In addition to preparing an Incident Employee Statement Form on January 31, 2014, Petitioner and his supervisor, Todd, also filled out what is titled Caterpillar Employee Incident Report. On question #1 of the Incident Report, Petitioner wrote " I was in heat treat 1st operation. I was transferring a part from the furnace to the quench. My thumb, index and middle fingers went numb. When my supervisor came over I informed his of the numbness." On the form, Petitioner provided that the machine involved unloading a hoist and his symptoms resulted from the incident. (PX 2)

Petitioner testified that after filling out the incident report, Todd sent him to Respondent's medical department. Records submitted records Petitioner complained of symptoms in his left hand including numbness in the index, thumb and middle fingers. (RX 1) Petitioner testified and the records show that nothing was done of consequence and Petitioner was instructed to return back to work full duty. (RX 1)

On February 3, 2014, Petitioner returned to Respondent's medical clinic where he was first seen by a doctor. Clinic records show Petitioner "...had sudden onset of pain, numbness and tingling, and weakness and had bad swelling last Thursday... He never experienced any of these symptoms before, except occasional numbness in the first 3 fingers in the right and left hands which started a few months ago. The left hand seems to have numbness in the 4th and 5th digits as well..." The doctor recorded that since bidding into a new job in November 2013, Petitioner worked in the heat treatment operations. The doctor opined that said job does not

require forceful or sustained movement. He indicated there is no significant sustained or forceful awkward postures. After performing an examination, Petitioner was assessed with 1st – 3rd fingers paresthesias, left greater than right, intermittent on the right. The doctor felt there was no significant exposure to account for the findings indicating Petitioner's condition was not work related because the onset happened so fast. He felt Petitioner was functionally doing well and no work restrictions were given. (RX 1) Petitioner testified that although he was returned to full duty work, his supervisor, Todd, assigned him to light duty work. Also at that time it was decided that he see his primary care physician.

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On February 4, 2014, Petitioner presented to Dr. LaShunda Williams at Proctor First Care. Records submitted show Petitioner presented with numbness and pain in left hand which had been present for two months and was getting worse with use at work. Noted was that Petitioner lifted a part at work and had swelling and tenderness over the left hand and wrist. Also noted was that Petitioner had been unable to hold an egg, was dropping cups and utensils and he had been having problems with holding anything with his hands. Further noted was that he had weakness with pain going up his arm. Petitioner was assessed with increasing hand pain. He was released with a work restriction to not engage in heavy lifting. (PX 6) Petitioner testified that he was experiencing symptoms in both hands, although the symptoms in his left hand were greater than his right. Petitioner also testified that at Proctor first Care it was conveyed to him for the first time that his condition of ill-being is related to the job duties that he performed at Caterpillar.

Petitioner followed up with Proctor First Care on February 12, 2014. At that time he was still experiencing problems with his left hand. It was noted in Proctor First Care medical records that Petitioner went back to work and his hand was getting worse with repetitive motion. At that time Petitioner was diagnosed with carpal tunnel syndrome and was referred to Dr. Li for an EMG. (PX 6)

Petitioner returned to Dr. Williams on February 26, 2014 with continuing complaints of left hand symptoms. On March 7, 2014, his complaints were worse depending on movement. Also noted was complaints of the right hand. At that time he was referred to an orthopedic doctor. (PX 6)

On March 10, 2014, Petitioner saw Dr. John D. Mahoney at Midwest Orthopaedic. Dr. Mahoney noted Petitioner was reporting significant numbness, tingling with both of his hands. Dr. Mahoney noted Petitioner was experiencing symptoms on the right but not as bad as the left. Petitioner reported at work he uses hoists, does some manual lifting and manipulation of smaller objects. The doctor also noted Petitioner had not worked since February 4, 2014. Dr. Mahoney performed an examination an examination of the left hand and reviewed the EMG that was performed which he indicated revealed moderately severe left carpal tunnel syndrome. Dr. Mahoney diagnosed Petitioner with carpal tunnel syndrome moderately severe on the left. At that time Dr. Mahoney discussed non-surgical treatment vs. surgery with Petitioner. Dr. Mahoney noted that Petitioner wanted to proceed with surgery, but at that time this was the subject of a disputed work comp claim. Dr. Mahoney also opined that "as best I understand his work duties (and his other life activities) I am not aware of any clear causative factor for the development of carpal tunnel in Mr. Ward. However, carpal tunnel syndrome in a 26 year old man is unusual and it may just be manipulative activates that he does throughout the day that cause it. Once his work comp status is resolved he would like to proceed with surgery. Planned surgery would be left endoscopic carpal tunnel release..." (PX 7)

Petitioner testified that Respondent denied approval of the surgery and/or treatment proposed by Dr. Mahoney. At the referral of his attorney, he commenced treating with Dr. Blair Rhode. Petitioner provided that no other doctor would treat him without prior approval.

Petitioner first saw Dr. Rhode on June 4, 2014. Dr. Rhode's medical records reveal that Petitioner presented to him for an evaluation of left wrist pain which symptoms were secondary to an injury while at work. Petitioner presented with complaints of palmar wrist pain with numbness and tingling to the thumb, index and long finger as well as symptomatology of the ring finger. Dr. Rhode noted that the Petitioner initially experienced symptomatology in October, 2010 when he was working at the Foundry at his current employer. Dr. Rhode noted that Petitioner operated an air hammer and would off load 1,000 heads per night. It was noted that when Petitioner was laid off, Petitioner's symptomatology improved. The doctor recorded that Petitioner subsequently had been working in the Heat Treat Department for 3.5 years and the symptoms returned on February 2, 2014. He recorded that Petitioner, as a Heat Treat Operator, was required to operate hoist with pistol grips. He noted that Petitioner is right handed but most of his gross motor action is performed with the left hand. It was also mentioned in the note that Petitioner was beginning to experience symptomatology on the right side. Dr. Rhode diagnosed carpal tunnel syndrome and recommended a course of conservative treatment which included a left wrist carpal tunnel steroid injection. (PX 8) Petitioner testified and Dr. Rhode's medical records show that Dr. Rhode continues to treat Petitioner conservatively for bilateral carpal tunnel syndrome left worse than right. Surgical intervention was ultimately prescribed in the form of a left carpal tunnel release. (PX 8) Petitioner testified he would like to move forward with the treatment being recommended by Dr. Rhode on his left hand.

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Brian Murphy on June 28, 2014. Petitioner provided a history of working as a Heat Treat Operator when on January 30, 2014 he developed pain, numbness and swelling on his left side while operating a hoist. The symptoms were present intermittently for months but they were constant after January 30th. Petitioner also provided that he had subsequently developed symptoms in his right hand, although, they weren't as severe as the left. Dr. Murphy provided that he reviewed records from Respondent's medical clinic, the records of Dr. Williams and Dr. Rhode as well as the EMG report. Dr. Murphy also noted that he reviewed a job video, Respondent's Exhibit #5, which showed hoists used in the heat treat job. After performing an examination and reviewing the above-mentioned, Dr. Murphy's impression was bilateral carpal tunnel syndrome. Dr. Murphy opined that same was not related to Petitioner's work duties at Respondent. The doctor noted that in his opinion, the video information provided and the records submitted did not appear to involve any significant repetitive or forceful gripping activities of the hand. He indicated the hoist requires minimal force of grip to operate which would not be consistent with occupational exposure that would induce carpal tunnel syndrome. Dr. Murphy also opined that Petitioner's increasing symptoms on the right side were further evidence the condition is not related to his work duties, as the right hand symptoms had increased despite Petitioner not working since February 2, 2014. Lastly, Dr. Murphy agreed that surgical intervention was the only viable option with respect to the left hand. He also added that Petitioner will likely require surgery to release the right hand as well. (RX 3)

Dr. Rhode testified via deposition on March 11, 2015. Dr. Rhode testified that he initially saw Petitioner on March 4, 2014. At that time Petitioner demonstrated evidence of left carpal tunnel syndrome. Petitioner further had subjective complaints consistent with right carpal tunnel syndrome. Ultimately, after undergong conservative care, Dr. Rhode provided that he requested authorization to proceed with the left carpal tunnel release. With respect to Petitioner's right carpal tunnel syndrome, he recommended continued conservative care. However; he noted that it was possible that surgical intervention would be necessary in the future. Dr. Rhode testified that his general practice is to see how well a person does with the contralateral side and then possibly do a steroid injection and that should determine the need for surgery. (PX 9, pgs. 8-13) During the deposition Dr. Rhode was provided with an extensive job description of Petitioner which was previously discussed as Petitioner's Exhibit 4 (a narrative job description of Petitioner's career at Caterpillar). After being posed with a hypothetical and reviewing the job description, Dr. Rhode testified that the job exposures outlined in Petitioner's Exhibit 4 are appropriate exposures. He stated "...[you] have what appears to

be a statement filled out by my patient. These are appropriate exposures. I believe it's appropriate, you know, force repetition, hand exposure, dose respond to be causative to the patient's carpal tunnel." The doctor added, "Well, we all feel that carpal tunnel syndrome causation is multi-factorial. There's certainly non-job related causative factors which were actually even acknowledge on the patient on his index visit. Specifically, his preexisting associative factors are the fact that his BMI was grated than 30. It was 38. That's known to be associated with carpal tunnel syndrome. It is not felt to be causative per say as is smoking. There is some data to support that it is associated with high incidents of carpal tunnel syndrome. Other than that, the patient's other preexisting factors would be diabetes, thyroid dysfunction which he did not have. Reviewing what this patient did on his job duties I believe are appropriate exposures, the types of tools that he used, the wrenches, the screwdrivers, the ratchets, hoists, sanders, files, pneumatic scribes, hand rollers, working on these sand molds, I've treated other patients with similar types of exposure where I felt it was causative. Also, I know that the IME physician talk about once the dose exposure is removed his symptoms persist. I would actually make the comment that early on when he develops the symptomatology in 2010 and he was laid off his symptomatology did improve again supportive that whether exposure he was being exposed to had a contributory component. We also know that as the disease process advances these changes become permanent and when you remove the exposure the symptomatology doesn't improve. So, again, I think that is actually supportive of the patient's causation." (PX 9, p.16)

Dr. Rhode testified that based on his experience, the tools that Petitioner used, including hand sanders, hand files, pneumatic scribes, hand rollers, using the sand molds performing a shakeout using a hammer to knock off chills and coupons and metal fins cause a vibratory exposure. Dr. Rhode indicated that the tools Petitioner used including hammers, ratchets, hoists would be the tools that would involve forceful gripping and grasping. The doctor indicated that "...it's even relative to the heat treat operator,...Again, he's showing a side dominance during that exposure where the patient felt although he was right-handed dominant most of his gross motor action was performed with his left which was his primary symptomatic side." (PX 9, pgs. 17-18) Dr. Rhode further testified that the literature supports that there is 1,000 years' worth of literature supporting work exposure and causal connection to compressive neuropathies. Dr. Rhode cited the Niosh Study originally performed in 1997 recently updated which he indicated they talk about high association with forceful repetition, vibration and exposure. The doctor stated that even with each one of these individual exposures there is still an association. When asked the following; "Doctor, in this particular instance knowing the job duties, again as listed in Petitioner's Exhibit 4, do you have an opinion that the job duties were forceful, repetitive and vibratory?, the doctor responded indicating that within a reasonable degree of medical and surgical certainty, all three were. (PX 9, pgs. 18-19)

On cross-examination, Dr. Rhode testified that when first saw Petitioner in March 2014, he provided a history that he had symptoms in 2010 and that the symptoms improved when he went on layoff. However; they returned on February 2, 2014 while Petitioner was operating a pistol grip hoist. Dr. Rhode went on to testify he hadn't reviewed Respondent's clinic medical records and it was his initial understanding Petitioner had been operating the pistol hoist for 3.5 years. He however learned later at a subsequent visit, that Petitioner had not been doing that job "that long." Dr. Rhode provided that Petitioner had a scheduled visit as a patient on March 11, 2015, (also the day of the deposition) wherein there was a "convoluted conversation" about the exposure. Dr. Rhode stated, "...I was confused on what he was describing as far as his index exposure being in October of 2010 which...we established that, yeah, that was when he initially experienced symptomatology, and he had a period that he was off. His symptoms got better, and then he started performing a multitude of jobs including this one that he was a heat treat operator." (PX 9, pgs. 20-23)

With respect to Petitioner's right hand, Dr. Rhode testified that during the initial visit, Petitioner had mild subjective complaints and mild physical exam findings which he was hopeful would respond to

conservative care. The doctor indicated that he didn't explicitly relate the right hand to work at that time nor did he know when Petitioner began experiencing symptomatology on the right. (PX 9, p.24) After reviewing medical records during the deposition, the doctor agreed that the earliest documented findings regarding the right hand was April 1, 2014. Dr. Rhode testified that if the documentation was correct and Petitioner had no symptomatology through the last day worked and did not complain of same until April 1, 2014, Petitioner's right sided symptoms would not be related to his work. (PX 9, p.26)

Dr. Murphy testified via deposition on April 2, 2015. Dr. Murphy testified that at the request of Respondent, he performed a Section 12 examination of Petitioner. The doctor provided that in addition to performing a physical examination, he also reviewed medical records and a job duty video. The doctor provided that Petitioner provided a history that while working at Respondent as a Heat Treat Operator, he developed pain, swelling, numbness and tingling in the left hand while operating a hoist. Dr. Murphy also provided that the medical records mentioned Petitioner had symptoms prior to his employment as a Heat Treat Operator; but that said symptoms significantly improved prior to Petitioner becoming symptomatic on January 30, 2014. (RX 4, pgs. 8-9) Dr. Murphy stated that after performing an examination, Petitioner appeared to have some mild right sided carpal tunnel syndrome and worsening carpal tunnel syndrome on the left. Dr. Murphy opined that Petitioner's left sided carpal tunnel was not related to his duties at work. (RX 4, p.14) Dr. Murphy stated, "After reviewing the video information and reviewing the records, it was my opinion that he did not do any significantly repetitive or forceful gripping activities at his or within his job duties that would have been consistent with an occupational exposure that would have brought about carpal tunnel syndrome." Dr. Murphy further explained he thought Petitioner's carpal tunnel syndrome to be more of a degenerative condition because Petitioner described worsening symptoms on the right and left side. He also thought Petitioner's age indicated a cause other than work because carpal tunnel is not prevalent in males in their mid-20's. He thought this factor leaned the cause more toward a genetic or atomic abnormality. (RX 4, pgs.15-16) Dr. Murphy also testified that he agreed with the treatment plan being recommended. (RX 4, pgs. 18-19)

During cross-examination, Dr. Murphy testified that he did not recall how long Petitioner had been working as a Heat Treat Operation. However, it was his impression that Petitioner did not work in that capacity very long. When asked if he knew what Petitioner was doing prior to working as a Heat Treat Operator, Dr. Murphy stated that he believed that Petitioner had been working at a different site within Caterpillar but he did not have an independent recollection of that and it does not appear that was part of his report. (RX 4, pgs. 22-23) Dr. Murphy provided that he was only provided with the job descriptions and the job duties Petitioner performed as a Heat Treat Operator. Dr. Murphy added that his causation opinion was based on Petitioner's job duties as a Heat Treat Operator and the video of same. (RX 4, p. 29) The doctor provided that he did not know what kind of tools Petitioner used prior to working as a Heat Treat Operator and he could not opine whether those tools required forceful gripping, grasping, or involved any vibration. (RX 4, pgs. 30-31)

During re-direct testimony, Dr. Murphy testified that it was highly unlikely for a male who is this young to have carpal tunnel syndrome due to any environmental exposure. He went on to explain, the waxing and waning symptoms described by Petitioner and degenerative course where the symptoms are full time and getting worse which would be consistent with an idiopathic cause. (RX 4, p.36)

Mr. Todd Dansizen testified on behalf of Respondent. Todd was Petitioner's section manager from November 18, 2013 through February 3, 2014. Todd agreed Petitioner had come to heat treat on November 18th and worked on the carb side first. He testified Petitioner would have been training on carb side for the first several weeks and this meant he would be sharing the job duties with another employee. Todd explained videos #1 and #2 in Respondent's Exhibit #5 which he indicated show the hoist work done on the carb side. He said this hoist could be described as a pistol hoist.

Todd went on to testify that Petitioner began training on the 1st op side of heat treat on January 29, 2014. He said the work on 1st op was done mainly with hoists. He testified the two hoists shown in video #3 of Respondent's exhibit #5 are two of the hoists used in 1st op. He also testified the hoist shown in Respondent's #11 is the other hoist used in 1st op and is the hoist used to take parts from the furnace to the quench hoist. He testified the operation of the three 1st op hoists are similar in that the control is in one hand and the operator uses their other hand to guide the part being lifted. He stated the only difference in the hoists is the two 1st op hoists in Exhibit #5 are hydraulic powered and the one in Exhibit #11 is electric.

Todd was presented with Respondent's Exhibit #12 and testified it was a job log he kept on Petitioner. Todd testified he kept similar logs for all his employees to keep track of their employment under him. Todd testified he keeps the log on his computer and records various occurrences, job reviews, job changes, etc. Todd testified he recorded in the log conversations, both oral and by text, he had with Petitioner after he reported his injury. Todd testified the conversations recorded in the email log were accurate. He testified he didn't find out Petitioner was claiming a work related injury until months later.

With respect to (C.) Did an accident occur that arose out of and in the course of Petitioner's employment with the Respondent, the Arbitrator finds as follows:

It is well established that the seminal ruling regarding repetitive trauma cases was established by the Supreme Court in Peoria County Belwood. As the court later explained in Durand, the standard of proof is the same as a single trauma case. Petitioner must simply prove that his work was a causative factor. In this case, Petitioner has satisfied his burden of proof on that issue. The accident date used should be the date when the injury manifested itself which is the date when both the fact of the injury and the causal relationship between the injury and Petitioner's employment would have become plainly apparent to a reasonable person. Here, Petitioner is alleging a repetitive trauma accident date of February 4, 2014, the date where he first sought treatment outside of Respondent's medical clinic. Petitioner credibly testified that he learned from Dr. Williams that he had carpal tunnel or tendonitis which is related to the job duties that he performed at Respondent. The evidence establishes that on or about that date Petitioner knew of his injury and knew that it might be related to his work.

With respect to Petitioner's job duties, the Arbitrator finds said testimony credible. Petitioner's Exhibit 2, Petitioner's Exhibit 3, Petitioner's Exhibit 4, Petitioner's Exhibit 5 and all of the medical records that were entered and admitted into evidence including the report of Respondent's Section 12 examiner ,Dr. Murphy, are all consistent. Also of note is the testimony of Petitioner's supervisor, Todd (who was present during the trial), that Petitioner's recitation of his job duties were accurate.

The Arbitrator finds Petitioner's testimony credible that his symptoms became worse to a point where he sought medical attention at the time he was working as a Heat Treat Operator. Petitioner testified that at the time he prepared the Employee Incident Report he did not know that it was a cumulative exposure at Respondent that contributed to his condition of ill-being. Petitioner testified that he always experienced problems with both of this hands, however, his left hand symptoms were predominant. Petitioner testified that when his left hand symptoms were getting better, after bracing, his right hand started to bother him. Based on all of this, the Arbitrator finds that Petitioner has met his burden of proof to show that he sustained accidental injuries manifesting on or about February 4, 2014.

With respect to (F.) Is Petitioner's condition of ill-being causally related to the injury, the Arbitrator finds as follows:

The Arbitrator finds Dr. Rhode's opinion on causation is more persuasive than the opinions conveyed by Dr. Murphy's. Although there appeared to be some confusion regarding timelines, Dr. Rhode credibly testified "...I was confused on what he was describing as far as his index exposure being in October of 2010 which...we established that, yeah, that was when he initially experienced symptomatology, and he had a period that he was off. His symptoms got better, and then he started performing a multitude of jobs including this one that he was a heat treat operator..." The doctor further added that "...Reviewing what this patient did on his job duties I believe are appropriate exposures, the types of tools that he used, the wrenches, the screwdrivers, the ratchets, hoists, sanders, files, pneumatic scribes, hand rollers, working on these sand molds, I've treated other patients with similar types of exposure where I felt it was causative. Also, I know that the IME physician talk about once the dose exposure is removed his symptoms persist. I would actually make the comment that early on when he develops the symptomatology in 2010 and he was laid off his symptomatology did improve again supportive that whether exposure he was being exposed to had a contributory component. We also know that as the disease process advances these changes become permanent and when you remove the exposure the symptomatology doesn't improve. So, again, I think that is actually supportive of the patient's causation." The doctor also added that "...it's even relative to the heat treat operator,...Again, he's showing a side dominance during that exposure where the patient felt although he was right-handed dominant most of his gross motor action was performed with his left which was his primary symptomatic side."

Dr. Rhode testified essentially that all of the job duties Petitioner did at Respondent required Petitioner to engage in vibratory exposure, repetitive exposure and forceful gripping and grasping. In contrast, Dr. Murphy testified that his causation opinion was based on Petitioner's job duties as a Heat Treat Operator and the video of same. Dr. Murphy stated, "After reviewing the video information and reviewing the records, it was my opinion that he did not do any significantly repetitive or forceful gripping activities at his or within his job duties that would have been consistent with an occupational exposure that would have brought about carpal tunnel syndrome." The doctor provided that he did not know what kind of tools Petitioner used prior to working as a Heat Treat Operator and he could not opine whether those tools required forceful gripping, grasping, or involved any vibration. Dr. Murphy only had specific knowledge of Petitioner's job duties as a Heat Treat Operator but did not know of any other job Petitioner held throughout his career with Respondent.

With respect to Petitioner's right hand, Dr. Rhode testified that during the initial visit, Petitioner had mild subjective complaints and mild physical exam findings which he was hopeful would respond to conservative care. The doctor indicated that he didn't explicitly relate the right hand to work at that time nor did he know when Petitioner began experiencing symptomatology on the right. After reviewing medical records during the deposition, the doctor agreed that the earliest documented findings regarding the right hand was April 1, 2014. Dr. Rhode testified that if the documentation was correct and Petitioner had no symptomatology through the last day worked and did not complain of same until April 1, 2014, Petitioner's right sided symptoms would not be related to his work. It is clear that Dr. Rhode's opinion was based on his reviewing of records shown to him during the deposition. However, the medical records submitted at trial suggest something different. On February 3, 2014, Petitioner returned to Respondent's medical clinic where he was examined. It is noted that Petitioner "...had sudden onset of pain, numbness and tingling, and weakness and had bad swelling last Thursday... He never experienced any of these symptoms before, except occasional numbness in the first 3 fingers in the right and left hands which started a few months ago. The left hand seems to have numbness in the 4th and 5th digits as well..." After performing an examination, Petitioner was assessed with 1st – 3rd fingers paresthesias, left greater than right, intermittent on the right. Also, on March 10, 2014, Petitioner saw Dr. John D. Mahoney at Midwest Orthopaedic. Dr. Mahoney noted Petitioner was reporting significant numbness,

tingling with both of his hands. Dr. Mahoney noted Petitioner was experiencing symptoms on the right but not as bad as the left. Lastly, Petitioner credibly testified that he was experiencing symptoms in both hands, although the symptoms in his left hand were greater than his right. All of which is consistent with the medical records, i.e., left greater than right.

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Based on all the above, the Arbitrator finds that Petitioner's bilateral carpal tunnel syndrome condition of ill-being is causally related to his accident claim of February 4, 2014.

With respect to (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, the Arbitrator finds as follows:

Having found the requisite causal relationship, the Arbitrator finds that the below medical expenses are reasonable and necessary. The medical bills are to be paid pursuant to Illinois Workers' Compensation fee schedule.

MEDICAL BILL LIST

NAME OF PROVIDER	ACCOUNT NUMBER	DATE OF SERVICE	TOTAL AMOUNT OF BILL
Proctor First Care	00002278-034	02/04/14-04/01/14	$599.00
Center for Pain Management and Rehabilitation	003410	02/20/14	$1,149.00
Midwest Orthopaedic Center	328841	03/10/14	$171.00
UnityPoint Health - Methodist	304894414	05/06/14	$96.00
Orland Park Orthopedics	WARJOS0002	06/04/14-06/08/15	$10,344.61
TOTAL			**$12,359.61**

With respect to (K.) What temporary benefits (TTD) are in dispute, the Arbitrator finds as follows:

Petitioner testified that the last day that he worked at Respondent was February 12, 2014. Dr. Williams provided Petitioner with restrictions of no use of his left hand on February 12, 2014. Petitioner's unrebutted testimony indicates Respondent did not accommodate that restriction. The medical records support that initially before June 2014, Dr. Williams either placed Petitioner on restrictive duty or off work. Subsequent to his treatment with Dr. Williams, Petitioner's current treater, Dr. Rhode, placed either modified restrictions on Petitioner or completely took him off work. Petitioner testified that from February 12, 2014, to the date of arbitration, June 17, 2015, he has not been back to work and has not collected any unemployment benefits. Petitioner has testified that he has received short term disability in the amount of $16,313.37.

Based on the above, the Arbitrator finds that Petitioner is entitled to TTD benefits from February 12, 2014 to June 17, 2015, for a period totaling 70 weeks. Pursuant to Section 8(j) of the Act, Respondent is entitled to a credit in the amount of $16,313.37 for short term disability paid.

With respect to (O.) Perspective Medical, the Arbitrator finds as follows:

Based on the Arbitrator' findings with respect to the disputed issues of accident and causal relationship, the Arbitrator finds that Respondent shall authorize the treatment regiment as prescribed by Dr. Rhode.

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STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify: Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

YARA RAMOS,

Petitioner,

16IWCC0191

vs.

NO: 14 WC 18717

MR. NATURAL SERVICES, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, permanent partial disability, and medical expenses. and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Findings of Fact and Conclusions of Law

1. Petitioner testified through an interpreter that previously she worked for Respondent beginning in March or April of 2013. She traveled between job sites. She did cleaning in the hallways and stairways "walking from residence to residence." Her job required that she lift items including vacuums which weigh 20 or 30 lbs and water buckets weighing 30 or 35 lbs. There was a lot to carry.

2. On February 25, 2014, Petitioner began working at 7 am; it was snowing pretty heavily and there was a lot of wind. While walking from entrance to entrance, she turned her head to avoid the wind and snow. At about 12:30 or 1 pm, she slipped on ice and fell on her back on which she was carrying a vacuum. She was also carrying a container with her supplies. She felt immediate pain in her back and her entire left side. She never had pain like that before. She got up but had difficulty walking because her left leg hurt. Her boss, Darren, just told her to take Ibuprofen. She continued working that day despite the pain.

3. Petitioner sought medical treatment one or two months later because she was trying to find a doctor who would treat her because she did not have insurance. She was finally able to get treatment on May 12, 2014 at Rehab Dynamics. Petitioner started physical therapy. After physical therapy she was referred to Dr. Vargas. He sent her for an MRI. Later, Petitioner saw Dr. Gerber, who continued physical therapy and instituted a 10-lb lifting restriction. She continued to work and continued to have pain. An injection was scheduled but was cancelled because she was not accompanied. The injection was not rescheduled because "insurance would not pay for it."

4. Dr. Gerber sent Petitioner to a spine specialist. Petitioner did not have any accidents after February 25, 2014. She was in pain every day. Currently she had 8/10 pain but it could get as bad as 10/10. She takes the pain medication Dr. Vargas prescribed. However, "the pain never goes away."

5. On cross examination, Petitioner testified no one was with her at the time of the accident because they work alone. She did not seek treatment the day of the accident because she did not have the resources or insurance. She continued to work and completed her work duties. She continued to work full duty through February and March. She had to continue working because she lives alone and has no resources. She tried to find help prior to May 12, 2014, but nobody would take her case because of her finances.

6. Petitioner agreed that she was suspended for two weeks on March 28, 2014 for misconduct. It was a few weeks after the suspension that she sought treatment from Rehab Dynamics. She agreed that thereafter she treated with physical therapy and chiropractic care at Rehab "for quite some time," despite her pretty constant pain. Respondent no longer offered her overtime and reduced her hours because they were not happy about her suspension.

7. Respondent provided Petitioner with an assistant because of her restrictions. In her current job she cleans a school; it does not involve much lifting. The vacuum is on wheels and she pushes it. Petitioner's doctor referred her to Dr. Gerber because Dr. Vargas would no longer treat her because of her lack of insurance. She no longer sees Dr. Gerber because he has done all he could for her.

8. Darren Storck was called to testify by Respondent for which he worked for 13 years. He was currently supervisor and supervised Petitioner. He recalled Petitioner calling him on February 25, 2014 reporting that she fell on some ice. He asked her if she wanted treatment and informed her of the protocol, that if she could walk she should come to the office and report the accident to the owner. He never told her she could not receive medical treatment.

9. Petitioner continued to work in the same job with the same hours. Petitioner never reported she could not continue working because of her back. She never asked for him to let her receive treatment.

10. On March 28, 2014, which was about a week after her suspension, Mr. Storck became aware that Petitioner was seeking medical treatment. Petitioner did not explain to him the reason for the delay in treatment. When Petitioner presented work restrictions, he honored them and allowed her numerous breaks and assigned her an assistant.

11. Mr. Stork also testified that on one occasion Petitioner was working within her restrictions and was assigned with an assistant to clean a vacant house. When the workers returned to Respondent's facility after that job, the witness and the owner saw Petitioner "with a 55-gallon bag of garbage over her shoulder, walking about 200 feet or so to a dumpster to dispose of this garbage." She did not seem to have any difficulty and "did it quite well, actually." The assistant was supposed to carry anything heavy.

12. On cross examination, Mr. Storck testified he was not sure Petitioner was always working within her restrictions. He did not remember the exact date of the garbage bag incident, but he thought it was probably in late May or early June, because he remembered it being warm outside, and that is traditionally the moving season. The bag contained "debris." He knew it did not contain dust from a vacuum because "the bags are emptied separately." He did not know how much the bag weighed.

13. The medical records indicated that on May 12, 2014, Petitioner presented to Dr. De Las Casas, D.C. complaining of 7/10 thoracic spine pain and 5/10 cervical and lumbar spine pain. She reported an accident in which she slipped on ice and fell on her back and left side. She continued working in pain. Symptoms had gotten worse since the accident. She was currently working modified duty.

14. Dr. De Las Casas diagnosed lumbar intervetebral disc syndrome with radiation, cervical intervetebral disc disorder, cervical radiculitis, and thoracic sprain/strain. Petitioner was restricted to 20 lbs lifting/pushing/pulling with limited bending/bending/twisting and the ability to frequently alternate between sitting/standing. Six sessions were anticipated.

15. By June 23, 2014, after apparently a total of 14 therapy sessions, Petitioner reported 35% improvement and 4/10 pain. The progress reports generally indicated that Petitioner had no new complaints and was progressing as expected. There were some notes that mentioned less pain or better movement.

16. On May 22, 2014, Petitioner presented to Dr. Vargas on referral from Dr. De Las Casas for evaluation of a history of mid and distal lower back axial pain with intermittent shooting lower extremity radiation. She reported the symptoms began after her accident. She felt an "immediate pop" in her mid and distal back and insidious back pain and intermittent shooting into the lower extremity. She continued working but experienced progressively worsening symptoms over the past several weeks. She reported current pain as 9-10/10 and 6/10 at its best.

17. After his examination, Dr. Vargas diagnosed lumbosacral discogenic radiculopathy and pain syndrome, lumbar facet pain syndrome, and paravertebral paraspinous mid back contusion. He prescribed additional physical therapy, medications, and an MRI.

18. An MRI taken on May 28th showed a 1.5 mm posterior central disc protrusion/early disc herniation at L5-S1 with associated central canal narrowing.

19. On June 12, 2014, Petitioner returned to Dr. Vargas who noted the MRI confirmed minimal pathology mostly at L5-S1. He noted that while the MRI findings were "not that impressive," Petitioner clinical presentation continued to be. Dr. Vargas recommended transforaminal epidural steroid injections and noted his opinion that his treatment was related to Petitioner's work accident.

20. On August 28, 2014, Petitioner presented to Dr. Patel on referral from Dr. Vargas. She reported an average of 5/10 pain. She had not noted any improvement with medication and physical therapy. Dr. Patel indicated that Petitioner's symptoms were consistent with the disc bulge at L5-S1, which was likely irritating the nerve root. Dr. Patel changed medication and recommended proceeding with the injections as recommended by Dr. Vargas.

21. On September 24, 2014, Petitioner presented to Dr. Gerber with complaints of pain and limited ROM in the law back with pain radiating into the left leg. She reported carrying a vacuum at work when she suddenly experienced low back and left leg pain. Dr. Gerber noted spasm and inflammation in the lumbar paraspinal musculature bilaterally and edema "around the site of the injury." The acute injury was "somewhat threatening normal function of the lower back," so medical attention was warranted. He administered physical therapy.

22. On October 16, 2014, Petitioner presented to Dr. Kiang for an EMG/NCV prescribed by Dr. Gerber. She reported current low back and left leg pain of 6/10. She was not improving with physical therapy so an MRI was taken which Dr. Kiang noted showed a diffuse disc bulge at L5-S1 with canal narrowing but no significant stenosis. The NCV/EMG results were consistent with acute mild radiculopathy likely due to the disc protrusion at L5-S1.

23. On December 6, 2014, Petitioner apparently had the last of what seems to be 21 additional physical therapy sessions. Petitioner reported persistent pain. Dr. Gerber also noted lumbar tenderness, diminished functional strength, and restricted ROM. She was discharged from treatment with no further explanation.

24. Dr. Bernstein examined Petitioner for an evaluation pursuant to Section 12 of the Act. He indicated his medical assistant acted as interpreter during the examination. Petitioner reported slipping on ice while carrying a vacuum on her back and falling on her left side in February of 2014. She continued working and did not see a doctor until April. Petitioner stated she was worried about injections and did not proceed with them. She was currently working restricted duty, which she found beneficial. Petitioner reported left low back pain radiation into the left leg, but Dr. Bernstein noted that the distribution of radiating pain was not in a dermatomal distribution.

16IWCC0191

25. Dr. Bernstein noted the MRI showed no evidence of a herniation or nerve compression. He felt it showed minimal, age-appropriate degenerative changes at L5-S1. Petitioner was 31 at the time of the accident. Dr. Bernstein's examination appears to have been normal. He concluded that the objective findings did not support Petitioner's subjective complaints. At most she suffered strains and contusions, was at maximum medical improvement, did not need any additional treatment, and could return to work without restrictions. In a later addendum report, Dr. Bernstein did not change his opinions after receiving subsequent medical records.

The Arbitrator found that Petitioner sustained her burden of proving that her work accident caused her current condition of ill-being. He awarded her all medical expenses incurred to date, amounting to $31,139.03, and 50 weeks of permanent partial disability benefits representing loss of 10% of the person as a whole. The Commission agrees that Petitioner did prove sustained an injury as a result of her work accident. However, the Commission concludes that she suffered only strains and contusions, as opined by Dr. Bernstein and modifies the Decision of the Arbitrator accordingly.

The Commission notes that Petitioner did not seek treatment for her condition until two and a half months after the accident and only after she was disciplined by Respondent for misconduct. In addition, one of Petitioner's treating doctors, Dr. Vargas, indicated in his second and final treatment note that the MRI findings were "minimal" and "not that impressive" and indicated he was basing recommended treatment based on her subjective clinical presentation and not objective pathology. The Commission infers from his treatment note that Dr. Vargas basically agreed with Dr. Bernstein's assessment that Petitioner's subjective complaints did not correspond to the objective findings. It is also interesting to note that Petitioner has not sought any additional prospective treatment after she was released by Dr. Gerber even though she continues to complain of persistent symptoms.

The Commission is persuaded by the opinions of Dr. Bernstein. We conclude that Petitioner sustained relatively minor injuries as a result of her February 24, 2014 work accident, she was at maximum medical improvement at the time of Dr. Bernstein's examination, and was able to return to her previous job without restrictions. Therefore, the Commission modifies the Decision of the Arbitrator to vacate the award of medical expenses incurred after July 14, 2014, the date of Dr. Bernstein's medical examination and report.

In addition, we note that Petitioner currently works in a job similar to that she performed with Respondent. She seems to have magnified the magnitude of her symptoms. Based on our analysis above, the Commission finds that the award of the loss of the use 10% of the person as a whole is excessive, and modifies the permanent partial disability award to the loss of the use of 5% of the person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $220.00 per week for a period of 25 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of the use of 5% of the person as a whole.

16IWCC0191

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay for medical expenses incurred through July 14, 2014 pursuant §8(a) of the Act subject to the applicable medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,000.00. The party commencing the proceeding for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: MAR 16 2016

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-2/24/16
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0191

RAMOS, YARA
Employee/Petitioner

Case# 14WC018717

MR NATURAL SERVICES INC
Employer/Respondent

On 7/1/2015, 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 0.11% 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:

0159 FRANCIS J DISCIPIO LAW OFFICE
JACK W BEECHY
1200 HARGER RD SUITE 500
OAK BROOK, IL 60521

0507 RUSIN & MACIOROWSKI LTD
JASON GLUSKIN
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

16IWCC0191

STATE OF ILLINOIS)
)SS.
COUNTY OF Lake)

- ☐ 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

YARA RAMOS
Employee/Petitioner

v.

MR. NATURAL SERVICES, INC.
Employer/Respondent

Case # 14 WC 18717

Consolidated cases: _____

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 **ANDROS**, Arbitrator of the Commission, in the city of **WAUKEGAN**, on **5/27/15**. 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 2/25/2014, 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 $18,200.00; the average weekly wage was $340.00.

On the date of accident, Petitioner was 31 years of age, *single* with 0 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 $0 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $0.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $31,139.03, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $220.00/week for 50 weeks, because the injuries sustained caused the 10% loss of the person as a whole, as provided in Section 8(d)2 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.

#01 George J. Bichon
Signature of Arbitrator

06-29-2015
Date

JUL 1 - 2015

FINDINGS OF FACT 14 WC 18717

Petitioner was employed by Mr. Natural Services, Inc. when in the course of her employment on February 25, 2014 she slipped and fell injuring her back requiring medical care and treatment. Petitioner testified that her job duties include cleaning hallways and stairways of apartments and condominium units. (Trial Transcript, Pg. 9) Petitioner has testified that as she was walking from one apartment building entrance to another in an apartment complex she slipped on fell on a patch of ice covered by snow on the sidewalk. (Trial Transcript. Pg. 11-12) Petitioner stated that it was a blustery, snowy day and she was forced to keep her head turned to the side in order to keep her face out of the wind. (Id.) Ms. Ramos stated she fell backwards and landed on her back and used her left hand to help stabilize herself. Furthermore, Ms. Ramos stated that she was wearing a vacuum similar to a backpack on her back and was carrying cleaning supplies when she fell. Ms. Ramos was immediately in pain after she fell. (TT, Pg. 12-13) She stated she felt pain all along her left side and primarily in her back and her left leg; so much so that she had to limp on her left side. Ms. Ramos never had pain similar to what she experienced following the fall. (TT, Pg. 12-13)

Immediately after the fall Ms. Ramos got up on her own and limped into the next building she was required to clean. Upon entering she called her Supervisor, Darren. Darren told her that she needed to take Ibuprofen. (TT, Pg. 14) Ms. Ramos continued to clean the remaining two units on her job list for the day with pain. (TT, Pg. 15) Despite being in continuing pain Ms. Ramos did not get any treatment for her injuries. Although, Petitioner did state that she had sought out treatment between February 25, 2014 and May 12, 2014, but was unsuccessful due to her limited knowledge of the area, her lack of insurance, and her lack of money. (TT, Pg. 15 & 32)

On March 28, 2014 Petitioner was suspended for two weeks without pay for laying on a couch and making hand gestures while a co-worker took photos. (TT. Pg. 48-50) This lowered Petitioners income significantly. She returned to work without incident on April16, 2014 after serving her suspension (TT, Pg. 33)

On May 12, 2014 Petitioner sought treatment with Dr. De Las Casas at Rehab Dynamix. petitioner stated that she was injured at work and that she had pain. She told Dr. De Las Casas that she has continued to work but has also continued to have pain. Petitioner told Dr. De Las Casas that she had trouble with her job duties since the accident. (Petitioner Exhibit 1, 5/12/14) She presented with back pain, neck pain and pain along her left side from the work injury. (PX1, 5/12/14 & TT, Pg. 16) Petitioner was prescribed and attended physical therapy and also given a weight restriction of lifting no more than 20 pounds. (PX1, PX1, 5/13,5/14,5/15,5/16)

On May 19, 2014 she followed-up with Dr. De Las Casas and noted improvement in her pain but was still having some pain in her back, on her left side, and down her left leg. Dr. De Las Casas prescribed more physical therapy and recommended she follow-up with a Pain Management Physician: Chicago Pain and Orthopedic. (PX1, 5/19/14) Petitioner continued physical therapy with Dr. De Las Casas on May 22, 23, 28, 29; June 2, 4, 5, 6, 9; seeking treatment from Dr. Vargas as well. (PX1) On June 23, 2014 Petitioner had her final visit with Dr. De Las Casas wherein she was released to Dr. Vargas' care. (PX1, 6/23/14)

Petitioner stated that she had her first visit with Dr. Vargas at Chicago Pain and Orthopedic on May 22, 2014. Petitioner presented to Dr. Vargas with lower back pain and lower extremity shooting pain. (PX2, 5/22/14 & TT, Pg. 17) Dr. Vargas stated that he believed that she had lumbo-sacral discogenic radiculopathy, pain syndrome, lumbar facet pain syndrome, and a back contusion. Dr. Vargas stated that the symptoms she was being treated for are directly related to her injury. He also stated that her course of treatment has been reasonable and is necessary. Dr. Vargas recommended an MRI and continued the weight restrictions given by Dr. De Las Casas. (PX2, 5/22/14)

On May 27, 2014 Petitioner received an MRI at Advantage MRI. (PX3 & TT, Pg.18) Her MRI revealed a 1.5 mm posterior disc protrusion/early herniation at L5-S1 with associated posterior central canal narrowing. (PX3)

Petitioner then followed up at Chicago Pain and Orthopedic on June 12, 2014. (PX2, 6/12/14 & TT, Pg. 18) Dr. Vargas noted that Petitioner had a mild disc protrusion but due to Ms. Ramos' continuing pain came to the conclusion that her workplace injury was likely the cause of her pain. Dr. Vargas prescribed a bilateral L5-S1 transforaminal epidural steroid injection and to continue weight restrictions. (PX2, 6/12/14) Petitioner was unable to receive the injection because she had traveled to the doctor's office alone. (TT, Pg. 22-23) Petitioner had a final follow-up at Chicago Pain and Orthopedic on August 28, 2014. Petitioner presented to Dr. Patel with continuing back pain and left sided pain with shooting pain to extremities. Petitioner was diagnosed with a herniated nucleus pulposus, lumbosacral radiculitis and cervical radiculitis. She was given more medication for her pain and an injection was again recommended. (PX2, 8/28/14) Petitioner was again not able to receive the injection because it was denied by insurance. (TT, Pg. 23)

Petitioner followed up with Dr. Gerber at Fullerton Drake Medical Center on September 24, 2014. (PX4 & TT, Pg. 19) Petitioner stated that she was required to seek an alternate doctor because Dr. Vargas had refused to continue treating her due to her lack of insurance. (TT, Pg. 38) Petitioner presented to Dr. Gerber at Fullerton Drake with pain in her low back and down her left leg due to a work place injury in February. Dr. Gerber noted that she had continuing pain since the date of the accident. (PX4, 9/24/14)

Dr. Gerber prescribed physical therapy, a series of medications to help alleviate her symptoms, and placed Ms. Ramos on work restrictions. (PX4, 9/24/14 & PX6 & PX7) Petitioner attended physical therapy for 20 visits through December 6, 2014 when she was discharged at Maximum Medical Improvement. (PX4) Until her discharge on December 6, Dr. Gerber noted continuing improvement in Petitioner's symptoms from physical therapy, although not completely diminished. (PX4) On October 13, 2014 Dr. Gerber recommended Petitioner obtain an EMG in order to address her continued pain and prescribed more medication to further help alleviate her continuing symptoms. (PX4, 10/13/14 & PX7) Petitioner's medication prescription was authorized and refilled by Dr. Gerber again on December 2, 2014. (PX7)

On October 16, 2014 Petitioner presented to Dr. Kiang at Spine MD pursuant to a recommendation from Dr. Gerber in order to obtain an EMG to assess her symptoms. Dr. Kiang performed the test and based upon petitioner's results diagnosed her with acute mild L5 radiculopathy likely due to her L5-S1 disc bulge. Dr. Kiang recommended continuing physical therapy with a gradual transition into work hardening in addition to her medication. (PX5)

Petitioner testified that she has continuing daily pain in her back and entire left side and has continuing pain at work, where she is employed to carry out janitorial services. (TT, Pg. 25-27) Petitioner stated that this pain is at an 8 out of 10, with 10 being the worst pain, on a daily basis. She also stated that her pain can flare up to a 10 out of 10, especially following work. (TT, Pg. 24-25)

Petitioner has stated that she slipped and fell on ice while walking with her vacuum on her back and cleaning supplies in her hand from one apartment entrance to the next in order that she may clean that next apartment to complete her job duties. Petitioner stated that as a part of her job duties she is required to clean the entrances and stairways of apartment buildings, condos, and houses. Petitioner stated that as a facet of the job she is required to carry with her all of her cleaning supplies. (TT, Pg. 9) One item that she was required to carry was a vacuum that weighed around twenty to thirty pounds. (TT, Pg. 9) Furthermore, Petitioner stated that she had to walk from apartment to apartment in order to clean the entryways and that she needed to carry all of her supplies with her. (TT, Pg. 11) Petitioner stated that a part of her job was vacuuming the entrances and stairs, thus she would need a vacuum to accomplish this. The vacuum utilized by employees at Mr. Natural Services, Inc. was one described by Petitioner to be worn on your back as if it were a back pack. (TT, Pg. 12)

Petitioner's supervisor Darren Storck also testified that Petitioner's job duties include cleaning the common halls, common areas, buildings, and vacant homes. (TT, Pg. 46) In order to clean all of the common areas Ms. Ramos would have to walk to each entranceway. As Ms. Ramos testified she had cleaned two entranceways, and still had two more entranceways to clean at the time of her fall. (TT, Pg. 15)

There is a risk inherent in having to walk from apartment to apartment with all of her cleaning supplies in her hands and on her back. It is intensified by the Chicago winter weather. On the day of the accident Petitioner was required to clean 4 entranceways, she had cleaned two at the time of the fall and was walking over to her third. Both Petitioner and Darren Storck stated that Ms. Ramos called Darren immediately after the fall to inform him of the accident. (TT, Pg. 14, 45) Wherefore, The Arbitator finds a a matter of law the Petitioner sustained an accident in the course and scope of her employment as alleged in the case at bar. Respondent witness' facts are supportive of the accident facts and its basis in law.

Petitioner has testified and Petitioner's exhibits have shown that her condition is causally related to the workplace injuries on February 25, 2014. "If a causal connection between the work activity and the injury is shown by competent testimony, no "limitation" or "exception" to compensation can be imposed to defeat a right to recovery." Twice Over Clean, Inc. v. Indus. Comm'n, 214 Ill. 2d 403 at 413 (2005) Petitioner's testimony is competent, and has not been refuted in any way. Petitioner testified that she has continuing pain in her back and left side extremities to this day. (TT, Pg. 24) She testified she has pain in her back going down her left side. Petitioner's current pain is consistent with the pain she had since her initial complaint following the fall. (TT, Pg. 13)

Petitioner presented to Dr. De Las Casas with complaints in her back and along her left side on May 12, 2014 (PX1) Petitioner then continued to present with pain in her back and in her left extremities with Dr. Vargas (PX2) Once Petitioner was no longer accepted as a patient by Dr. Vargas she presented to Dr. Gerber with pain in the same location she felt as the day of the fall. (PX4) During her testimony before the court petitioner claimed that her pain was 8, on a scale of 1-10 with 10 being the worst, in her back and down along her left side. (TT, Pg. 24) She also stated that the pain would flare up at times and would be 10 out of 10. Petitioner stated that her pain would be a 10 out of 10 when she finishes work. (TT, Pg. 25, 27) Petitioner has testified that she did not have any other accidents between February 25, 2014 and when she first sought treatment on May 12, 2014. (TT, Pg. 23-24) Petitioner has stated that she attempted to find a provider prior to May 12, 2014 but was unfamiliar with the area and did not have insurance or enough income to pay doctors bills. (TT, Pg. 15, 31) Petitioner also stated she was not aware of any free clinics or where Condell Medical Center was located. (TT, Pg. 39)

Petitioner sought treatment when she could not deal with her pain any longer and when she found a doctor that would accept a patient without insurance. Petitioner has had the same pain in her back and down her left side since the day of the accident in February 2014, and has stated that her pain affects her when she works and the pain is at its worst when she finishes working.

Wherefore, the Arbitrator finds as a matter of law the Petitioner at bar has proven by way of her testimony and by the records of her treating physicians that a causal connection exists between the workplace accident alleged and her current condition of ill-being.

Petitioner has testified to care thus the necessity and reasonableness of her medical visits and Respondent shall be required to pay all appropriate charges which total $31,139.03.
Petitioner testified that her pain due to the fall required that she seek medical treatment. Dr. De Las Casas at Rehab Dynamix instructed Petitioner to attend physical therapy to help relieve her symptoms. Dr. De Las Casas also instructed Petitioner to follow up with a pain management doctor in order to further assess her symptoms. (PX1, 5/12/14) After one week of physical therapy Petitioner noted some improvements, thus Dr. De Las Casas instructed her to continue attending therapy. (PX1, 5/19/2014) Petitioner continued to have mild improvements while attending physical therapy, but was eventually released to Dr. Vargas', at Chicago Pain and Orthopedic, care in order that he may take control of her treatment (PX1, 6/23/14)

At Chicago Pain Petitioner had two visits with Dr. Vargas and one with Dr. Patel. Dr. Vargas came to the conclusion that her symptoms are directly related to her workplace incident and that the treatment up to that point had been reasonable and necessary. (PX2, 5/22/14) In order to fully assess the Petitioner Dr. Vargas required an MRI, which was obtained by Ms. Ramos on May 27, 2014. (PX3) Ms. Ramos then was required to have a follow-up appointment with Dr. Vargas to discuss her MRI results. At the June 12 appointment Dr. Vargas again noted reasonableness and necessity of the treatment and recommended Ms. Ramos obtain injections to help her with her pain. Petitioner was unable to receive an injection on that day. (PX2 6/12/14 & TT, Pg. 18, 22-23) Petitioner was still in pain at her third visit to Chicago Pain with Dr. Patel; who also recommended an injection. (PX2, 8/28/14) Petitioner stated she was unable to obtain the injection because insurance would not approve of it and Ms. Ramos remained in pain. (TT, Pg. 23) Petitioner then stated Chicago Pain and Orthopedics refused to treat her any longer because she was uninsured. (TT, Pg. 38)

Dr. Gerber at Fullerton Drake Medical Center then took over treatment of Ms. Ramos. Dr. Gerber instructed Ms. Ramos to take anti-inflammatories and analgesic medicine to help her symptoms and also prescribed physical therapy. (PX4, PX6, PX7) Throughout Petitioners treatment at Fullerton Drake Dr. Gerber continuously noted that Petitioner was improving at physical therapy, but still had some pain in her back and along her left side. (PX4) Petitioner also testified that the physical therapy did help relieve her pain. (TT, Pg 22) Due to the physical therapy not entirely relieving her symptoms Dr. Gerber wished to further assess her radicular symptoms. (PX4, 10/13/2014) Petitioner, following the instruction of Dr. Gerber, followed up with Dr. Kiang at Spine MD for a EMG. (PX5) Her EMG resulted in a diagnosis of acute mild L5 radicular symptoms. Dr. Kiang instructed Ms. Ramos to continue physical therapy. (PX5)

Petitioner is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of a claimant's injury. City of Chicago v. Illinois Workers Comp. Comm'n, 409 Ill. App. 3d 258 at 267 (1st Dist. 2011) All of the above stated treatment was necessary and reasonable as stated by her treating physicians. Petitioner's doctors have a better insight into the care that Petitioner required and understood the cause of the injury to a better degree than the Section 12 doctor. The Arbitrator finds as a matter of law that the treatment to the Petitioner in the case at bar was necessary and reasonable pursuant to 820 ILCS 305/8(a).

The Respondent's Exhibit 1 is the copy of the report from their doctor pursuant to Section 12. Dr. Bernstein states that Ms. Ramos at most suffered from strains and contusions and placed her at MMI on July 31, 2014. However, Respondents did not make any payment on any treatment rendered prior to the July 31, 2014 consultation. Furthermore, following July 31, 2014, Petitioner's unrefuted testimony stated that she was in continuing pain in the same areas she had been complaining of since the fall. Petitioner's back pain caused Petitioner to seek out treatment from Dr. Gerber. Subsequently, Dr. Bernstein issued an addendum to his report stating that Ms. Ramos did not need any further treatment following her visit on July 31, and made the report without seeing the patient and without reference to which medical records he had seen in making his determination. (emphasis added) The Arbitrator finds the greater weight of the evidence is given to Petitioner's treating physicians and unrefuted testimony. Thus, the Arbitrator finds as a matter of law in the case at bar the treatment sustained by Petitioner was necessary and reasonable.

Wherefore, the Respondent is required to pay to the Petitioner and his attorney at bar all medical expenses in the amount of $31,139.03, according to the fee schedule.

Petitioner injured her back in the course of her employment. At the age of 31, Ms. Ramos sustained a severe and permanent injury as a result of this accident. She was diagnosed with a herniated nucleus pulposus a 1.5mm disc protrusion at L5-S1, and with acute mild L5 radiculopathy due to her disc bulge. As a result of the injury Petitioner has stated that she has continuing daily pain in her back and down along her left side. (TT, Pg. 24-25)

Based upon the totality of the evidence, the Arbitrator finds as a matter of law the Petitioner herein is entitled to receive permanent partial disability to the extent of 10% or fifty weeks thereunder under section 8(d)2 of the Act. Said Award is payable to Petitioner and her attorney.

The Arbitrator finds probative the following case precedent:

See, Danek v. Cook County, 05 WC 00432, Commission awarded 10% man as a whole for a bulging lumbar disc.; See, Diaz v. Dr. Pepper Snapple Group, 08 WC 47026, Commission awarded 12.5% man as a whole for a bulging lumbar disc treated without surgery.; See, Reding v. Timmerman Milk Service, Inc, 07 WC 34734, Commission awarded 10% man as a whole for a herniated lumbar disc treated without surgery.; See, Lococo v. A Preferred Paving, 09 WC 4727, Commission awarded 10% man as a whole for a lumbar strain.; See, Luviano v. Greenbrier Rail Service, 10 WC 2432, Commission awarded 10% man as a whole for a bulging lumbar disc treated without surgery.)

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse: Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify:	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRONSON BENJAMIN,

Petitioner,

16IWCC0192

vs. NO: 14 WC 36001

T.H. RYAN CARTAGE, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, and temporary total disability, and being advised of the facts and law, reverses the Decision of the Arbitrator, finds Petitioner did not sustain his burden of proving a compensable accident, and denies compensation.

Findings of Fact and Conclusions of Law

1. Petitioner testified he worked for Respondent for about nine years as a "diesel technician." As part of his job he has to clock in and out. Respondent provides a uniform which consists of boots, pants, shirts, T-shirts, socks, and underwear. After their shifts, employees go to the locker room, change back to their street clothes, and put their work clothes into bins to be laundered; these actions occurred after employees clock out.

2. On October 7, 2014, Petitioner completed his shift and changed into his street clothes in the locker room. A lunchroom is adjacent to the locker room. Petitioner clocked out and was on his way to put the work clothes in the bin. He put the pants on a table in the lunch room to go through the pockets to make sure he had all his personal possessions while putting the rest of the clothes in the bins. A coworker took exception to the pants being on a lunch table and loudly and profanely expressed his objection.

3. The door between the rooms was open and Petitioner heard the coworker's complaints. He was on a cell phone call at the time. Petitioner entered the lunch room, retrieved his pants, and he and the coworker had an unpleasant conversation. The coworker got close to him and Petitioner backed up into the locker room. The co-worker slammed shut the door between the rooms. Petitioner placed the pants in the bin, put the padlock on his locker, and tried to reenter the lunch room. He was moving fast and was still on his cell phone. He turned the doorknob and slammed into the door thinking it was unlocked. However, it was locked and he twisted his "shoulder, elbow banged up some things," and "bounced off the door." He noticed a sharp pain in his right elbow. He had never injured that elbow previously.

4. The next day, Petitioner reported the incident to his supervisor and tried to put on his uniform but he was unable to get his right arm into the shirt. Respondent directed him to U.S. Healthworks.

5. That day he also saw his general practitioner, Dr. Alexandre. Petitioner continued to see Dr. Alexandre for his injuries until she referred him to specialist, Dr. Evans, whom he first saw on November 4, 2014. He eventually performed surgery on Petitioner's right elbow on March 11, 2015.

6. Petitioner was able to work light duty for a period, but Respondent did not have any such jobs available. He was released to full duty work as of May 20, 2015. Petitioner continues to treat with Dr. Evans and he wants Petitioner to return in about a month to see how he was doing with work. Petitioner was to begin physical therapy for his elbow the day of arbitration. He also hurt his right knee in the accident.

7. On cross examination, Petitioner testified he was on a personal call at the time of the accident. He was holding the cell phone with his left hand so he could reach with the right. He banged his right elbow and right knee on the door. He also complained of right shoulder and neck pain after the accident "but all that stuff kind of went away." Petitioner agreed that he had a previous injury to his right knee and had microfracture surgery in around 2012. He also agreed that he was previously diagnosed with early arthritis in the right knee. He was not currently receiving treatment for his right knee.

8. On redirect examination, Petitioner testified the accident occurred immediately after he clocked out. On questioning by the Arbitrator, Petitioner testified the bins are not in the locker room, but the shop area. Different articles of clothing were put in different bins. One travels from the locker room through the lunch room to get to the bins.

9. On re-cross examination, Petitioner testified he reentered the locker room after depositing his work clothes to make sure he did not leave any personal possessions.

16IWCC0192

10. The medical records indicate that October 8, 2014, Petitioner presented to Dr. Alexandre and reported hitting his right elbow at work at about 5:45 pm the previous day. It was hurting when he awoke. Dr. Alexandre ordered an x-ray, which was normal. Four days later Petitioner returned for a referral for an MRI for his neck, shoulder, and lower back.

11. Also on October 8, 2014, Petitioner presented to Dr. Peoples at U.S. Healthworks reporting that the previous day at work he hit a door with full force but it was locked. His chief complaint was pain in the right wrist and his secondary complaint was pain in the right elbow. Dr. Peoples prescribed Naproxen and released Petitioner to work without restrictions the next day. Petitioner was to return on October 15th if the pain did not resolve. Later that day, Petitioner returned to supplement the medical record reporting an injury to his right knee and low back. Four days later, Petitioner returned to supplement the medical record reporting an injury to his neck.

12. On November 4, 2014, Petitioner presented to Dr. Evans on referral from Dr. Alexandre. He reported injuring his right elbow and right knee when he walked into a closed door at work on October 7th. He initially also had neck and shoulder pain, but he felt those were improving. Dr. Evans noted x-rays showed mild to moderate arthritis in the knee and a large enthesophyte in the right elbow but no significant degeneration. Dr. Evans diagnosed right elbow epicondylitis and triceps tendinitis. He prescribed physical therapy and anti-inflammatories for both Petitioner's knee and elbow.

13. On December 16, 2014, Petitioner reported little progress after starting physical therapy. Dr. Evans continued physical therapy and administered injections in the knee and elbow.

14. On January 27, 2015, Petitioner reported complete relief after the injection for about a week and a half, but the pain slowly started to come back. He currently had less complaints regarding the knee that the elbow. Petitioner wanted to proceed with surgery. On March 11, 2015, Dr. Evans performed right elbow lateral epicondylosis resection for lateral epicondylitis.

The Commission does not agree with the assertion of Respondent that the accident did not occur in the course of Petitioner's employment. Even though he had clocked out immediately prior to the incident, he was still on Respondent's premises and performing an activity mandated by Respondent as a part of his employment.

However, the Commission finds that the incident did not arise out of Petitioner's employment. The Commission concludes the simple act of attempting to open and pass through a door is an activity which members of the general public perform every day and any risk associated with attempting to open the door with such speed and force was purely personal in nature. In addition, at the time of the incident Petitioner was on a personal cell phone call and hurrying to leave his place of employment. These activities simultaneously increased the relative personal nature of Petitioner's risk and reduced his relative employment-related risk.

16IWCC0192

Therefore, the Commission reverses the Decision of the Arbitrator, finds Petitioner did not sustain his burden of proving a compensable accident, and denies compensation. Because the Commission finds that Petitioner did not prove a compensable accident, all other issues are moot.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 22, 2015 is hereby reversed and compensation is denied.

The party commencing the proceeding for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: MAR 16 2016

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-2/24/16
46

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ruth Ann Heberlein,
Petitioner,

vs.

NO: 02 WC 49523
02 WC 49524

Homecare Medical Equipment,
Respondent.

ORDER

This cause comes before the Commission on Respondent's Motion to Vacate the Arbitrator's decision and Petitioner's Motion for Additional Compensation and Attorneys' Fees. Due notice having been given, this matter came on for hearing before the Illinois Workers' Compensation Commission on August 6, 2015 and October 15, 2015 in Springfield, Illinois and on December 21, 2015 in Chicago, Illinois.

In order to rule on the above stated motions, the Commission believes it is imperative to set forth the purported events that transpired in relationship to these claims. The pertinent facts are as follows:

On September 30, 1999 and October 1, 1999, Petitioner alleges she sustained accidental injuries arising out of and in the course of her employment with Respondent, Homecare Medical Equipment. Respondent, Homecare Medical Equipment, was a subsidiary of Integrated Health Services, Inc. or Rotech Medical Corporation. On February 2, 2000, Rotech Medical Corporation and its subsidiaries filed for Chapter 11 Bankruptcy allowing for a reorganization of said corporation. On June 23, 2000, the United States Bankruptcy Court issued an Order granting Respondent's Motion to establish a last date for filing of proofs of claim and approving the procedures for service and notice in connection thereto. On February 13, 2002, the United States Bankruptcy Court discharged all debts and potential debts against Rotech Medical Corporation and its subsidiaries. On September 24, 2002, Petitioner filed Applications for Adjustment of Claims (AAC) for the two above noted claims. On the alleged dates of accident, Respondent was insured by Travelers Insurance. At that time of the filing of the AAC, Respondent was

physically located at 1026 Maine Street Quincy, Illinois. On September 26, 2002, November 5, 2004 and July 6, 2005 the Commission sent status hearing notices to Respondent at the 1026 Maine Street address. On November 5, 2004, the Commission sent a notice of consolidation to Respondent. On February 8, 2005, the Commission sent a notice of case dismissal to Respondent. Both mailings were sent to the 1026 Maine Street address. On November 1, 2004, Respondent moved to 2439 Broadway, Quincy, Illinois. Subsequent to September 24, 2002, said claims were dismissed for want of prosecution and were re-instated. On February 18, 2009, the Arbitrator assigned to said claims issued an Order setting the date for trial on May 20, 2009 and ordering Petitioner to provide a copy of the order to Respondent. On May 20, 2009, an Arbitration hearing took place. Petitioner's attorney stated that they sent notices of said hearing to Respondent at the 1026 Maine Street address four days before the trial date. The Arbitration hearing proceeded ex-parte. On June 11, 2009, the Arbitrator issued a decision. Neither party appealed the decision and said decision was mailed to the parties as a final decision of the Commission. However, a Commission representative testified that the Commission no longer has in its possession proof of the mailing.

The following facts are disputed: Petitioner's attorney claims that the Commission sent the June 11, 2009 arbitration decision to the 1026 Maine Street address. Petitioner's attorney further claims that on October 29, 2012 Petitioner sent Respondent a certified letter, return receipt requested, demanding payment of the award and enclosing a copy of the award to the 2439 Broadway address. Petitioner's attorney further contends that the return receipt was signed by Sue Martin, Respondent's location manager. Ms. Martin denies having received such a letter and Steven Burres, the assistant general counsel for Respondent, states Respondent has no record of receiving said letter. Respondent asserts it never received any notice of the claim prior to the May 20, 2009 hearing and states it did not file an appearance at any time before January 12, 2015. Petitioner is now seeking additional compensation and attorneys' fees for the nonpayment of the Illinois Workers' Compensation award.

The Commission further believes that it is important to set forth the Bankruptcy laws in effect at the time of the above noted events. They are as follows:

> 11 USC, §1141(d) provides, in part, that, "the confirmation of a plan... discharges the debtor from any debt that arose before the date of such confirmation...whether or not...a proof of the claim based on such debt is filed..."

Furthermore,

Section 524 (a) of the Bankruptcy Code provides, in part, that:

> " A discharge...voids any judgment at any time obtained, to the extent that such judgment is a determination of the personal liability

> of the debtor with respect to any debt discharge under Section....1141... [and] operates as an injunction against the commencement or continuation of an action, the employment of process, or an act, to collect, recover or offset any such debt as a personal liability of the debtor..."

Moreover, the February 13, 2002 confirmation order specifically provides that:

> "All equity interests of any kind, nature or description whatsoever against or in Rotech, debtors of any of their assets or properties... Except as provided in the Plan and this Conformation Order, on the Effective Date, all existing Claims against Equity Interests in the Rotech Debtors, shall be, and shall be deemed to be, discharged, satisfied, released and terminated in full, and all holders of Claims and Equity Interest shall be precluded and enjoined form asserting against the Reorganized Rotech Debtors and New Rotech, their successors and assigns, or any of the respective assets or properties, any other or further Claim or Equity Interest based upon any act or omission, transaction, or other activity of any kind or nature that occurred prior to the Effective Date, whether nor not such holder has filed a proof of claim or proof of equity interest and whether or not the facts or legal basis therefore were known or existed prior to the Effective Date."
> +

Based on the above, the Commission finds that prior to the filing of the 2000 Chapter 11 Bankruptcy, Petitioner claims she sustained two worker compensation accidents. The Commission having reviewed the language contained in the United States Bankruptcy Statute along with the language contained in the February 13, 2002 confirmation Order finds that said Order operated as an injunction against the continuation of Petitioner's workers' compensation claims. The Commission further finds that regardless of the United States Bankruptcy Order, Petitioner's claims proceeded to trial and a decision was issued by an Illinois Workers' Compensation arbitrator on June 11, 2009. The Commission finds while Respondent has requested that the Commission vacate the June 11, 2009 Arbitration decision and void the same, that Illinois Workers' Compensation Act does not provide the Commission with the jurisdiction to void and vacate the Arbitrator's decision.

In terms of the Petitioner's Petition for Additional Compensation and Attorneys' Fees, the Commission holds that the Petitioner must prove that proper notice of the May 20, 2009 ex-parte Arbitration hearing was provided to Respondent in order to establish the Commission's jurisdiction. Even assuming arguendo that proper notice was provided and there is a legitimate June 11, 2009 Arbitration decision, the Commission would find that it does not have jurisdiction under the Act to assess the enforceability of said decision in relationship to the United States Bankruptcy Act and as such it will not address Petitioner's Petition for Additional Compensation and Attorneys' fees under the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that it does not possess the requisite jurisdiction to Void and Vacate the June 11, 2009 Arbitration decision and as such Respondent's motion is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that it does not possess the requisite jurisdiction to assess the enforceability of the June 11, 2009 decision in relationship to the United States Bankruptcy Act and as such it will not address Petitioner's Petition for Additional Compensation and Attorneys' fees under the Act.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 4 - 2016

Mario Basurto

MB/jm

R: 8/6/15, 10/15/15
& 12/21/15

David L. Gore

43

Stephen Mathis

STATE OF ILLINOIS)	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF COOK)	☒ Reverse Causal connection	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BERNARD STALLWORTH,

Petitioner,

vs. NO: 03 WC 35568

CITY OF CHICAGO,

16IWCC0148

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, temporary total disability, and nature and extent, and being advised of the facts and law, reverses on the issue of causation, modifies the Decision of the Arbitrator as stated below, and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission finds that Petitioner is not entitled to temporary total disability benefits after July 1, 2003, when he was returned to work full duty and discharged by Dr. Arnold. The note of that visit indicated that Petitioner was doing much better with no radicular pain and minimal and diffuse tenderness on palpation. Dr. Arnold's diagnosis was status-post lumbosacral strain. We also note that Dr. Arnold had referred Petitioner to Dr. Spencer for an examination on June 17, 2003. Petitioner testified that Dr. Spencer examined him prior to his return to full duty. We don't find Petitioner's testimony credible that he was still in a lot of pain at the time of this release. Petitioner then sought treatment from his family physician Dr. Jovanovic, an internist, who appears to have written off work slips primarily because Petitioner asked him to do so. We don't find Petitioner's continued medical treatment to be indicative of anything more than a degenerative condition that was not aggravated by his work-related lumbar strain, based on the persuasive opinion of Respondent's §12 physician, Dr. Graf. We note that when Petitioner was finally motivated to look for work, he obtained a job immediately.

The Commission finds that Petitioner is entitled to 9-6/7 weeks of temporary total disability from April 24, 2003 through July 1, 2003 and has sustained the loss of use of 5% of the

16IWCC0148

person as a whole under §8(d)2 of the Act.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $649.60 per week for a period of 9-6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $542.17 per week for a period of 25 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of use of 5% of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 3 - 2016

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

SE/
O: 1/20/16
49

HOUSTON

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STALLWORTH, BERNARD
Employee/Petitioner

Case# **03WC035568**
04WC014570

16IWCC0148

CITY OF CHICAGO
Employer/Respondent

On 1/5/2015, 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 0.13% 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:

2909 RHONDA L WALKER
33 N LASALLE ST
SUITE 3300
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
JOSEPH A ZWICK
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

16IWCC0148

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

- ☐ 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

Bernard Stallworth
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **03** WC **35568**

Consolidated cases: **04 WC 14570**

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 **Brian Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **February 7, 2014**. 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 **April 23, 2003**, 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 $**50,668.80**; the average weekly wage was $**974.40**.

On the date of accident, Petitioner was **42** years of age, *single* with **0** dependent children.

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

Respondent *has* paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**6,867.94** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**6,867.94**.

Respondent is entitled to a credit of $**51,586.08** under Section 8(j) of the Act.

ORDER

TEMPORARY TOTAL DISABILITY

Respondent shall pay Petitioner temporary total disability benefits of $**649.60** per week for **101-5/7** weeks commencing **April 24, 2003** through **July 1, 2003**, and **July 25, 2003** through **April 5, 2005**, as provided in Section 8(d) of the Act.

Respondent shall be given a credit of $**6,867.94**.

PERMANENT PARTIAL DISABILITY

Respondent shall pay Petitioner permanent partial disability benefits of $**542.17** per week for **37.5** weeks because the injury sustained caused **7.5%** loss of use, man as a whole, as provided in Section 8(d)2 of the Act. Respondent shall receive a credit for any overpayment of benefits.

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.

Signature of Arbitrator

January 4, 2015
Date

ICArbDec p. 2

JAN 5 - 2015

STATE OF ILLINOIS)
) SS
COUNTY OF)

16IWCC0148

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Bernard Stallworth Petitioner, vs. City of Chicago Respondent.	)	No. 03 WC 35568 04 WC 14570

INTRODUCTION

On February 7, 2014, before commencement of a hearing on the merits, the Arbitrator granted Petitioner's motion to reinstate the two consolidated cases, over the objections of Respondent. (Transcript of Proceedings, p. 13)

FINDINGS OF FACT

Petitioner testified that he worked as a Sanitation Laborer in the Department of Streets and Sanitation for the City of Chicago. Petitioner testified that on April 23, 2003, he noticed a "deep" and "jolting" pain in his back, as well as pain in his right leg, after picking up a sofa and carpet. Petitioner submitted a Report of Occupational Injury or Illness, which he signed and dated by on the same day the accident occurred. (Px 9) He indicated that he was performing his duties and felt a pain in his lower part of back after picking up debris (couch and carpet). The report further indicates that Petitioner's back stiffened and became painful and hard to maneuver as time progressed. (Px 9) Petitioner also testified that he notified his supervisor of the injury and, further, that the supervisor

sent him to MercyWorks Occupational Medicine Center. Petitioner noted that MercyWorks sent him to Dr. Spencer. (Rx 1, Px 11) The records from MercyWorks reflect that Petitioner was released for full-duty employment as of July 1, 2003 and discharged from care. At that time, Petitioner reported doing much better and indicated that there was no radicular pain. Petitioner's strength and gait were normal. Contrary to the doctor's notes, Petitioner testified that he "still had a lot of pain" when he was discharged.

Petitioner testified that he returned to his regular job on July 7, 2003. He performed the same duties that he had previously performed. Petitioner further testified that his pain level got worse every day. Petitioner also testified that he attempted to continue to work and thought that the pain would subside. Petitioner testified that the pain was "excruciating." Petitioner did not work a full day on July 17, 2003, returned to the yard and reported to his supervisor, Mr. Excell Brown.

Petitioner completed, signed and dated as 7/17/03, a Report of Occupational Illness or Disease. (Px 10) Excell Brown also signed such document. A section of such form asks Petitioner to provide a detailed description of injury or illness, to explain what caused the incident, to identify the duties he was performing at the time of the incident and to be specific and accurate as to body part. In such section, Petitioner wrote the following:

> "Upon return date of work 7-7-03, I aggravated previous back problem. While working during days at duty, it got worse and until it reached a point where I could no longer perform duties on 7-17-03. My duties are working on garbage which I'm doing a lot of lifting heavy objects, pulling, bending, twisting, stooping, jumping on and off truck."

Petitioner testified that he returned to the yard. He was then sent back to MercyWorks Occupational Medicine Center. At MercyWorks, J. Mata recorded the following Progress Note:

"The patient presented to the clinic with an authorization card. He noted that he has had increased pain in his lower back area as well as his "privates" with associated numbness and tingling in his legs. He denied any specific injury other than his routine daily work. He stated this started in the later part of last week and has continued into this week. He noted that he started back to full duty of 7/7/03. Spoke with Angie Cavanough of the C.O.F. regarding the above, who then spoke with Dr. Arnold. At this time no approval has been given to re-open the patient's claim. He was advised of the above and provided with the number to the C.O.F. to have his case possibly re-opened. Case closed unless otherwise informed by the C.O.F." (Rx 3)

Petitioner testified that on July 17, 2003, MercyWorks Occupational Medicine Center released him to return to work.

Petitioner testified that on July 18, 2003, he saw Dr. Jovanovic, his family doctor. Petitioner testified that Dr. Jovanovic referred him for physical therapy and further testified that he continued to notice pain throughout his course of treatment with Dr. Jovanovic. Dr. Jovanovic issued a disability slip dated July 25, 2003, in which he indicated that Petitioner had been under his care for a back injury since July 18, 2003 and he recommended that Petitioner stay off until further notice. (Px 12)

Dr. Jovanovic's records indicate that on March 29, 2004, Petitioner phoned his office and told them that he went to the emergency room that day for his low back pain. (Px 12)

Petitioner testified that about this time in 2004, he participated in group physical therapy that included stress reduction and yoga classes.

Petitioner testified that he received epidural injections and continued to follow-up with Dr. Jovanovic through 2005 and 2006.

Petitioner testified that he sought a second opinion at Cook County Hospital where he saw Dr. Saqueton, a specialist in internal medicine. Dr. Saqueton testified that he first saw Petitioner at the end of 2004. (Px 17, p. 10) Dr. Saqueton issued a report dated January 4, 2005. Said report reflects that Petitioner underwent an updated MRI on December 21, 2004, which revealed mild bulging L4-L5

disc with a small annular tear and mild disc space narrowing along with mild bulging of the L5-S1 disc with a small annular tear and mild disc space narrowing with facet arthropathy.

Dr. Saqueton's report, dated January 4, 2005, further stated Petitioner had been started on Elavil, Lidoderm patch and TENS treatment by the Physical Medicine Specialist, but that his symptoms had not yet improved. Dr. Saqueton further indicated Petitioner was scheduled to receive steroid injections for his low back pain on January 13, 2005. His report also indicated that he supported Petitioner's request to have his medical leave extended. (Px 17, Deposition Exhibit)

In a report dated April 5, 2005, also authored by Dr. Saqueton, he wrote that Petitioner's low back condition did not improve with intensive treatment and therapy and "is now a chronic (life-long) condition." (Px 17, Deposition Exhibit)

Dr. Saqueton testified that Petitioner's low back disease was most likely brought on by the heavy lifting he had to do at work. Dr. Saqueton further testified that at the time he wrote his report, he did not believe that Petitioner could perform the job of a Sanitation Laborer. (Px 17, Deposition Exhibit). Dr. Saqueton testified that his concern was that lifting that heavy of a weight, especially something in excess of 100 pounds, would actually make his disc disease worse. (Px 17, p. 22) On cross-examination, Dr. Saqueton agreed that he did not review anything or see anything in terms of an objective measure as to whether or not a 10-pound restriction would be an accurate measure of Petitioner's lifting abilities. (Px 17, p. 49)

Petitioner testified that he also sought treatment with Dr. Glick, a neurosurgeon at Stroger Cook County Hospital.

Near the end of Exhibit Number 15, there is a handwritten note that indicates that Petitioner had been referred by neurosurgery "for an unknown reason per patient." Such note indicates that Petitioner's primary care physician – identified in the note as Dr. Saqueton – also did not know the

reason for the referral. Dr. Saqueton testified that Dr. Glick ordered a repeat MRI to evaluate for spinal cord and spinal canal damage, which Petitioner underwent on January 11, 2006.

According to the testimony of Dr. Saqueton, Petitioner saw Dr. Glick on November 14, 2005. Dr. Saqueton testified that these MRI findings showed mild disc bulging at L4-L5 and L5-S1. At L5-S1, there was a small or central right paracentral disc protrusion, mildly deforming the right thecal sac. Dr. Saqueton testified that it now appeared that Petitioner had a proximal right S1 nerve root impingement.

Petitioner submitted the records from Stroger Cook County Hospital (Dr. Saqueton) as Exhibits Numbers 14 and 15. Although Dr. Saqueton testified that he referred Petitioner to neurosurgeon, Dr. Glick, and further testified that Dr. Glick referred Petitioner for pain management, those records do not appear in Exhibits 14 or 15.

Petitioner testified that he last saw Dr. Jovanovic in 2009 and has not received any further treatment. Petitioner further testified that he moved to Tennessee and just never felt able to perform his prior duties for the City of Chicago.

Petitioner testified that he handed the Request for Reasonable Accommodation form (Px 1) to an unidentified clerk in City Hall. Petitioner testified that he attempted to follow-up with regard to his request for accommodation but was unable to identify the individual he claims to have contacted. Moreover, such alleged attempts would have occurred in 2005. Other than his request for accommodation, Petitioner testified that he did not apply for other jobs in the City of Chicago. Petitioner did not perform a diligent job search. Instead, he moved to Tennessee and applied for work at Kroger, the Nashville Public Schools and one other position. Petitioner advised that he received offers of employment from Kroger and Nashville Public Schools and accepted a position as Custodian for Nashville Public Schools. Petitioner states that he was laid off from that position in

June of 2010 and found employment thereafter at Wallenius Wilhelmsen Logistics, which is a company that is involved in the distribution of vehicles.

Petitioner submitted into evidence a job description of his job with Nashville Public Schools. (Px 2) The job included sweeping, scrubbing, refinishing and polishing floors using dust mops, mops or power cleaning appliances, assisting in lifting and moving of school furniture, equipment and supplies, arranging equipment for special events, performing repetitive bending to pick up paper and trash as well as numerous other, general housekeeping duties. Petitioner testified that he would not perform all of the duties listed in the job description and that he received help doing his job. Petitioner testified that he was a member of a custodial crew.

Petitioner testified that he was paid $9.08 per hour at Nashville Public Schools and earns $14.60 per hour for Wallenius Wilhelmsen Logistics. Petitioner provided W2 forms and some wage records from Nashville Public Schools, but did not wage records from Wallenius Wilhelmsen Logistics.

On October 7, 2011, at the request of Respondent and pursuant to Section 12 of the Act, Petitioner submitted to an evaluation by Dr. Graf. After such examination, Dr. Graf issued a report. (Rx 2) In such report, Dr. Graf opined that Petitioner's diagnosis should be considered a lumbar strain and noted that he was unable to substantiate Petitioner's ongoing subjective complaints of pain given a lack of objective findings. Dr. Graf noted that Petitioner appeared to be physically fit and was able to accomplish the entire physical examination despite the subjective complaints. Dr. Graf felt that Petitioner was able to return to full-duty employment without restrictions and further stated, "It is apparent Mr. Stallworth reached MMI many years ago." Dr. Graf stated that there was no objective basis to support the claimed limitations. Dr. Graf stated that Petitioner had mild, age appropriate degenerative lumbar changes and, further, states that Petitioner's alleged injury did not aggravate or accelerate the same. (Rx 2)

Petitioner submitted as Exhibit Number 16, the transcript from the evidence deposition of Dr. Dragomir Jovanovic on October 23, 2012. Dr. Jovanovic was Petitioner's family physician and is board certified in family medicine and geriatrics. (Px 16, p. 6) Dr. Jovanovic first saw Petitioner in connection with his back in July of 2003 and was under the impression that Petitioner had been seeing a county doctor for the same. (p. 10) Dr. Jovanovic identified letters attached to the deposition as Exhibit Number 3 and dated October 10, 2003, April 2, 2004, June 24, 2004, October 1, 2004 and April 7, 2005 as letters that he authored. (p. 17) Dr. Jovanovic stated that he prepared the letters, "Because I think Mr. Bernard Stallworth asked me that, to do that." (p. 18) Dr. Jovanovic noted that he was aware Petitioner was seeing a Dr. Saqueton at Stroger Cook County Hospital and further stated that it was his impression that Petitioner's employer had required the same. (p. 19)

Dr. Jovanovic testified that the diagnosis for Petitioner "was always lower back pain and herniated disc." (p. 33) Dr. Jovanovic asked if he knew whether or not Petitioner had a lifting restriction. Dr. Jovanovic stated, "He had a 10-pound lifting restriction by Dr. Saqueton." (p. 35) Dr. Jovanovic stated that he agreed with the 10-pound restriction. When asked to further explain why Petitioner would be reportedly unable to return to his prior employment as a garbage collector, Dr. Jovanovic states, "He cannot. In order for me to say that he cannot go back to work, I would have to refer the patient to the work-hardening evaluation and that he will give – be given the task that he is – as he would work at his work basically, that he would work with, and then he would be evaluated and be able to have exact measures, and we will be able to say exactly his functional status." (pp. 41-42) Dr. Jovanovic agreed that he wrote the notes taking Petitioner off of work because Petitioner was asking the doctor to provide such notes. (p. 67) The first time Dr. Jovanovic saw Petitioner was on July 18, 2003. Dr. Jovanovic agreed that the full extent of his physical examination included tenderness to palpation, normal range of motion and normal strength. (pp. 45-46) Dr. Jovanovic stated that tenderness to palpation was from "kind of tap on the back and ask if that hurts."

Respondent submitted as Exhibit Number 1 the evidence deposition of Dr. Graf. Dr. Graf testified in accordance with is report. The report was submitted as Exhibit Number 2.

Respondent also submitted as Exhibit Number 3, the treating records from MercyWorks. The records from MercyWorks reveal that an MRI was prescribed. The MercyWorks physician reviewed the MRI and noted a finding of a bulging disc. As of July 1, 2003, Petitioner reported that he was feeling much better. Petitioner was discharged from care and released to return to full-duty employment.

Respondent submitted as Exhibits Numbers 4 and 5 letters sent to Petitioner from the City of Chicago and from the Laborers Benefit and Annuity Fund of Chicago. The letter from the City of Chicago reveals that Petitioner had retired and resigned his employment. Petitioner received non-occupational disability benefits from the Laborers Benefit Fund.

CONCLUSIONS OF LAW

CASE NUMBER 03 WC 35568

In connection with issue (F) causal connection, the Arbitrator finds as follows:

Dr. Saqueton did not causally relate Petitioner's low back condition of ill-being to a specific lifting accident on April 23, 2003. He did relate such condition of ill-being to "the heavy lifting he had to do at work." (Px 1)

During the deposition of Dr. Jovanovic, the following exchange took place on direct examination:

Q: Okay, very good. And do you have an opinion to a reasonable degree of medical and surgical certainty whether the conditions he exhibited are related to the work accidents he suffered which were in April and July 2003?

A: I believe so that he start - - he exacerbated whatever condition if he ever had anything that was exacerbated with the lifting and pushing and pulling. I think that day he had - - I believe he lifted something or - - where he started to have problem.

Q: And, again, do you concur with Dr. Saqueton's findings in that regard?

A: Yes, I do. (Px 16, pp. 36-37)

In a letter dated April 2, 2004, Dr. Jovanovic wrote, in pertinent part, the following: "Mr. Stallworth has been under my care for an injury of his back since July 18th . 2003. He originally injured himself in April of 2003, and after returning to work in July, re-injured himself." (Px 12)

Expert medical evidence is not essential to support the Commission's conclusion that a causal relationship exists between a claimant's work duties and her condition of ill-being. International Harvester v. Indus. Comm'n, 442 N.E.2d 908, 66 Ill. Dec. 347 (1982).

A chain of events suggesting a connection may suffice to prove causation. Consolidation Coal Co, v. Indus. Comm'n, 639 N.E.2d 886, 203 Ill. Dec. 327 (1994).

No evidence was presented to indicate that Petitioner had complaints of or treatment to his low back before April 23, 2003. Petitioner has had continuous complaints of low back pain since April 23, 2003.

Based on Petitioner's testimony, the medical records, the opinions of Doctors Jovanovic and Saqueton and the chain of events, the Arbitrator finds that Petitioner's current condition of ill-being of his low back is causally related to the lifting accident he sustained on April 23, 2003 while working for Respondent.

In relation to (K) temporary total disability, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner is entitled to temporary total disability benefits from April 24, 2003 through July 1, 2003 and from July 23, 2003 (the date Dr. Jovanovic took Petitioner off work) through April 5, 2005 (the date Dr. Saqueton found that Petitioner's low back condition did not improve with intensive treatment and therapy and "is now a chronic (life-long) condition.") With regard to Petitioner's entitlement to TTD benefits, the Arbitrator relies on the opinions of treating physicians Dr. Saqueton and Dr. Jovanovic.

Dr. Graf examined Petitioner on one occasion, October 7, 2011, which was 8-1/2 years subsequent to the accident. During his July 19, 2013 deposition, Dr. Graf, after reviewing some of the medical records (there is no evidence that he reviewed Dr. Jovanovic's records), opined that Petitioner would have reached maximum medical improvement ("MMI") in July 2003. (Rx 1, p. 11) Dr. Graf relied on the information provided on the Work Requirements/Work Capacities for a Sanitation Laborer form (Rx 1, Dep. Ex. 3) Such document indicates that the position is a medium-duty position that requires 50 pounds of lifting, and includes, *inter alia*, frequent twisting, constant standing and walking and constant pushing and pulling, There is no evidence that such work requirements applied for the position in the years 2003-2005.

Petitioner testified that when he worked as a Sanitation Laborer for Respondent, he picked up garbage cans, sofas, carpet, sheetrock and bags of leaves.

After reviewing Deposition Exhibit 4 of Rx 1, Dr. Graf testified that the job of Custodian for the Nashville Public Schools "appears to be a pretty heavy duty job." Dr. Graf testified that Petitioner was capable of performing such job, and thus, would have been able to perform the job of Sanitation Laborer for Respondent. Dr. Graf was not aware of specific accommodations that might have been afforded to him in the job of Custodian.

Petitioner testified that he worked with a custodial crew and received help doing the job.

Dr. Graf opined that the Dr. Javonovic's records reveal that he provided Petitioner with a 10-pound lifting restriction. Dr. Javonovic testified that on November 24, 2003, he requested a work hardening evaluation for Petitioner but that the City of Chicago would have needed to approve such request. Dr. Javonovic stated that he would have preferred that Petitioner had undergone a functional capacity, or work hardening, evaluation. Dr. Jovanovic felt that Dr. Graf's examination was not complete because he did not have any functional capacity evaluation results. On cross-examination of Dr. Jovanovic, the following exchange took place:

Q: Okay. By the same token to provide restrictions of 10 pounds is somewhat arbitrary would you agree because - -

A: Yeah, absolutely.

Q: Okay.

A: 100 percent arbitrary because I don't know. I don't have any functional evaluation that I can send the patient on, and that's a very actually a - - a brave move to send somebody on a full duties (sic) with a possibility the patient can injure himself on a full duty without knowing what he can and cannot do. (Px 16, p. 66)

Dr. Jovanovic stated that he was deferring to Dr. Saqueton with regard to the restrictions placed on Petitioner.

Dr. Saqueton authored a note in which he opined that it would be beneficial for Petitioner to move into a position such as delivering garbage carts or rodent control where he would not exacerbate his low back pain. On cross-examination, Dr. Saqueton testified that this note was generated simply based upon Petitioner's request seeking a change of employment to a comparable position.

Without the benefit of a functional capacity evaluation, Doctors Saqueton and Jovanovic, Petitioner's treating physicians, imposed a ten-pound lifting restriction on Petitioner. Dr. Saqueton is a physician who specializes in internal medicine and Dr. Jovanovic is a physician who specializes in family practice.

Without the benefit of a functional capacity evaluation and without reviewing all of the medical records, Doctor Graf, Respondent's examining physician, released Petitioner to return to full-duty work. Dr. Graf is an orthopedic surgeon. Dr. Graf examined Petitioner 8-1/2 years after the accident.

In weighing the testimony and the evidence, the Arbitrator finds the records and medical opinions of Petitioner's treating physician to be more persuasive than the opinions of the Section 12 examining physician. Edgecomb v. Indus. Comm'n, 181 Ill.App.3d 398 (1998).

The Arbitrator further finds that Petitioner is not entitled to any maintenance benefits since he did not conduct a diligent job search.

In connection with (L) nature and extent of the injury, the Arbitrator finds as follows:

Petitioner alleges that his injuries resulted in an impairment of his earnings and thus seeks permanency partial disability benefits under Section 8(d)1 of the Act. In connection with same, Petitioner submitted paystubs and other documents related to the job of Custodian that he held with the Metropolitan Board of Education in Nashville, Tennessee, from 2007-2009. (Px 2-5, Px 7) Petitioner offered into evidence a job description. (Px 2) Petitioner testified that he was a member of a custodial crew and that he received help doing the job. Petitioner further testified that after he was laid off from this custodian job, he found a job with Wallenius Wilhelmsen Logistics in Tennessee, where he still works. The duties of such job include assembling small parts, installing floor mats and face plates and wrapping vehicles in film. In such job with Wallenius Wilhelmsen Logistics, Petitioner testified, he does not perform any heavy lifting, earns $14.60/hour and works 40-60 hours per week.

Section 8(d)1 of the Act states:

16IWCC0148

If, after the accidental injury has been sustained, the employee as a result thereof becomes partially incapacitated from pursuing his usual and customary line of employment, he shall, except in cases compensated under the specific schedule set forth in paragraph (e) of this Section, receive compensation for the duration of his disability, subject to the limitations as to maximum amounts fixed in paragraph (b) of this Section, equal to 66-2/3% of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or is able to earn in some suitable employment or business after the accident. For accidental injuries that occur on or after September 1, 2011, an award for wage differential under this subsection shall be effective only until the employee reaches the age of 67 or 5 years from the date the award becomes final, whichever is later. (Emphasis added)

Petitioner failed to prove up a wage differential claim as he did not offer into evidence the amount he would currently be able to earn as a laborer in the Department of Streets and Sanitation for the City of Chicago. No recent union contract or testimony by a union or City of Chicago official was offered. Petitioner only testified that the last hourly wage he earned as a Sanitation Laborer was $24.62. He earned such hourly wage in 2003. Please see Greaney v. Indus. Comm'n, 832 N.E.2d 331 (1st Dist. 2005).

The Arbitrator cannot speculate as to the hourly wage Petitioner would currently be able to earn as a laborer in the Department of Streets and Sanitation for the City of Chicago.

Moreover, Petitioner did not file a petition for vocational rehabilitation.

Petitioner bears the burden of proving all elements of his claim by a preponderance of the evidence.

In his April 5, 2005 letter, Dr. Saqueton causally related Petitioner's low back condition to the heavy lifting he had to do for Respondent. He noted that the December 21, 2004, lumbar MRI revealed mild bulging of the L4-L5 disc with a small annular tear and mild disc space narrowing along with mild bulging of the L5-S1 disc with a small annular tear and mild disc space narrowing facet

arthropathy. Dr. Saqueton's report, dated January 4, 2005, further stated Petitioner was prescribed Elavil, Lidoderm patch and TENS treatments, as well as steroid injections for his low back pain. Dr. Saqueton opined, at that time, that Petitioner's low back condition "is now chronic (life-long) in nature." Dr. Saqueton recommended that Petitioner perform a job that is less strenuous than that of Sanitation Laborer.

On June 10, 2005, Petitioner completed a Request for Reasonable Accommodation in which he sought light-duty jobs with the City of Chicago.

Petitioner testified that his current job at Wallenius Wilhelmsen Logistics does not involve any heavy lifting and not as much twisting and bending, and that in his former job as custodian at the Metropolitan Board of Education in Nashville, Tennessee, he received help doing his job.

Petitioner testified that he stopped treating at Stroger Cook County Hospital because he moved to Tennessee. Petitioner further testified that he is not currently treating for his low back because his doctor in Tennessee moved.

Petitioner did not offer into evidence any treating records of Petitioner's Tennessee physicians or medical professionals.

Dr. Saqueton testified that "does not have an exact date" of the last time he saw Petitioner. Dr. Saqueton testified that he treated Petitioner after April 2006, but that he does not have the printed records of those visits. Dr. Saqueton testified that he stopped working at Stroger Cook County Hospital in May or June 2008. (Px 17, pp. 38-39, 41-42)

Dr. Jovanovic's records show that the last time he saw Petitioner was on June 15, 2009. At that time, he felt Petitioner's back condition had reached a plateau, and that he cannot lift or push more than 10 pounds, he cannot bend at all and he cannot twist with anything heavy. Prior to the June 15, 2009 visit, Dr. Jovanovic last saw Petitioner on June 22, 2006.

Dr. Graf examined Petitioner on October 7, 2011. Dr. Graf's report, which he authored following the examination, indicates that Petitioner told him that he has not seen any doctors for his lumbar spine for years. Petitioner told Dr. Graf that he currently rates his pain at 5/10, which would be the pain level on a normal day. He also told Dr. Graf that this pain level can go up to 9/10 after working. Yet, Petitioner stated he is taking no pain medication. Dr. Graf opined that Petitioner's diagnosis should be considered a lumbar strain and noted that he was unable to substantiate Petitioner's ongoing subjective complaints of pain given a lack of objective findings. Dr. Graf noted that Petitioner appeared to be physically fit and was able to accomplish the entire physical examination despite the subjective complaints. (Rx 2)

At the February 7, 2014 arbitration hearing, Petitioner testified that the maximum he can lift without feeling any pain is 10-20 pounds. He further testified that anything stronger than Alieve makes him sick and that he performs his home exercises in the evenings and during the day.

Based on the foregoing, the Arbitrator finds that as a result of the lifting accident on April 23, 2003, Petitioner sustained a loss of use, man as a whole, of 7.5%, pursuant to Section 8(d)2 of the Act. The Arbitrator places great weight on the fact that Petitioner has not seen a physician for his back in years, that he does not take *any* type of prescription pain medication, even on rare occasions, and that he did not offer into evidence any medical records from his Tennessee doctor.

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeremy Agnitsch,

Petitioner,

vs. NO. 09WC003273

Continental Tire North America,

16IWCC0159

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical care, notice, permanent disability, temporary disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 28, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 4 - 2016
SJM/sj
o-2/11/2016
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

AGNITSCH, JEREMY
Employee/Petitioner

Case# 09WC003273

16IWCC0159

CONTINENTAL TIRE NORTH AMERICA
Employer/Respondent

On 4/28/2015, 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 0.09% 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:

0384 NELSON & NELSON
DAVID C NELSON
420 N HIGH ST PO BOX Y
BELLEVILLE, IL 62222

0299 KEEFE & DePAULI PC
JAMES K KEEFE JR
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

16IWCC0159

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jeremy Agnitsch
Employee/Petitioner

v.

Continental Tire North America
Employer/Respondent

Case # **09** WC **3273**

Consolidated cases: _____

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 **Michael Nowak**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **12/9/14**. 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. [x] 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. [x] 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. [x] 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. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] 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 _____

16IWCC0159

FINDINGS

On **12/11/08**, 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 $**47,013.95**; the average weekly wage was $**904.11**.

On the date of accident, Petitioner was **28** years of age, ***single*** with **2** dependent children.

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**18,860.85** for other benefits, for a total credit of $**18,860.85**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $602.74/week for 141 4/7 weeks, commencing 12/13/08 through 8/30/11, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $636,602.60 as set forth in Px. 14, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent and total disability benefits of $**602.74**/week for life, commencing **8/31/11**, as provided in Section 8(f) of the Act.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) 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.

Signature of Arbitrator

4/20/15
Date

APR 28 2015

FINDINGS OF FACT

Petitioner alleges he sustained an accidental injury to his low back while working for Respondent on December 11, 2008. Petitioner is currently 33 years of age. He began working for Respondent in 2006 as a tire builder and later moved to a set-up tech position as a salaried employee. Petitioner described the set-up tech job as heavy work. He started his shift 12/10/08, at 11:00 p.m. He worked until approximately 3:00 a.m. at which point he took his lunch break. Petitioner testified that he injured his low back changing a bladder between 3:00 a.m. and the end of his shift at 7:00 a.m. on 12/11/08. He described the lift as awkward because he had to lean forward with his arms extended and the bladder weighed 50-80 pounds. Petitioner stated he did not report the injury at that time because he thought the problem was simply a pulled or torn muscle. Petitioner testified that on 12/11/08 after work he was hurting. He went home and slept until the early evening. The pain in his low back was severe when he awoke. Petitioner returned to work at approximately 10:30 p.m. for his 11:00 p.m. shift. Petitioner testified that towards the end of his shift, on the morning of 12/12/08, he called his mother and told her that he was hurt and asked her to make a doctor's appointment for him.

Jason Kuberski's testified by deposition which was taken on 10/17/13. Mr. Kuberski worked for Respondent from March 2007 through July 2013. (Px. 21 at 5, 20) Kuberski worked with Petitioner for the four months immediately preceding the accident. (Px. 21 at 5) He described the job as physical and repetitive. (Px. 21 at 11) Kuberski testified that toward the end of the shift on 12/12/08 he noticed Petitioner stretching his back and Petitioner said his back was hurting or he had hurt his back. (Px. 21 at 18). Mr. Kuberski did not witness the injury. (Px. 21 at 22 and 18, 14) He made no specific inquiry about the injury when Petitioner mentioned his back was hurt. (Px. 21 at 22) Mr. Kuberski completed a witness statement for Respondent on Friday 12/19/08. The statement indicates, "Jeremy Ag [sic] said he was going to the doctor Friday 12/12 for back pain but not sure if he hurt at work or at home." (Px. 21 at Exhibit 1) He stated that he assumed Petitioner had just injured his back. (Px. 21 at 17) He did not believe Petitioner already had an appointment scheduled with a doctor; but that he intended to make one (Px. 21 at 24)

After his shift was over on the morning of 12/12/08, Petitioner drove to his mother's house. Petitioner testified his mother had already made an appointment and took him to Dr. Moffett at Herrin Chiropractic. Petitioner testified that he completed an intake form prior to being examined examination. The intake form indicates Petitioner suffered an injury on 12/11/08 when grabbing a bag that fell off the center shaft and he placed it back on the shaft. (Px. 2 at 3-5) The Arbitrator notes the terms "bags" and "bladders" are used interchangeably by Respondent's employees. Petitioner marked on the intake form that he had pain in the low back. The written history from the chiropractor indicates that Petitioner reported low back pain from lifting. He had experienced back pain periodically in the past, but his pain was now radiating down the left leg. (Px. 2 at 7). Dr. Moffett took Petitioner off work. (Px. 2 at 12) Petitioner testified that after his chiropractor visit, his mother drove him to Kroger grocery store where he faxed the off work slip to Respondent's medical department known as Health Services. Petitioner testified that shortly after faxing the off work slip he called and left a message for Health Services that he had an injury and had to be off work.

Melissa Barkley is Petitioner's mother. She confirmed these activities during her testimony. At the time of Petitioner's injury, Petitioner lived apart from his mother although they lived relatively close to one another. Ms. Barkley confirmed that on the morning of Friday12/12/08 she received a call from her son indicating he had hurt

his back and asking her to make a doctor's appointment as soon as possible. She waited for the office to open, and then called the nearby chiropractor, Dr. Moffett, and made Petitioner an appointment for 9:00 am. She testified that Petitioner drove to her home from his work, and that she then drove him to the chiropractor's office. She did not accompany him into the exam room, but after the visit, she drove him to Kroger so that he could notify his employer of his expected absence from work the next day, and also in order to use Kroger's fax machine to send Respondent a note from the chiropractor authorizing her son off work. Petitioner and his mother then drove to her house where he remained for the weekend.

Petitioner testified that on Saturday, 12/13/08, his supervisor, James Johnson called Petitioner's cell phone. Petitioner's mother answered the phone and brought it to Petitioner who was lying on the couch. Petitioner set his phone to operate through the external speaker. Petitioner testified Mr. Johnson asked how Petitioner was doing. Petitioner and his mother testified that Petitioner specifically told Johnson he injured himself at work changing a bladder.

Petitioner testified that on Sunday, 12/14/08, his supervisor's boss, Curt Hoelscher called Petitioner's cell phone. Petitioner's mother answered the phone and brought it to Petitioner who was lying in bed. Petitioner again selected the speaker phone option. Petitioner signaled for his mother to stay in the room after she delivered the phone to him. Petitioner and his mother testified that Mr. Hoelscher asked how Petitioner was doing and what happened. Petitioner and his mother testified that Petitioner told Mr. Hoelscher that he injured his back at work changing bladders.

Petitioner testified that he called Mr. Johnson Wednesday, 12/17/08, to tell him he had the results of his testing and he was going to come to work. Petitioner testified that Mr. Johnson told him that he should not bother coming to work, that the injury did not happen there. Petitioner could not recall where he was when he called Johnson or whether his mother was present. Petitioner then went to the plant to report the injury in writing. (see Px. 23) The Arbitrator found the testimony of both Petitioner and Ms. Barkley Credible.

Petitioner called Curt Hoelscher as an adverse witness. Mr. Hoelscher, was Department Manager on the day of accident, the most senior of Respondent's witnesses. He was hired in 1982 and worked for Respondent until 2013. He did not recall how he became aware of Petitioner's injury. He testified that he called Petitioner on Sunday, 12/14/08, because Petitioner had not shown up for work. He stated he did not know before calling that Petitioner had been injured; he only knew that he had missed work. Mr. Hoelscher testified that when he phoned Petitioner, Petitioner told him that he "got hurt at home." He could not remember any other details regarding Petitioner's injury. Mr. Hoelscher stated that under the circumstances as he alleged them to be (that Petitioner was simply a no show for work) Petitioner should have received "points" for failing to show up at work if the condition were not work-related. Respondent did not produce Petitioner's personnel file, or provide any evidence that Petitioner ever received points or any other "flag" such as a memo or email in his personnel file. Mr. Hoelsher could not recall that Petitioner came in to fill out an injury report. He indicated that if Petitioner had done so, he should have seen the report. He did not recall ever seeing the report, which is Petitioner's Exhibit 23. Mr. Hoelscher indicated that, if he had seen Petitioner's injury report, which would have been "normal procedure," he would have written a memo or "something" indicating that Petitioner's report was not consistent with what he had been told on the phone. While questioning Mr. Hoelscher, Respondent's counsel produced a printed email, later marked as Respondent's Exhibit 4 (Rx. 4). In response to questions by

Respondent's counsel, Mr. Hoelscher confirmed that the email on Wednesday, 12/17/08, was in reply to an email from one of his superiors, Steve Crane. In the email Mr. Hoelscher wrote "I called [Jeremy Agnitsch] at home Sunday from the plant and his comment to me was that he fell at home." (Rx. 4) Mr. Hoelscher did not recall sending any other emails.

The Arbitrator notes Mr. Hoelscher's email responds to another email, and may have been followed by other email responses, however no other emails were introduced or described. The email is time-stamped 6:28 a.m., which the Arbitrator finds significant. 6:28 am is hours before Petitioner drove to Continental to complete the injury report. (Px 23) Therefore it would seem the email could not have been sent in response to Mr. Hoelscher having seen or become aware of Petitioner's injury report because that document was turned in later that day. It would appear the work-related injury claim must have been known to Respondent before 6:28 a.m. on Wednesday 12/17/08. Clearly the entire e mail chain regarding this issue was within Respondent's control and could have been produced. The Arbitrator further notes Mr. Hoelscher was evasive in his testimony. and had a less than clear recollection of the details of these events.

James Johnson was also present at the request of Respondent and was called as an adverse witness by Petitioner's counsel. He is currently employed at Continental Tire. He was a lead supervisor at the time of the alleged injury. He testified he first spoke with Petitioner on Monday, 12/15/08. He denied calling Petitioner Saturday, 12/13/08. Mr. Johnson confirmed that Petitioner should have received some kind of demerit for having missed work as a result of an unreported non-work-related injury which resulted in lost time, but again, Respondent offered no evidence or documentation of any such discipline. Mr. Johnson testified that when he called Petitioner on Monday, 12/15/08, Petitioner told him that he fell at his mother's house and hurt his hip or back and was seeing a doctor. Mr. Johnson formed the impression that the injury had just happened very recently. He further said that he believed Petitioner called him the next day, Tuesday 12/16/08, "and reported something about the x-rays" and asked to come back to work on light duty. Mr. Johnson testified he informed Petitioner light duty was not available for non-work related injuries. He claimed he then instructed Petitioner to come to the plant (i.e. to "Health Services") in order to complete paperwork and take a drug test. He did not recall when the Petitioner came to the plant to fill out an accident report, but Petitioner testified, and his accident report confirms, Petitioner did so on Wednesday, December 17.

Mr. Johnson also filled out an Incident Report. (Rx. 3) The report is actually marked with two dates; the 17th and the 18th. More specifically, the Arbitrator notes that Mr. Johnson's signature is dated the 17th, Wednesday, while the date appearing in the space adjacent to the employee's signature line is the 18th, meaning Thursday. Further, the employee's signature is not present; rather, Mr. Johnson wrote the words "By Phone" in the box for the Petitioner's signature. Petitioner did not sign the document, and had not seen it before the trial. Mr. Johnson testified he wrote the following words on the form, in a space reserved for describing how the accident occurred: "Employee now states he felt pain while changing bladders. Originally told the Dept. Mng [Hoelsher] and Lead Supervisor [Johnson – the author] 'He fell at his mother's'. Nothing in normal job function to lead to this problem. See memo attached also." The Arbitrator notes that no other Incident Report corresponding to a non-work related injury was produced, nor was the referenced "memo" introduced. Also of note, the Incident Report indicates that the injury was reported on Friday 12/12/08 to "Health Services." Johnson called the "12/12/08" date for the reported date of injury as "their date" referring to Health Services. In other words, it was apparently a date written by Health Services, not by Mr. Johnson, and certainly not by the Petitioner. The words

"Health Services" are also written in the same box as the reported date. The incident report has a back side, which includes space for describing other aspects of the accident; it was left completely blank.

Melody Cravens testified on behalf of Respondent. She is the Respondent's workers' compensation coordinator. She indicated the custom and practice was for her to receive email notifications of all injuries. She does not remember receiving any email regarding Petitioner's injury.

The Arbitrator found the testimony of Petitioner and Ms. Barkley more persuasive than that of Respondent's employees.

As indicated above Petitioner first sought treatment from Dr. Moffett on 12/12/08. Petitioner first saw his primary care physician on 12/22/08 for this injury; the history states that Petitioner was injured at work 12/11/08 when he went to put a bag on a press. The physician assistant Julie Adkins told Petitioner to follow up with Dr. Moffett as scheduled. (Px. 1 at 3). Petitioner followed up with Julie Adkins 1/6/09. The history states he was there for a two week medication checkup. Julie Adkins told Petitioner to follow up with Dr. Moffett. (Px. 1 at 5). On 1/14/09, Petitioner underwent an x-ray of the low back. A handwritten note states Petitioner should undergo physical therapy. (Px. 1 at 9). On 3/10/09, Ms. Adkins ordered an MRI for his low back. (Px. 1 at 12). On 3/13/09, Petitioner underwent an MRI of the low back. The radiologist's impression was slight disc degenerative change and facet arthropathy especially at L4-5 with no significant neuroforaminal narrowing. A handwritten note states, "no disc herniation - Discussed with Dr. Neal to get functional capacity evaluation." (Px. 1 at 13). Petitioner continued to see Ms. Adkins for medication and treatment; a note on 4/2/09 note reflects that Petitioner was to see a neurosurgeon 4/20/09.

On 4/20/09, Petitioner saw a surgeon, Dr. Frank Hayward. Petitioner described low back pain, bilateral hip pain and right foot numbness. Petitioner gave a consistent history of the injury at work. Dr. Hayward interpreted the MRI to show disc desiccation at L4-5 and to a lesser extent L5-S1 with minimal facet arthropathy at L5-S1. The assessment was lumbar discogenic pain, most likely a result of the patient's accident. Dr. Hayward felt Petitioner exhausted conservative care and recommended a discogram to help determine the etiology of the back pain. (Px. 4 at 3-4). Petitioner saw Julie Adkins later that day and reported the surgeon was going to order a discogram and that Petitioner may require surgery on his disc. Dr. Hayward performed the discogram June 4, 2009. The findings state discogenic pain L5-S1, annular tears L4-5. (Px. 4). On 6/5/09, Dr. Hayward felt that the results of the discogram at L5-S1 were unreliable due to the way he had performed the injection and that L4-5 was Petitioner's symptom source. He ordered a facet block at L4-5. (Px. 4 at 8; Px. 6 at 9). On 9/21/09, Petitioner reported approximately 15-20 minutes of relief from the L4-5 facet injection. Dr. Hayward opined that this was diagnostic of facet arthropathy. (Px. 4 at 13). On 11/12/09, Dr. Hayward performed anterior L4-5 inter body fusion. Petitioner last saw Dr. Hayward 3/26/10. Dr. Hayward opined Petitioner had not yet fused and referred him to Dr. Jurgens for pain management. (Px. 4 at 30).

Petitioner deposed Dr. Hayward 5/11/10. Dr. Hayward first saw Petitioner 4/20/09, on referral from a family friend. (Px. 17 at 8-9, 37) At the first visit Dr. Hayward diagnosed discogenic low back pain. (Px 17 at 9). Dr. Hayward reviewed the 6/4/09, discogram and interpreted an annular tear at L4-5 as well as 10/10 pain at L5-S1. (Px. 17 at 10). Dr. Hayward testified that the 10/10 pain response was not reliable at L5-S1 because he actually injected the annulus. (Px. 17 at 10). Post-operatively at 5 months, Petitioner did not have a solid fusion. (Px. 17

at 13).Dr. Hayward testified that it takes up to one year for a fusion to take. (Px. 17 at 24). Dr. Hayward opined he could not state what caused the facet arthritis in the lumbar spine but the accident caused the annular tear at L4-5. (Px. 17 at 31). Dr. Hayward testified that Petitioner denied low back problems prior to December 2008. (Px. 17 at 39).

Respondent deposed Dr. David Lange. (Rx. 2). Dr. Lange performed an independent medical examination 3/9/09. (Rx. 2 at 5). Dr. Lange testified at the time of the exam Petitioner denied low back problems prior to the claimed work accident. (Rx. 2 at 7-8). Dr. Lange reviewed the MRI and interpreted early degenerative disc disease at L4-5. (Rx. 2 at 11). He opined Petitioner was not a surgical candidate based upon the MRI scan. (Rx. 2 at 11-12). On cross examination, Dr. Lange testified that Dr. Hayward's surgery was not appropriate because he ordered a discogram to determine the symptomatic level and then disregarded the results when he operated L4-5 which was not painful during the discogram. (Rx. 2 at 30).

Respondent also deposed Dr. Brett Taylor. (Rx. 1). Dr. Taylor had performed a record review on 3/18/10. (Rx. 1 at 5). Dr. Taylor also saw Petitioner for an independent medical examination 4/13/10. (Rx. 1 at 6). Dr. Taylor opined that the 3/13/09, lumbar MRI was normal. He opined that the treatment provided by Dr. Hayward was not related to any work injury. Dr. Taylor added that the more concerning issue was that the discogram indicated the painful level was L5-S1 and Petitioner had now undergone a floating fusion at L4-5, which would increase the L5-S1 symptoms. (Rx. 1). He diagnosed a non-union at L4-5 and pain at L5-S1. (Rx. 1 at 10) He opined that the L4-5 surgery performed by Dr. Hayward was not warranted. (Rx. 1 at 7). Simply put, Dr. Taylor questioned the usefulness of the discogram test generally, and in this case specifically. Further, he stated that Dr. Hayward had improperly interpreted the results of the test, and as a result he had chosen to operate on levels where surgery was not indicated. However, Dr. Taylor would not describe Dr. Hayward's conduct as malpractice. He opined that if Petitioner wanted additional surgery he would require anterior/posterior fusion at L4-5 and L5-S1. Dr. Taylor also believed that Petitioner's lumbar condition and the surgery were not causally related to any work event or exposure. (Rx. 1). Petitioner testified that he liked Dr. Taylor and requested that he assume care. On 7/29/10, Dr. Taylor performed a posterior fusion from L4 to S1. On 8/8/10, Dr. Taylor performed anterior lateral inner body fusion from L4-S1. Petitioner last saw Dr. Taylor 8/31/11. Dr. Taylor opined Petitioner was at MMI and could not work based upon his current symptoms and narcotics usage. (Px. 7 at 139-140).

Petitioner deposed Dr. David Volarich 6/24/11 and 9/26/12. Dr. Volarich examined Petitioner twice at the request of Petitioner's attorney. Dr. Volarich testified Petitioner gave a history of a work accident in December 2008 when lifting bags at work. (Px. 19 at 8). Dr. Volarich opined the mechanism of accident was consistent with a lumbar injury and that the work accident caused the need for the treatment Petitioner received to date. (Px. 19 at 9-10). After that deposition Dr. Volarich re-examined Petitioner on 2/29/12. He opined that Petitioner had reached maximum medical improvement on August 30, 2011 and that he could perform only sedentary work. (Px. 20 at 10-11).

Petitioner testified that he attended special education classes starting in the first grade. He played varsity football and was an all-state wrestler in school. After graduating high school, he worked a variety of jobs, but his job working for the Respondent was by far the best he ever had. He earned nearly $50,000.00 per year. The Arbitrator noted Petitioner appeared to function at a limited intellectual level.

Petitioner deposed his vocational expert Stephen Dolan 7/25/12. (Px. 16). Mr. Dolan completed reports 2/17 and 3/12/12. Mr. Dolan opined that Petitioner was permanently and totally disabled from returning to substantial gainful employment. (Px. 16).

CONCLUSIONS OF LAW

Issue (C): Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner credibly testified that he sustained an accident while engaged in his employment with the Respondent. That testimony is supported by numerous, consistent histories given to medical providers describing an accidental injury in the same way Petitioner testified at trial. The trial testimony and the subsequent medical histories are also consistent with Petitioner's written report of injury to the Respondent. (Px. 23)

The Arbitrator finds especially persuasive the first two iterations of Petitioner's work-related injury that occurred on 12/12/08 at the office of Dr. Moffett. It is unrefuted that Petitioner told his treating doctor on that date that he suffered an injury at work and that the chiropractor charted that history in the record. Moreover, it is unrefuted that at the same visit, the Petitioner filled out a form at the chiropractor's office in which he described the mechanism of injury at that time - "changing bladers [sic] in curring [sic] press." (Px. 2, at 3)

Two of Respondent's employees testified that in separate conversations on 12/15/08 and 12/16/08, Petitioner stated he had been injured at his house or his mother's house. The Arbitrator did not find the testimony of these witnesses persuasive. If their testimony is to be believed, on 12/12/08 Petitioner told his chiropractor, and wrote down on paper, that he was injured at work, then told his bosses on two consecutive days that he was injured outside of work following which he drove into work and wrote on an injury report that he was injured at work. That inconsistency is simply implausible in present context.

As indicated, the Arbitrator found Petitioner to be forthright and credible in his testimony. The Arbitrator found his testimony persuasive. The Arbitrator found the records of Dr. Moffett which clearly indicate Petitioner said he was injured at work even more persuasive.

Dr. Hayward and Dr. Volarich each testified that the Petitioner's accident caused his need for surgery and his residual disability. The discogram clearly demonstrated extravasation of the dye indicating annular tearing. Dr. Hayward felt the annular tears described by the diagnostic studies and the symptoms there from were related to the accident. Dr. Taylor agreed that Petitioner had torn discs. Although he was of the opinion that they were probably present before the accident, he conceded that they could have been aggravated by the accident. He further admitted that his opinion that the Petitioner's condition was not related to the employment was based, in part, on the assumption that there had been an intervening injury at home as he had been told by Respondent's counsel. The Arbitrator found that no such injury away from work occurred. Dr. Lange testified that when he examined Petitioner on 3/3/09 he had back pain rated at 8 out of 10 and mild radiculopathy. He believed Petitioner's symptoms on the day of the accident were caused or triggered by the accident of 12/11/08. (Rx. 2 at 15) This included both the pain and radicular symptoms. He agreed that a disc injury could account for the radicular symptoms. (Rx. 2 at22) In discussing the results of the post discogram CT scan which showed annular

tears at L4-5 and L5-S1 Dr. Lange stated "although most are asymptomatic and due to degeneration, there certainly can be symptomatic annular lesions, and some of those may well be traumatic in nature and might be consistent with the mechanism of injury described by Mr. Agnitsch." (Rx. 2 at 26)

Further, the records in evidence do not establish that Petitioner had any significant back symptoms in the months and years preceding the accident. The medical records are significant because they contain consistent histories by the Petitioner of the mechanism of injury. There is no reference in the medical records that suggest Petitioner suffered serious injury to his low back in any way or at any time other than as he testified at hearing. Though he did have some discomfort from time to time, there is absolutely no evidence that any medical treatment was required or obtained prior to this accident.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner met his burden of establishing he suffered an accidental injury arising out of and in the course of his employment with Respondent on 12/11/08.

Issue (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?

Dr. Hayward and Dr. Volarich both testified that the Petitioner's accident caused his need for surgery and his residual disability. Dr. Hayward felt Petitioner exhausted conservative care and recommended a discogram to help determine the etiology of the back pain. (Px. 4 at 3-4). Dr. Hayward performed the discogram June 4, 2009. Dr. Hayward stated that the results of the discogram at L5-S1 were unreliable because he had injected the annulus which was what triggered Petitioner's pain response, and that L4-5 was Petitioner's true symptom source. The discogram clearly demonstrated extravasation of the dye indicating annular tearing, He ordered a facet block at L4-5. (Px. 4 at 8; Px. 6 at 9). Petitioner reported approximately 15-20 minutes of relief from the L4-5 facet injection. Dr. Hayward opined that this was diagnostic of facet arthropathy and recommended surgery. (Px. 4 at 13). On 11/12/09, Dr. Hayward performed anterior L4-5 inter body fusion. Petitioner last saw Dr. Hayward 3/26/10. Dr. Hayward opined Petitioner had not yet fused and referred him to pain management. (Px. 4 at 30).

When asked if Petitioner was a surgical candidate Dr. Lange responded "I thought not" because based on the MRI he felt there was a "less than ideal indication for invasive treatment." (Rx. 2 at 11-12) Dr. Lange explained that he disagreed with the decision of Dr. Hayward to operate because the source of Petitioner's low back pain "was not definitely defined." (Rx.2 at 31)

Dr. Taylor opined that the L4-5 surgery performed by Dr. Hayward was not warranted. (Rx. 1 at 7). Simply put, Dr. Taylor questioned the usefulness of the discogram test generally and in this case specifically. Further, he stated that Dr. Hayward had improperly interpreted the results of the test, and as a result he had chosen to operate on levels where surgery was not indicated. He felt that the 3/13/09, lumbar MRI was normal. Dr. Taylor added that the more concerning issue was that the discogram indicated the painful level was L5-S1 and Petitioner had now undergone a floating fusion at L4-5, which would increase the L5-S1 symptoms. (Rx. 1). He diagnosed a non-union at L4-5 and pain at L5-S1. (Rx. 1 at 10) He opined that if Petitioner wanted additional surgery he would require anterior/posterior fusion at L4-5 and L5-S1. Petitioner testified that he liked Dr. Taylor and requested that he assume care. On 7/29/10, Dr. Taylor performed a posterior fusion from L4 to S1. On

8/8/10. Dr. Taylor performed anterior lateral inner body fusion from L4-S1. Petitioner last saw Dr. Taylor 8/31/11. Dr. Taylor opined Petitioner was at MMI and could not work based upon his current symptoms and narcotics usage. (Px. 7 at 139-140).

The Arbitrator notes that Dr. Taylor did not even see Petitioner until after the failed fusion surgery. Dr. Lange, who examined the Petitioner prior to the first surgery disagreed with Dr. Hayward's decision to operate, but his opinions were not persuasive. The fact that two practitioners may differ in their opinion regarding either diagnosis or the course of treatment pursued does not equate to the performance of treatment which is not reasonable or necessary. The reality is that medicine is not a perfect science and legitimate differences of opinion may well exist. The Arbitrator found the testimony of Dr. Hayward, Petitioner's first surgeon more persuasive regarding the reasonableness and necessity of the procedure he performed. The second procedure performed by Dr. Taylor was clearly reasonable and necessary in light of the failure of the first fusion to form an appropriate union.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds the medical treatment provided to Petitioner was both reasonable and necessary. Therefore Respondent shall pay reasonable and necessary medical services as set forth in Petitioner's Exhibit 14 pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act.

Issue (K): What temporary benefits are in dispute?

It is uncontested that Petitioner never returned work following the injury. Instead, at all times following 12/12/08, Petitioner was either authorized off of work, or restricted in his work duties. It is also uncontested that the Petitioner was never offered restricted work by the Respondent. Petitioner was placed at MMI by Dr. Taylor on 8/31/11. Therefore the Arbitrator finds Petitioner is entitled to TTD benefits in the amount of $602.74 per week beginning on 12/13/08 through 8/30/11 (141 4/7 weeks). By stipulation of the parties, Respondent is entitled to credit for amounts paid under its disability policy in the amount of $18,860.85.

Issue (L): What is the nature and extent of the injury?

It is uncontested that Petitioner was given very substantial lifting restrictions by his treating doctor and further advised that he was unable to maintain employment due to his ongoing need for narcotics; it was similarly acknowledged by the independent examiners that he had significant work restrictions. Petitioner nonetheless asked more than 200 employers for work without arousing even the slightest interest from any employer. A highly qualified and credible vocational rehabilitation specialist, Stephen Dolan, reviewed Petitioner's medical treatment and restrictions, reviewed his past employment history and educational performance, performed relevant testing to measure Petitioner's abilities and employability, and concluded Petitioner was unemployable. Respondent did not introduce any evidence to the contrary. Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner is totally and permanently disabled as of 8/31/11, the date he reached maximum medical improvement. Petitioner is therefore entitled to receive $602.74 per week for life.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in Section 8(g) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kirby Helvie,
Petitioner,

16IWCC0142

vs.

NO: 09 WC 6063

Joe Kinsella & Son Inc,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, statute of limitations, temporary disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 22, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 1 - 2016
o2/10/16
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0142

HELVIE, KIRBY
Employee/Petitioner

Case# 09WC006063

JOE KINSELLA & SON INC
Employer/Respondent

On 6/22/2015, 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 0.10% 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:

0384 NELSON & NELSON
BOB NELSON
PO BOX Y
BELLEVILLE, IL 62222

0507 RUSIN & MACIOROWSKI LTD
THEODORE J POWERS
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

16IWCC0142

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Kirby Helvie
Employee/Petitioner

Case # 09 WC 6063

v.

Consolidated cases: N/A

Joe Kinsella & Son, Inc.
Employer/Respondent

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 **Collinsville,** on **1-28-15 and 4-22-15**. 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 the 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 the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

E. ☒ Was timely notice of the accident given to respondent?

F. ☒ Is the Petitioner's present 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?

K. ☒ What amount of compensation is due for temporary total disability?

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 Statute of Limitations

16IWCC0142

FINDINGS

On 7-3-08, 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 not*** sustain an accident that arose out of and in the course of employment.

Petitioner's current condition of ill-being ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $59,333.79; the average weekly wage was $1,141.03.

On the date of accident, Petitioner was 57 years of age, ***single*** with 0 children under 18.

Necessary medical services ***have*** been provided by the respondent.

To date,$ 0.00 has been paid by the respondent for TTD, maintenance benefits, or group non-occupational disability benefits for which credit would be allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that he sustained an accident on July 3, 2008 that arose out of and in the course of his employment with Respondent or that his condition of ill-being was causally connected to his employment and/or accident. Petitioner's claim for compensation is denied and no benefits are awarded.

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 of 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 Hadley
Signature of arbitrator

6.21.15
Date

JUN 22 2015

KIRBY HELVIE v. JOE KINSELLA & SON, INC., 09 WC 6063

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

Petitioner has filed this claim alleging that his bilateral shoulder condition was related to his employment duties at Respondent's construction business. (AX 2). Petitioner has brought this claim under a theory of repetitive trauma based upon his job duties as a carpenter for Respondent. He is alleging an accident/manifestation date of July 3, 2008. (AX 2). Issues in disputes at the hearing included accident, notice, causal connection, medical bills, temporary total disability, statute of limitations and nature and extent. (AX 1). The hearing began on January 28, 2015 but was bifurcated to allow for additional evidence. Proofs were closed on April 22, 2015.

The Arbitrator finds:

According to the medical records, Petitioner initially sought treatment with Dr. James Rushford on July 9, 2008 after noticing the left biceps drop. (RX 3). Petitioner gave Dr. Rushford a history of having bilateral shoulder discomfort for a number of years. He related his shoulder problems to 2002 when he was lifting trash out of a barrel that weighed approximately 50-60 pounds and felt some crunching in his shoulders. Petitioner's new patient information confirms Petitioner's history of injury in 2002. (PX 5) Petitioner further gave a history to Dr. Rushford on July 3rd that he noticed he had a bulge in his biceps muscle. He denied any significant pain. (RX 3)

Dr. Rushford noted that Petitioner had a positive pop out deformity of the left upper extremity. X-rays of Petitioner's shoulders showed degenerative changes. Evidence of narrowing of the acromial humeral interval was noted suggesting rotator cuff pathology. X-rays

also showed cystic changes in the humeral heads bilaterally suggestive of chronic impingement. (PX 1, RX 3).

Dr. Rushford's impression was of left shoulder pain felt to be on the basis of a probable chronic rotator cuff tear with underlying acute on chronic aseptic tenosynovitis with tearing. Dr. Rushford further noted Petitioner's right shoulder was felt to have a chronic impingement with possible rotator cuff tear, full thickness versus significant partial thickness tearing and underlying bicipital tenosynovitis.

Dr. Rushford ordered bilateral MRIs of the shoulders and left humerus. Petitioner completed a questionnaire as part of the MRI procedure. He noted an injury date of 7/3/08 due to lifting. He did not indicate a work injury. In response to how the injury happened, Petitioner noted, "Unknown." (RX 3).

Petitioner's MRIs demonstrated chronic tears of the supraspinatus tendons bilaterally involving the inferior two-thirds with significant thinning of the remaining one-third. There was also evidence of attenuation of the right biceps tendon with no evidence of tearing. There was also evidence of a partial tear of the left biceps tendon. (PX 1). The MRI also showed evidence of arthritic changes of the AC joint of the left shoulder as well as sloping acromion. (PX 1).

Petitioner returned to see Dr. Rushford on July 6, 2013. Petitioner related a long history of bilateral shoulder discomfort. The doctor felt that Petitioner had a complete tear of the long head of the biceps tendon. (RX 3). Based upon the MRI, he believed that Petitioner suffered from bilateral rotator cuff tears, felt to be on a chronic basis with an acute injury to the left long head of the biceps tendon and chronic right shoulder bicipital tenosynovitis. This was in addition

to evidence of AC joint arthritis and longstanding impingement. Dr. Rushford recommended left shoulder surgery. (PX 1, RX 3).

Dr. Rushford performed diagnostic arthroscopic surgery of the left shoulder with minimal debridement of Type I SLAP tear, open subacromial decompression and distal clavicle resection with biceps tenodesis and a complete open repair of the rotator cuff. In the Operative Report, the doctor noted, " ...without any specific trauma, [he] noted one day that he had a prominence of the biceps muscle on the left side. The patient has a history of bilateral shoulder discomfort for a number of years. He is a carpenter by trade." (PX 1). Dr. Rushford's post-operative diagnosis was of a Type I lesion SLAP lesion of the left shoulder, complete rupture of the long head of the biceps tendon and chronic left rotator cuff tear, left-sided impingement and AC joint arthritis.

Post-operatively, Dr. Rushford recommended Petitioner undergo physical therapy. He further recommended Petitioner undergo surgery for the right shoulder for rotator cuff pathology and probable biceps tendon pathology. (PX 1).

Petitioner gave a recorded statement to Mark Lageveen on July 31, 2008 in connection with an alleged accident. (RX 1). Petitioner knew that the statement was recorded and it met with his approval. (RX 1, p.1). At the conclusion of the recorded statement, Petitioner agreed that he had understood all of the questions asked and the information that he provided was true and correct to the best of his knowledge. He also agreed that the recorded statement was taken with his permission. (RX 1, p. 21).

In his recorded statement, Petitioner stated that what brought about this claim was he tore his biceps loose. (RX 1, p. 4). Petitioner said that he was standing in front of the mirror to shave and noticed that something was wrong with his left arm. He saw that there was a big ball of

tissue just above his elbow and he needed to seek medical treatment for that. (RX1, p.4). In discussing the cause of the biceps tear, Petitioner stated the following in his recorded statement:

> There was nothing traumatic about when that happened. It could have been... it could have been the 2nd it could have been the 3rd. I don't know when it was. Both those were work days. I did not have to be at work. I came home and did things around to house too and uh, even had gone to an auction on July...the evening of July 3rd and helped people at this auction, you know, move furniture. So it could have been the furniture too. I really don't know when it happened. I just know that on July 4th, I saw that I had a torn...that my bicep had torn loose from my shoulder.... (RX1, p.4).

In his recorded statement Petitioner further said there no point at which he had pain or sensation of something coming loose or any sound which is what he had when he tore his rotator cuffs. Petitioner said there was nothing that indicated he had hurt himself. Petitioner further said that as he did not have any symptoms, there was no way for him to say when or where is happened. (RX 1, p.15). He said he probably would never have had his rotator cuffs repaired except he could not let his bicep go. (RX 1, p.5).

Petitioner said that he was told by his boss that he had 10 days to two weeks to get repaired. (RX1, p.4). Petitioner also said in the recorded statement that he was talking to his next door neighbor, who is a director of physicians at a local hospital and the neighbor told him that he had five days to have the same rectified or the biceps tissue would begin to attach to whatever it was closest to. (RX 1, p.5).

The recorded statement also reflects Petitioner volunteering that an accident occurred in 2000 or 2001 when he tore both his rotator cuffs on the job. (RX 1, p.3) Petitioner said that the accident occurred when he was loading heavy material into a dumpster. (RX 1, p.3). Petitioner said he had a definite moment there where he knew he had done damage to his shoulders. He said he heard a loud cracking, ripping noise and immediate sharp pain in both shoulders. (RX 1, p.3-4) He recalled that the injury occurred first thing in the morning when he was loading debris

from a job site into a dumpster. (RX 1, p.6). Petitioner said that he picked up the bag of trash to throw into the dumpster and while lifting it above his head to throw it over the side, he hurt himself. (RX 1, p.19).

Petitioner said no one was present at the time he was at work when the accident occurred. Petitioner was at work early. (RX 1, p.19). Petitioner did not know how much the trash weighed but knew it was very heavy. (RX 1, p.19). He picked up the trash and had to lift it over his head and that is when he tore the rotator cuffs. (RX 1, p. 19). Petitioner said that he mentioned the injury to his shoulders to everyone at work that day. (RX 1, p.19).

Petitioner further said in his recorded statement that, at the time, he thought maybe he had strained some muscles and anticipated giving it some time to heal and everything would be fine. He had no idea that he had damaged his shoulder so severely. (RX 1, p. 19-20). Petitioner also said that by the time he realized that the pain wasn't going away, he decided he was just going live with it. (RX 1, p.19-20).

In his recorded statement, Petitioner expanded upon the reason that he did not seek treatment with a doctor after that. Petitioner stated that he had terrible luck with doctors and figured he would rather live with the pain than to take a chance on being able to find a doctor that would do him more good than harm. (sic) (RX 1, p.4,15). Petitioner added that doctors either "misdiagnosed me or did not diagnose me at all for about five things in a row" that he thought were major and should have easily been known. (RX 1 p.15).

In regard to not filing a claim for the injuries to his shoulders due to the earlier injury, Petitioner said in his recorded statement that he doesn't like workers' comp and wasn't about to go through it. Petitioner claimed that workers' comp doesn't pay and they charge employers a horrendous amount of money. He states that is why he did not file a claim. Petitioner also said

in his recorded statement that he had a bad experience with workers' comp. He said that he actually referred to it as "worthless comp." (RX 1, p.4, 16).

Petitioner received physical therapy at Ace Physical Therapy for his left shoulder beginning on August 1, 2008. In the Initial Evaluation note Petitioner indicated he had injured both his shoulders but was unsure as to how it had occurred or when. (PX 2).

When Petitioner initially sought treatment with Dr. Yamaguchi for his right shoulder condition on September 10, 2008, he completed a patient questionnaire. At that time, Petitioner noted that there was no known reason for what caused the problem to start, although he noted that the problem started at work. Petitioner also noted that he had pain for 5 years noting that the injury occurred on the job. (RX 2). Petitioner also indicated on the questionnaire that a workers' compensation claim would not be filed. (RX 2).

Petitioner saw Dr. Yamaguchi on September 24, 2008 for his right shoulder. (PX 3) Dr. Yamaguchi's initial office notes also reflect that Petitioner's history as to his development of shoulder symptoms. Petitioner gave a history to Dr. Yamaguchi of lifting heavy objects at work when he sustained bilateral shooting pain and sharp pain into both shoulders. Petitioner reported living with the pain until July of that year (2008). (RX 4). Dr. Yamaguchi noted that the MRI showed a medium right-sided rotator cuff tear involving the supraspinatus and part of the infraspinatus tendons. Dr. Yamaguchi recommended arthroscopic surgery for the rotator cuff repair and biceps tenodesis. (PX 3).

Petitioner continued with therapy through September 30, 2008 at which time it was stopped due to his upcoming right shoulder surgery. (PX 2)

Dr. Yamaguchi performed arthroscopic surgery on October 6, 2008. (PX 3). The post-operative diagnosis was of a right shoulder rotator cuff tear and right biceps tendinopathy. (PX 3).

Petitioner followed up post-operatively with Dr. Yamaguchi. Petitioner was prescribed physical therapy for his right shoulder as well. Petitioner underwent physical therapy at Ace Physical Therapy. (PX 2,3).

Petitioner signed his Application for Adjustment of Claim herein on February 3, 2009. (AX 2)

Petitioner was discharged from therapy on April 30, 2009. (PX 2). On May 6, 2009 Dr. Yamaguchi released Petitioner to full duty work. They were a little concerned about his return to carpentry as Petitioner would be doing a lot of lifting overhead but they decided to see how he did. Petitioner also asked the doctor if he remembered their initial conversation regarding workers' compensation origin versus private insurance. The doctor told Petitioner that he did remember the conversation with him and how Petitioner had related that while he felt his problem was a workers' compensation type of injury he was going through personal insurance to expedite care. Petitioner had asked the doctor at that time whether or not the doctor felt his situation was work-related and because of his relative young age when he sustained the tears and the vigorous overhead nature of his work, his work "certainly is likely to have contributed to the development of this problem" (PX 3) The work status noted Dr. Yamaguchi states "return to carpentry work; doing a lot of overhead activity status post bilateral rotator cuff repairs will be a potential issue, however we can only try and see how he will do." (PX 3).

Petitioner was examined by Dr. Richard Lehman on January 11, 2011 at Respondent's request. Dr. Lehman took a history from Petitioner, including a history as to the injuries to his

shoulders in 2003. Petitioner stated that his injuries began in 2003 while trying to push some trash and he experienced bilateral shoulder pain. He was unable to use his arms for a prolonged period of time thereafter and had significant soreness. He had been experiencing discomfort for a long period of time and been a carpenter for a long period of time with stress to his shoulders but the majority of his pain began in 2003. Dr. Lehman also examined Petitioner's medical records as well as radiological studies and performed a physical examination, (RX 5).

Dr. Lehman expressed the opinion that Petitioner had a chronic long-term breakdown of the rotator cuff bilaterally which occurred in 2003. Dr. Lehman stated that although he opined that Petitioner's job as a carpenter involved repetitive activities, his complaints started in 2003. (RX 5).

Dr. Lehman further opined that the breakdown in Petitioner's biceps tendon was a chronic long-term process as evidence by the MRI that may have manifested itself in 2008. Dr. Lehman further opined that Petitioner's main problem occurred from the injury in 2003. Based upon Petitioner's history, Dr. Lehman further opined that Petitioner's problem started in 2003 based upon history, and pathology may have started prior. (RX 5).

Petitioner returned to see Dr. Yamaguchi on January 18, 2011 and the office note reflects Petitioner's history as to his development of shoulder symptoms. Petitioner's questionnaire indicates that he was seeing the doctor for left shoulder pain and weakness since July of 2008. He acknowledged having filed a workers' compensation claim. Petitioner complained of weakness and pain in his left shoulder. He had been working as a carpenter with much difficulty. Petitioner's right shoulder was doing well. Dr. Yamaguchi suspected a possible left rotator cuff tear. He ordered x-rays, and an MRI and ultrasound. Dr. Yamaguchi believed that the

radiological studies reflected an acute or chronic quadrilateral space syndrome or teres minor atrophy. (PX 3)

Petitioner followed up with Dr. Yamaguchi on February 23, 2011 with a subacromial injection. Dr. Yamaguchi further discussed the possible need for a release of the teres minor nerve. Exercise was prescribed to increase shoulder strength. (PX 3). Petitioner then returned to Dr. Yamaguchi in August, 2011. He advised that the injection did not provide relief; however, he did have improvement due to the exercises. Dr. Yamaguchi recommended an MRI in three months. (PX3). Petitioner did not return as instructed.

At the request of Petitioner's attorney, Dr. Volarich evaluated Petitioner on August 29, 2012 and four years after the alleged accident. (PX 4, p. 26). Dr. Volarich's deposition was also taken. Dr. Volarich is not board certified in occupational medicine. His only board certification is in nuclear medicine and as an independent medical examiner. (PX 4, p.25). Dr. Volarich noted that Petitioner gave a history of the incident at a job in 2003 which resolved within a month. (PX 4, p.9,44,46). Dr. Volarich also testified that Petitioner gave a second history of injury on July 3, 2008, when lifting a 50 pound saw. (PX 4, p.10,)

Dr. Volarich opined that the repetitive nature of Petitioner's work as described in the history and job activities section of his report was the cause of Petitioner's bilateral shoulder internal derangements, including the rotator cuff tears, impingement and biceps tendon injuries. (PX 4, p.21).

Dr. Volarich testified that he assumed Petitioner's history to Dr. Yamaguchi of lifting a heavy object involved a 50 saw Petitioner said he lifted on July 3, 2008. (PX 4, p.37-38).

Dr. Volarich did opine that Petitioner's incident of lifting trash (later, at trial, to be referred to as the O'Fallon job) could have caused bilateral rotator cuff tears, but claimed there

was no mention of weakness in Petitioner's history. Dr. Volarich also said he would have expected Petitioner to have sought medical treatment at that time. (PX 4, p.40, 42). Dr. Volarich also opined that if Petitioner had torn his rotator cuffs in 2002 or 2003 he would have expected significantly more complaints and difficulties in his ability to his job. (PX 4, p.42). He further understood Petitioner's shoulder condition from 2002 and 2003 had resolved based upon Petitioner's history. (PX 4, p. 43-44).

In discussing Petitioner's ruptured biceps tendon, Dr. Volarich stated that the condition can be chronic or acute. If chronic, people don't know that they have ruptured the biceps tendon, particularly if they don't have pain. If the condition is due to an acute event, there would be evidence of bruising due to bleeding. (PX 4,p.45) Dr. Volarich stated that if Petitioner had sustained an acute biceps rupture lifting a 50 pound saw on July 3, 2008, he would have expected Petitioner to have immediate complaints of pain. (PX 4, p.31).

Petitioner did not have the MRI and did not return to see Dr. Yamaguchi until approximately a year and a half later on May 29, 2013. (PX 3). At that time Dr. Yamaguchi suspected a rotator cuff tear based upon Petitioner's physical examination and he recommended an ultrasound. If the rotator cuff was not torn he recommended the subacromial injection. Dr. Yamaguchi also discussed Petitioner possibly undergoing a diagnostic injection. (PX 3).

Petitioner was then re-evaluated by Dr. Lehman on December 10, 2013. (RX 8). Dr. Lehman agreed with the diagnosis of teres minor atrophy but did not believe Petitioner required further treatment. He further would not relate Petitioner's complaints and condition to the July 3, 2008 alleged accident. (RX 8).

Petitioner's case proceeded to arbitration on January 28, 2015.At the time of the alleged accident, Petitioner was 57 years old. (AX 1) Petitioner was hired by Respondent as a carpenter

in 1997. Petitioner has been a carpenter since 1976. He has been working full-time as a carpenter for Respondent since 1999. (RX 1)

Petitioner performed general carpentry work-from framing to finished work. In addition to his carpenter work, Petitioner was a foreman for Respondent.

Evidence was provided regarding Petitioner's job duties. This included a job description Petitioner prepared. (PX 7).

Respondent's business basically involves residential construction. Petitioner stated that 95% of his job involves residential carpentry. (RX 1, p.7). Respondent would hire subcontractors for jobs. This would include subcontractors for electricity and plumbing. (RX 1, p.8). Petitioner also said that Respondent even hires out for roofing anymore. Six to eight years earlier Respondent used to do roofing. Respondent also subcontracted for roofing and foundations as concrete is a nemesis. (RX 1, p8).

Petitioner testified that while he may have stated in the recorded statement that the accident occurred in 2001 or 2002, he now believed it was 2003. He couldn't remember what date it was.

Petitioner testified that the injury in 2003 occurred as he was throwing some trash bags into a dumpster. Petitioner said it was early in the morning his shoulders were cold and he hurt his shoulders. He claimed he had a burning sensation and pain into his shoulders. Petitioner recalled the injury occurred at the Wojtal Job in O'Fallon, Illinois. (Hereinafter "O'Fallon job".) Petitioner claimed that because it was cold and it was early and he wasn't warmed up, he thought that was the extent of it. Petitioner said he just strained something was how he referred to it.

After the accident at the O'Fallon job, Petitioner testified that he had some discomfort and pain in the shoulders. Petitioner claimed that after the accident he was mindful how he use

his shoulders and what he lifted for a week or two and within a month the pain had lessened to where he could see it was getting better. Petitioner said that within a year he didn't give his shoulders much thought at all. Petitioner said that he went back to work doing what he had always done, lifting walls and windows into place, lifting sheets of drywall and plywood overhead. Petitioner claimed that he didn't miss a single day of work after the accident 2003.

Petitioner testified that he noticed that his shoulder had become weaker and the pain grew more intense from 2005 to 2008. Petitioner testified as to the difficulty he had performing overhead work. He said it was the overhead work that caused the discomfort in his shoulders.

On cross-examination, Petitioner admitted that he gave a recorded statement to Respondent's insurance company in connection with his alleged claim. Petitioner testified on cross-examination that Respondent's insurance adjuster had suggested the injury occurred in at the O'Fallon job 2000 or 2001. Petitioner stated that when he looked back at his records it occurred in 2003.

On cross-examination, Petitioner testified that at the time of his shoulder injury he heard a sound and he experienced pain. Petitioner said that he knew he was hurt but he didn't know how much of a problem. Petitioner also testified that he initially had pain and then it went away. Petitioner said that the pain subsided from the injury and that he went back to his normal duties within a year or less.

Petitioner also testified on cross-examination that he did not have immediate limitation as to movement of his shoulders immediately after the accident. Petitioner also testified that after the accident at the O'Fallon job he had pain for maybe two to three weeks. He claimed that within a year he didn't even think about it.

Petitioner denied on cross-examination that he had any limitations in the use of his shoulders. He claimed that slowly over the next two, three or four years things began to deteriorate. Petitioner said that he initially had pain in his shoulders after the accident at the O'Fallon job, but then he didn't have pain and then it started to get progressively worse. Nevertheless, Petitioner also testified that he was having pain and limited mobility with his arms for several years after the injury to his shoulders at the O'Fallon job.

Petitioner said that he did not have a diagnosis for the problem with his shoulders and he was incapable of diagnosing the cause of pain he was having. Petitioner further testified that he didn't know something was wrong. He knew he had pain in his shoulders and he had decreased use of his shoulders which he attributed to old age. He said he had no reason to believe he had a torn rotator cuff.

However, Petitioner admitted that he had conversations with co-employees about his shoulder pain and limited mobility a couple years ago and discussed torn rotator cuffs. (see, RX 1, p.4). Petitioner further testified that the rotator cuff tears meant nothing to him because he was not going to file any claims and he was doing fine with the pain and limited mobility.

After the injury to his shoulders at the O'Fallon job, Petitioner did not seek any medical treatment. Petitioner also did not file a workers' compensation claim stemming from the injury to his shoulders at the O'Fallon job.

Petitioner testified he didn't like going to see a doctor unless there was something pretty acute going on. Petitioner said at the time he first injured his shoulders he didn't go to a doctor because he thought he could work through the pain and not go to a doctor. Petitioner acknowledged that he really does not care for doctors.

On July 4, 2008, Petitioner noticed that his left bicep muscle had slipped. There was no traumatic injury and no simple accident that occurred; nothing that he could put his finger on. Petitioner also testified that he did not have any particular onset of pain that he remembers leading up to his bicep dropping. Petitioner claimed there was never any pain, no bruising or signs of trauma. Petitioner was shaving and noticed that his bicep muscle had moved down in the mirror.

Petitioner testified that July 3rd was the last day that he worked. However, Petitioner also testified that he worked up until the date he had left shoulder surgery on July 15, 2008. Petitioner testified that he would probably not have done anything about his shoulder pain and shoulder discomfort if it hadn't been for his bicep tearing loose. Petitioner explained that the only reason he went for treatment was because his bicep had dropped in his left arm. Petitioner stated that it was his talking to his neighbor after he noticed his bicep had dropped that it took him to seek medical treatment. It turned out that Petitioner's neighbor held a position at St. Elizabeth's Hospital in Belleville. Petitioner testified that he did not tell anyone that he was injured 2008. He said there was no traumatic injury that he knew of, so there was nothing to relate there.

Petitioner discussed his job activities for several weeks leading up to July 4, 2008. Petitioner said nothing traumatic occurred while performing this work. It was work as usual.

Petitioner testified that he was told by Dr. Rushford that he tore his rotator cuffs at the time of the O'Fallon job. Petitioner said that he had seen the doctor and was told that this must have been causally related to the O'Fallon incident. Petitioner then claimed that Dr. Rushford was guessing. Petitioner also testified that Dr. Rushford told him that the biceps tendon might have also been torn.

Petitioner testified he was off work from July 15, 2008 to May 19, 2009 and is seeking TTD for this time period. However, Petitioner stated in his recorded statement that after the initial surgery with Dr. Rushford, he was being assigned bid work which Petitioner had always done for Respondent. He would get an hour here and an hour there, a couple hours a week. (RX 1, p.18). Petitioner also said in his recorded statement that Dr. Rushford did not provide Petitioner with an off work slip. (RX 1, p.18).

Petitioner was released to work without restrictions by Dr. Yamaguchi on May 9, 2009. (PX 3).

Petitioner said that since he has been released from treatment and back to work he has had continual pain in his left shoulder and problems sleeping at night. Petitioner also claims that he cannot lift a sheet of plywood with his left arm. He claims he cannot lift more than 30 pounds with the left arm.

Petitioner also claims that he had a loss of income compared to what he was earning before the alleged accident on July 3, 2008. He stated he was making half of what he used to make.

Petitioner also testified that he has been working light duty since he returned to work in 2009 and claimed that as a result he does not have as many opportunities for work hours.

Petitioner also testified that he is unable to swim long distances like he used to. However, in his recorded statement, Petitioner stated that he stopped swimming due to leg cramping, not his shoulders. (RX 1, p.20).

With regard to Petitioner's loss of income, Petitioner testified that he has been laid off for a very short period of time once or twice since 2008, but agreed that there was a downturn in the

amount of business. Petitioner noted that Respondent has gone from ten carpenters in 2006 to two carpenters at the current time.

Petitioner's W-2 statements from 2009 and 2014 do reflect earnings less than what he had earned prior to the date of the accident. (See, RX 9). However, Tom Kinsella, the owner of Respondent's business testified that business has been horrible since 2008. Mr. Kinsella stated that the economy has collapsed. (RX 10, p.9). Mr. Kinsella stated that between 2008 and 2015, on an annual basis, there has been a loss of income in terms of monies that Respondent has earned. He states this is due there being less work to do. (RX 10, p.10). Mr. Kinsella also stated that if he had a project, Petitioner would be working some portion of it. (RX 10, p.17).

The Arbitrator concludes:

1. Accident and Causal Connection.

Petitioner failed to prove he sustained an accident on July 3, 2008 that arose out of and in the course of his employment with Respondent or that his condition of ill-being in his shoulders and biceps was causally connected to his work accident or his employment duties with Respondent.

A claimant has a burden of proving by preponderance of the credible evidence, all of the elements of this claim to recover benefits under the Illinois Workers' Compensation Act. *Illinois Bell Telephone Company v. Industrial Commission,* 265 Ill. App. 3d 381, 638 N.E. 2d 307 (1994). The burden of establishing the necessary causal relationship between an injury and the employment rests with the claimant. *Saunders v. Industrial Commission* 189 Ill. 2d 623, 727, N.E. 2d 247 (2000).

Liability under the Illinois Workers' Compensation Act cannot be premised on speculation or conjecture, but must be based on facts contained in the record *Deichmiller v.*

Industrial Commission, 147 Ill. App. 3d 66,497 N.E. 2d 451 (1986). The burden rests on the claimant to establish his case by competent evidence Heyman *Distributing Company v. Industrial Commission*, 376 Ill. 90, 32 N.E. 2d 894 (1941).

Testimony as to the mere possibility is insufficient to sustain an award. *Gudeman Co. v. Industrial Commission* 399 Ill. 279, N.E. 2d 807 (1948). The mere possibility that a claimant have become afflicted with the condition of ill-being in the course of the employment is not sufficient to support an award. *Byrd v. Industrial Commission* 33 Ill. 2d 115, 210 N.E. 2d 535 (1965).

Petitioner herein has failed to meet his burden of proof on the issues of accident and causal connection. The credible evidence shows that Petitioner should have sought treatment after the O'Fallon accident (2003 accident), but for personal reasons, including his bad experiences with physicians, he chose to live with his pain and symptoms. Petitioner had a viable claim stemming from the O'Fallon accident, but also chose to not pursue a claim or seek medical attention under the workers' compensation system based upon his personal views. Unfortunately, the statute of limitations has long run for this claim. Petitioner chose not to pursue a claim or seek medical treatment. He chose to live with the pain by his own admission.

The Arbitrator also notes that Petitioner's testimony at trial minimizing the nature of his symptoms after the O'Fallon accident is in marked contrast with his comments as to the problems he was experiencing with his shoulders from the time of the O'Fallon accident up until he observed his left bicep muscle drop while shaving on July 4, 2008 as reflected in his recorded statement and in early medical records generated prior to the filing of his claim herein. His testimony that the injury was minimal is refuted by the comments he made about his condition in the recorded statement and the chronic and significant shoulder pathology seen through the

medical evidence. A minimization of the injury is also refuted through Petitioner's description of his physical difficulties with his shoulders since the O'Fallon accident and comments to the medical providers freely admitting ongoing problems with his shoulder since that time up to July 4, 2008. He claims he lost no time from work, but told Dr. Lehman he could not use his arms for a prolonged period of time. The O'Fallon accident was more than a shoulder strain. The different way in which Petitioner portrayed the events preceding his filing of his Application for Adjustment of Claim throws a shadow of doubt on his overall credibility. The Arbitrator gives considerable weight to Petitioner's recorded statement which was freely given and prior to his claim having been filed.

The Arbitrator therefore rejects Petitioner's testimony that he had sustained a shoulder strain due to the O'Fallon accident which subsequently resolved with no problems whatsoever for several years only for symptoms subsequently develop and progress later up until July 3, 2008 due to his general job duties.

The Arbitrator also finds that Petitioner failed to prove a work-related cause for the left bicep rupture that he observed while shaving on July 4, 2008. Petitioner's testimony, as well as the recorded statement, clearly shows that Petitioner could not relate either his regular job duties or a specific incident at work to the bicep condition. Petitioner freely admitted he had no idea either when or where it occurred. He admitted it could have occurred at home or at an auction.

Furthermore, the medical expert evidence fails to prove a causal relationship between Petitioner's job duties and his shoulder conditions. The Arbitrator rejects the opinion evidence of Dr. Volarich. His opinion was based upon Petitioner's flawed history of the O'Fallon accident having resolved with no further symptoms or problems for years leading up to the biceps rupture. Dr. Volarich's understanding of a mild bilateral shoulder strain was incorrect.

Dr. Volarich also relied upon Petitioner being involved in a lifting incident on July 3, 2008 (lifting a fifty pound saw on the 3rd) as a cause even though there was no evidence at trial to support this.

While Dr. Yamaguchi reported that Petitioner's work certainly was likely to have contributed to the development of Petitioner's problem, Dr. Yamaguchi never reviewed any of Petitioner's prior medical records which would have shed light on the complete history of Petitioner's shoulder injuries/conditions. It is also concerning that this discussion was held shortly after Petitioner had filed his Application for Adjustment of Claim herein. Furthermore, the exact context within which the conversation/discussion between Petitioner and the doctor was conducted is not entirely clear and the doctor's deposition was not taken. Petitioner clearly related the 2003 accident to Dr. Yamaguchi when first seen in 2008 and it did occur at work. Thus, Petitioner's belief that he may have had a worker's compensation type of injury was not incorrect. However, the statute of limitations for that injury has passed. In the end, Dr. Yamaguchi never provided a causation opinion based upon a full and complete understanding of the facts.

Consequently, based upon all of the evidence, Petitioner has failed to meet his burden of proving that he sustained an accident arising out of and in the course of his employment or that his condition of ill-being in his shoulders is causally related to the alleged accident on July 3, 2008. Based upon the denial of this claim on the basis of accident and causation, the issues of TTD, medical liability, maintenance and nature and extent of the injury need not be addressed. Petitioner's claim for compensation is denied.

****

STATE OF ILLINOIS)	☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF WILLIAMSON)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Donald Inchliff,

Petitioner,

vs.

NO: 09 WC 19739

Southern Illinois University Carbondale,

16IWCC0169

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 10, 2015 is hereby affirmed and adopted.

No bond or summons required for State of Illinois cases.

DATED: MAR 11 2016

MB/mam
o:2/11/16
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

INCHCLIFF, DONALD
Employee/Petitioner

Case# **09WC019739**

16IWCC0169

SOUTHERN ILLINOIS UNIVERSITY CARBONDALE
Employer/Respondent

On 7/10/2015, 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 0.08% 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:

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0499 CMS RISK MANAGEMENT
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0558 ASSISTANT ATTORNEY GENERAL
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0904 STATE UNIVERSITY RETIREMT SYS
PO BOX 2710 STATION A
CHAMPAIGN, IL 61825

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

JUL 10 2015

RONALD A.RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

16IWCC0169

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

☐ 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

DONALD INCHCLIFF
Employee/Petitioner

v.

SOUTHERN ILLINOS UNIVERSITY CARBONDALE
Employer/Respondent

Case # **09** WC **19739**

Consolidated cases: _____

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 **McCarthy**, Arbitrator of the Commission, in the city of **Herrin**, on **June 12, 2015**. 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 **TTD overpayment/credit**

FINDINGS

On **April 16, 2008**, 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 not*** 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 N/A causally related to the accident.

In the 35 weeks preceding the injury, Petitioner earned $**15,649.04**; the average weekly wage was $**447.12**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **0** 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 $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

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

ORDER

The Arbitrator finds that Petitioner did not sustain an accident arising out of and in the course of his employment with Respondent. The claim for benefits is denied.

AS NO BENEFITS ARE AWARDED, THERE ARE ALSO NO CREDITS AVAILABLE TO THE RESPONDENT.

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.

D. Dyle McCarthy
Signature of Arbitrator

July 7, 2015
Date

JUL 10 2015

STATE OF ILLINOIS)
)SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DONALD INCHCLIFF,
Employee/Petitioner

v.

Case # 09 WC 19739
10 WC 20730

STATE OF ILLINOIS – SOUTHERN ILLINOIS UNIVERSITY CARBONDALE,
Employer/Respondent

FINDING OF FACTS

Petitioner is employed as a kitchen helper for Southern Illinois University Carbondale. Petitioner alleges on April 16, 2008 that he suffered a work-related injury to his left shoulder. This case was tried before Arbitrator McCarthy at the Herrin docket on June 12, 2015. The issues in dispute are accident, causal connection, total temporary disability overpayment/credit, medical bills, and nature and extent. Petitioner has also filed a claim for his right shoulder; Illinois Workers' Compensation Commission file number 10 WC 20730. At the time of Arbitration, Petitioner moved to dismiss claim 10 WC 20730 and there was no objection from Respondent. As such, 10 WC 20730 is dismissed with prejudice.

On May 1, 2008, Petitioner presented to Dr. Matin Nekzad at Shawnee Health Services complaining of left shoulder pain. (PX1). Petitioner indicated he injured his shoulder three weeks prior by lifting a pan out of an oven. (PX1). It was noted that Petitioner smoked one pack of cigarette a day. (PX1). Petitioner was given a prescription for pain medication. (PX1).

On May 1, 2008, Petitioner filled out an Employee's Notice of Injury indicating he injured his left shoulder on April 23, 2008 when he was loading a pan of roasted potatoes in the oven. (RX1). Petitioner indicated there were no witnesses to the injury. (RX1). On the same date, Petitioner contacted CareSys Inc. to complete the Illinois Form 45. (RX3). The date of injury was listed as April 16, 2008. (RX3).

On May 12, 2008, Petitioner followed up with Dr. Nekzad for his left shoulder pain. (PX1). Petitioner's range of motion was limited. (PX1). Petitioner was given a cortisone injection into his left shoulder and a prescription for physical therapy. (PX1).

On May 23, 2008, Petitioner followed up with Dr. Nekzad. (PX1). Petitioner indicated the cortisone injection helped significantly, but it did not completely take away the pain. (PX1). On physical examination, Petitioner had full abduction, flexion, and extension. (PX1). Petitioner

was to continue physical therapy and anti-inflammatories. (PX1). Petitioner was to remain off of work until he completed physical therapy. (PX1).

On June 6, 2008, Petitioner followed up with Dr. Nezkad. (PX1). Petitioner indicated that the injection helped with pain, but he was having difficulty with range of motion and physical therapy was not helping. (PX1). On physical examination, abduction and forward flexion were very uncomfortable. (PX1). Dr. Nekzad recommended an MRI of Petitioner's left shoulder. (PX1).

On June 9, 2008, Petitioner underwent an MRI of his left shoulder. (PX1). The impression was: subacromial impingement and inhomogeneous increased signal in the supraspinatus tendon, no full thickness tear revealed, a partial tear is not excluded, and some degenerative changes are suspected at the glenohumeral joint as well. (PX1). Petitioner was referred to an orthopedic surgeon. (PX1).

On July 7, 2008, Petitioner presented to Dr. Steven Young at the Orthopedic Institute of Southern Illinois. (PX2). Petitioner filled out a Patient Intake Form indicating he injured his left shoulder pulling a 20 pound tray of potatoes out of the oven. (PX2). Petitioner indicated that he smoked a pack of cigarettes a day for 40 years. (PX2). Dr. Young noted Petitioner had injured himself on April 23, 2008 while lifting some heavy objects at work when he felt a pop in his shoulder and went down to the ground. (PX2). On physical examination, Petitioner had full forward flexion, but pain with abduction. (PX2). Dr. Young noted the official MRI report was not available to review, but it appeared Petitioner may have a tear in the rotator cuff, biceps tendon was intact, and Dr. Young could not appreciate any labral pathology. (PX2). Dr. Young noted Petitioner had failed conservative treatment and wished to proceed with surgical intervention. (PX2). An addendum indicated Dr. Young reviewed the radiographs and MRI report which revealed AC arthrosis; also, nofull thickness tear of the rotator cuff was identified, but it was felt there might be a partial tear. (PX2). Petitioner was kept off of work. (PX2).

On August 1, 2008, Petitioner underwent surgery by Dr. Young. (PX2). The procedures performed were: left shoulder subacromial decompression with rotator cuff repair and distal clavicle excision. (PX2).

On August 21, 2008, Petitioner followed up with Dr. Young. (PX2). Dr. Young noted Petitioner was making good progress. (PX2). Petitioner was fairly stiff with forward flexion. (PX2). Petitioner was to continue physical therapy and return in four weeks. (PX2).

On September 18, 2008, Petitioner followed up with Dr. Young. (PX2). Petitioner indicated that he had made some gains, but still had some slight tenderness and pain and still had limited abduction and overhead range of motion. (PX2). Petitioner was to continue physical therapy. (PX2). Petitioner was kept off of work. (PX2).

On September 29, 2008, a nurse's note indicated Petitioner had an injury to his left shoulder over the weekend and that he was very sore. (PX2).

On October 15, 2008, Petitioner followed up with Dr. Young. (PX2). Petitioner indicated he felt that he was improving. (PX2). Petitioner was to continue with physical therapy and given a prescription for Celebrex. (PX2). Petitioner was given light duty work restrictions. (PX2).

On November 20, 2008, Petitioner followed up with Dr. Young. (PX2). On physical examination, Petitioner had some limitation with abduction and forward flexion, but he had improved from his last appointment. (PX2). Petitioner was to continue physical therapy and return in four weeks, at which point work hardening would be considered. (PX2).

On December 18, 2008, Petitioner followed up with Dr. Young. (PX2). Petitioner indicated that he was doing well and had started strengthening. (PX2). Petitioner did have slight tenderness on palpation of the AC joint area and experienced a pop when he fully abducted the arm above 90 degrees. (PX2). Dr. Young noted he thought this was inflammation and gave Petitioner a prescription for Naproxen and a Medrol dose pack. (PX2).

On January 15, 2009, Petitioner followed up with Dr. Young. (PX2). Petitioner indicated that he was still having pain and popping in his left shoulder. (PX2). Dr. Young recommended two weeks of work hardening, and then indicated at that point he would likely release Petitioner p.r.n. and return him to work. (PX2).

On February 12, 2009, Petitioner followed up with Dr. Young. (PX2). Petitioner indicated he was still having pain and limited range of motion. Dr. Young referred Petitioner to Dr. Treg Brown. (PX2).

On February 23, 2009, Petitioner presented to Dr. Treg Brown at the Orthopedic Institute of Southern Illinois. (PX2). Petitioner filled out a Patient Intake Form indicating he injured his left shoulder removing 25 pounds of potatoes out of the oven. (PX2). Petitioner also indicated that he participated in organized sports like fishing. (PX2). On physical examination, Petitioner had limited range of motion. (PX2). Dr. Brown diagnosed Petitioner with postoperative adhesive capsulitis with probable incomplete healing of the rotator cuff repair. (PX2). Dr. Brown recommended an MRI. (PX2).

On April 1, 2009, Petitioner underwent an MRI of his left shoulder. (PX2). The findings were: 1) status post-reconstruction of the rotator cuff, there is articular surface irregularity involving the anterior and central insertional fibers of the supraspinatus tendon consistent with a partial-thickness articular surface tear involving less than 50% of the tendon thickness without identification of a discrete full-thickness tear or tendon retraction; 2) moderate tendinosis involving the long head of the biceps tendon within its intra-articular segment; 3) trace fluid in the subacromial/subdeltoid bursa; and 4) postoperative changes of the acromion, minimal degenerative changes of the acromioclavicular joint. (PX2).

On April 8, 2009, Petitioner followed up with Dr. Brown. (PX2). Petitioner indicated he was still experiencing pain in his left shoulder and his physical examination was unchanged. (PX2). Dr. Brown reviewed the MRI and indicated no definitive tear was seen, but there was significant fluid in that region. (PX2). Dr. Brown noted the supraspinatus, infraspinatus, and subscapularis appear to be intact, and the bicep tendon is round and contour and is located

normally in the bicipital groove. (PX2). Dr. Brown recommended a closed manipulation and an arthroscopic intraarticular examination of the rotator cuff with probable rotator cuff revision repair. (PX2).

On April 27, 2009, Petitioner underwent left shoulder surgery with Dr. Brown. (PX2). The procedures performed were arthroscopic revision of rotator cuff tear, arthroscopic biceps tenodesis, and arthroscopic lysis of adhesions with manipulation. (PX2).

On May 14, 2009, Petitioner followed up with Dr. Brown. (PX2). Petitioner indicated that he was doing fairly well and weaning himself off of the pain medication. (PX2). On physical examination, Petitioner had smooth range of motion to 90 degrees forward elevation, 30 degrees external rotation. (PX2). Petitioner was to continue with physical therapy. (PX2).

On June 17, 2009, Petitioner followed up with Dr. Brown. (PX2). Petitioner indicated the he is off of all pain medication and improving slowly. (PX2). Dr. Brown noted Petitioner has been out of the sling for a week and is being quite protective of his repair. (PX2). On physical examination, Petitioner had passive range of motion of approximately 100, 20 with abduction of 60 degrees. (PX2). Dr. Brown noted he believed Petitioner was progressing appropriately and recommended Petitioner continue with physical therapy. (PX2).

On July 29, 2009, Petitioner followed up with Dr. Brown. (PX2). Petitioner indicated that he is having difficulty with pain and function. (PX2). Dr. Brown noted Petitioner had been going to physical therapy and was being quite protective of his shoulder. (PX2). On physical examination, Petitioner's passive range of motion was approximately 110 and 30 with 80 degrees of abduction. (PX2). Dr. Brown recommended Petitioner continue to slowly progress through physical therapy. (PX2).

On September 9, 2009, Petitioner followed up with Dr. Brown. (PX2). Petitioner indicated that he continues to have pain and crepitus. (PX2). On physical examination, Petitioner had 125 degrees of forward elevation and 60 degrees of external rotation. (PX2). Dr. Brown ordered an MRI arthrogram to evaluate the integrity of the repair site. (PX2).

On November 3, 2009, Petitioner underwent an MRI arthrogram of his left shoulder. (PX2). The impression was: 1) postoperative changes of the rotator cuff, there is a small focus of articular surface irregularity involving the posterior insertional fibers of the supraspinatus involving less than 25% of the tendon thickness, this suggests articular surface fraying versus a very shallow articular surface tear, no full thickness tear or tendon retraction; 2) overall diminished size of the superior labrum which may represent degenerative tear versus prior surgery at the site, there is a 3 mm cleft of contrast undercutting the superior labrum which may represent a prominent biceps labral sulcus though correlation with details of prior surgery recommended, no paralabral cyst identified; 3) the long head biceps tendon is not visualized within its intra-articular segment which may be related to prior tenodesis versus a tear, correlate clinically; and 4) postoperative changes of the acromion. (PX2).

On November 11, 2009, Petitioner followed up with Dr. Brown. (PX2). Petitioner continued to complain of pain and crepitus with his left shoulder. (PX2). On physical

examination, Petitioner's passive range of motion is approximately 110 degrees, 45 degrees external rotation, and 50 degrees abduction. (PX2). Dr. Brown reviewed the MRI arthrogram and his impression of Petitioner's left shoulder was intact revision rotator cuff repair with adhesive capsulitis. (PX2). Dr. Brown recommended a closed manipulation and possible arthroscopic lysis of adhesions. (PX2).

On January 12, 2010, Petitioner followed up with Dr. Brown. (PX2). Petitioner indicated that he is still having pain and is getting worse. (PX2). Petitioner also indicated he was losing range of motion. (PX2). Dr. Brown recommended closed manipulation, lysis of adhesions, and possible revision rotator cuff repair. (PX2).

On February 16, 2010, Petitioner underwent left shoulder surgery by Dr. Brown. (PX2). His preoperative and postoperative diagnosis was adhesive capsulitis. (PX2). The procedures performed were arthroscopic lysis of adhesions and manipulation. (PX2).

On March 2, 2010, Petitioner followed up with Dr. Brown. (PX2). Petitioner indicated that his range of motion was improving. (PX2). On physical examination, Petitioner's passive range of motion was 130 degrees forward flexion, 50 degrees external rotation, and 60 degrees abduction. (PX2). Dr. Brown recommended Petitioner continue with physical therapy. (PX2).

On April 13, 2010, Petitioner followed up with Dr. Brown. (PX2). Petitioner indicated that he was making significant improvement. (PX2). On physical examination, Petitioner's active range of motion was improved. (PX2). Dr. Brown progressed Petitioner to work hardening regarding his left shoulder and gave Petitioner work restrictions of light to medium duty. (PX2).

On May 11, 2010, Petitioner followed up with Dr. Brown. (PX2). Petitioner indicated that he made significant improvement in work strengthening, but still lacked some range of motion and strength. (PX2). On physical examination, Petitioner had active range of motion of 140 degrees forward elevation, 60 degrees external rotation, and internal rotation of level L1; Petitioner's strength was 4+/5 supraspinatus, 5/5 infraspinatus, 5/5 subscapularis, and 5/5 biceps, triceps, and deltoid. (PX2). Dr. Brown recommended two more weeks of work hardening that panned to release petitioner to full duty. (PX2).

On May 26, 2010, Petitioner followed up with Dr. Brown. (PX2). Petitioner indicated that he is significantly better than before, but still has pain sometimes. (PX2). Dr. brown did not feel Petitioner was ready for a full release and noted Petitioner was to return in six weeks. (PX2).

On June 9, 2010, Petitioner consulted with Dr. Brown for right shoulder pain. (PX2).

On July 8, 2010, Petitioner followed up with Dr. Brown regarding his left shoulder. (PX2). Petitioner indicated that he has had numbness and tingling in his hand since surgery and it has not gotten better. (PX2). Petitioner also complained of difficulty with overhead activity and pain at night. (PX2). Dr. Brown recommended a nerve conduction study and a diagnostic ultrasound of Petitioner's left shoulder. (PX2).

On August 18, 2010, Petitioner underwent a diagnostic ultrasound of his left shoulder. (PX2). The impression was a partial thickness tear supraspinatus tendon, otherwise unremarkable ultrasound of the shoulder. (PX2). Dr. Brown reviewed the ultrasound and noted it was consistent with incomplete healing of the articular surface of the anterior supraspinatus. (PX2). Dr. Brown referred Petitioner to Washington University for a second opinion. (PX2).

On October 26, 2010, Petitioner presented to Dr. Leesa Galatz at Washington University Orthopedics in St. Louis for a second opinion regarding his left shoulder. (PX2). Petitioner indicated he injured his left shoulder on March 23, 2008. (PX2). It was noted Petitioner smoked a pack of cigarettes a day for 40 years. (PX2). Dr. Galatz recommended an ultrasound. (PX2).

On November 16, 2010, Petitioner followed up with Dr. Galatz. (PX2). Dr. Galatz noted the ultrasound showed heterogeneous signal, but an intact rotator cuff, no rotator cuff tear was identified. (PX2). Dr. Galatz did not recommend any further surgery as she did not identify a specific problem that she thought could be improved with another surgical procedure. (PX2). Dr. Galatz recommended Petitioner follow up with either an occupational medicine specialist or a pain management specialist and discharged Petitioner from her care. (PX2).

On January 31, 2011, Petitioner underwent surgery for his right shoulder with Dr. Brown. (PX2). The procedures performed were an arthroscopic rotator cuff repair, subacromial decompression, and labral debridement. (PX2).

On February 15, 2011, Petitioner followed up with Dr. Brown regarding his right shoulder. (PX2).

On March 8, 2011, Petitioner followed up with Dr. Brown for his left shoulder. (PX2). Petitioner complained of continued numbness and tingling in his hand and continued weakness in his left shoulder. (PX2). Dr. Brown recommended a nerve conduction study. (PX2).

On March 29, 2011, Petitioner underwent a nerve conduction study that showed moderate left median neuropathy at the wrist. (PX2). There was no evidence of ulnar neuropathy at the elbow or cervical radiculopathy. (PX2).

On April 19, 2011, Petitioner followed up with Dr. Brown regarding his left shoulder. (PX2). Petitioner complained of numbness and tingling in his left hand and pain in his left shoulder. Dr. Brown reviewed the nerve conduction study and noted it showed moderate carpal tunnel syndrome and no abnormalities in the ulnar nerve. (PX2). Dr. Brown impression was Petitioner had cubital tunnel syndrome, carpal tunnel syndrome, and left shoulder dysfunction. (PX2). Dr. Brown noted that he had nothing left to offer regarding Petitioner's left shoulder and referred Petitioner to Dr. Golz for carpal and cubital tunnel syndrome. (PX2).

On May 25, 2011, Petitioner followed up with Dr. Brown regarding his right shoulder. (PX2).

On June 14, 2011, Petitioner followed up with Dr. Brown regarding his left shoulder. (PX2). Petitioner complained he still had pain and dysfunction in his left shoulder. (PX2). Dr. Brown recommended a diagnostic ultrasound and gave Petitioner work restrictions. (PX2).

On July 7, 2011, Petitioner underwent a diagnostic ultrasound of his left shoulder. (PX2). The impression was an intact rotator cuff repair, mild degeneration of the subscapularis tendon, and normal biceps tendon. (PX2).

On July 27, 2011, Petitioner followed up with Dr. Brown regarding his right shoulder. (PX2). Petitioner was released to return to work without restrictions for his right shoulder and to follow up p.r.n. for his right shoulder. (PX2).

On August 11, 2011, Petitioner followed up with Dr. Brown regarding his left shoulder. (PX2). Petitioner complained of continued pain and lack of function in his left shoulder. (PX2). Dr. Brown reviewed the ultrasound and noted the repair site appeared to be intact. (PX2). Petitioner was given a steroid injection into his left shoulder. (PX2).

On September 15, 2011, Petitioner followed up with Dr. Brown regarding his left shoulder. (PX2). Petitioner complained of consistent pain. (PX2). On physical examination, Petitioner had tenderness over the AC joint, proximal biceps region, and anterior joint line region; however, his range of motion was good but pain on the extremes of forward flexion. (PX2). Dr. Brown's impression was Petitioner had residual pain from his surgeries and prescribed a TENS unit. (PX2).

On December 15, 2011, Petitioner followed up with Dr. Brown. (PX2). Petitioner indicated that his left shoulder was not improved. (PX2). Dr. Brown noted Petitioner had reached maximum medical improvement and ordered an FCE. (PX2).

On January 19, 2012, Petitioner underwent a functional capacity evaluation for his left shoulder at Southern Orthopedics Associates. (PX3).

On February 1, 2012, Petitioner followed up with Dr. Brown. (PX2). Dr. Brown reviewed the FCE and noted Petitioner was capable of working in the light classification position with restrictions of no lifting more than 25 pounds, occasional floor to waist lift/carry five pounds, occasional overhead lift, and minimal repetitive overhead activities. (PX2). Dr. Brown noted Petitioner may have some improvement over the next two to three years. (PX2). Petitioner was released from care and told to return as needed. (PX2).

On March 25, 2013, Petitioner presented to Dr. John Wood at the Orthopedic Institute of Southern Illinois with bilateral hand complaints. (PX2). Petitioner filled out a Patient Intake Form and indicated that this was not workers' compensation. (PX2). It was noted Petitioner smoked on pack of cigarettes a day. (PX2). Petitioner was diagnosed with bilateral carpal tunnel syndrome. (PX2).

On April 23, 2013, Petitioner underwent a carpal tunnel release and cortisone injection with Dr. Wood. (PX2).

On May 2, 2013, Petitioner followed up with Dr. Wood regarding his carpal tunnel syndrome. (PX2).

On June 13, 2013, Petitioner followed up with Dr. Wood regarding his carpal tunnel syndrome. (PX2). Petitioner indicated that he was doing extremely well, but wanted to hold off on getting his right side done as he had a lot of fishing tournaments coming up. (PX2).

On June 24, 2014, Petitioner underwent a Section 12 examination with Dr. Richard Lehman regarding his left shoulder. (RX6). Petitioner indicated that he injured his left shoulder on April 18, 2008 when he was unloading a pan of potatoes above his head. (RX6). Dr. Lehman noted Petitioner's medical history included a previous heart attack and bladder cancer. (RX6). Dr. Lehman further noted Petitioner smoked a pack of cigarettes a day for 45 years. (RX6). On physical examination, Petitioner's shoulder incision was somewhat tender on the AC joint, positive Popeye deformity, limited flexion, Petitioner's range of motion was 135 degrees elevation actively, 165 degrees elevation passively, 35 degrees external rotation, 70 degrees of external rotation and abduction; Petitioner supraspinatus and infraspinatus strength was 5/5; no instability or swelling; Petitioner had complaints of pain with internal and external rotation; and Petitioner's functional extension and flexion were neurologically intact. (RX6). Dr. Lehman opined that Petitioner's left shoulder condition was not related to Petitioner's work or a work injury. (RX6). Dr. Lehman noted Petitioner's MRI of his left shoulder showed spurring, subacromial arthritic changes, mild increase in the tendon, intrasubstance breakdown and chronic changes in the rotator cuff, but no acute pathology suggestive of a rotator cuff tear. (RX6). Dr. Lehman also noted arthritic changes in Petitioner's right shoulder. (RX6). Dr. Lehman diagnosed Petitioner with pain of unknown origin in Petitioner's left shoulder and mild adhesive capsulitis in Petitioner's right shoulder. (RX6). Dr. Lehman opined that Petitioner's pathology is long term and chronic in nature and there appeared to be no acute pathology nor anything in the scans that would correlate an acute pathology. (RX6). Dr. Lehman also noted Petitioner's subjective complaints were not supported by the objective findings. (RX6). Petitioner's subjective symptoms were excessive as related to his manual testing and not corroborated by his examination. (RX6). Dr. Lehman reviewed the 2012 FCE and opined that Petitioner had improved since that time and was capable of returning to work without restrictions. (RX6).

No further medical records were entered into evidence.

The parties stipulated that Petitioner was off of work and paid total temporary benefits from May 12, 2008 to July 29, 2014. (AX1). Petitioner returned to work without restrictions on August 11, 2014.

Petitioner testified at arbitration that he has been employed at Southern Illinois University Carbondale as a kitchen helper for 10 or 11 years. (Tr. 10). Petitioner testified that on April 16, 2008, he was pulling a tray of potatoes out of the oven when his shoulder kind of locked up and he set the pan down and his shoulder popped. (Tr. 11-12). Petitioner testified that the oven was approximately eye level with him and the pan was above shoulder height. (Tr. 12-13). Petitioner testified that he continued to work for about a month before getting it evaluated. (Tr. 12-13). Petitioner testified that he was taken off of work by his treating doctor. (Tr. 15). Petitioner testified that after his second surgery on his left shoulder he started recovering pretty good, but

then things got bad again. (Tr. 17-18). Petitioner testified that his recovery from the third procedure went fairly good and that he is working. (Tr. 19). Petitioner testified that he underwent an FCE in 2012 and Respondent was unable to accommodate his restrictions. (Tr. 22). Petitioner testified that he was off of work from May 12, 2008 to July 29, 2014 and paid temporary disability during that time. (Tr. 22).

Petitioner testified that he is currently working in the dish room. (Tr. 23). Petitioner testified that he takes two Aleve every morning. (Tr. 23). Petitioner testified that his left shoulder mainly bothers him in the morning if he sleeps on it wrong. (Tr. 24).

On cross examination, Petitioner testified that he indicated the alleged accident took place on April 16, 2008. (Tr. 24-25). Upon being presented with the Employee's Notice of Injury he completed, Petitioner admitted that he wrote the date of injury was April 23, 2008. (RX1, Tr. 25-26). Petitioner testified that he did not know why he wrote down that the injury occurred on April 23, 2008. (Tr. 26).

Petitioner testified that he is a smoker and that he smoked about a pack a day. (Tr. 27). Petitioner testified that he has smoked for 25 to 30 years, but would not have any reason to dispute his medical records if they indicated that he had smoked for 40 to 45 years. (Tr. 27). Petitioner testified that he has had a heart attack and he has treated for bladder cancer. (Tr. 28-29).

Petitioner testified that his hobby is fishing. (Tr. 29). Petitioner testified that he was still off of work in 2013 for his shoulder and was treating for carpal tunnel syndrome. (Tr. 30). Petitioner asked if he had indicated to Dr. Wood on June 13, 2013 that he had a lot of fishing tournaments coming up, and Petitioner testified no. (Tr. 30). Petitioner was then asked if his medical records reflected that he did tell Dr. Wood that, Petitioner admitted that he may have. (Tr. 30). Petitioner admitted that he did fish tournaments at that time. (Tr. 30-31).

Petitioner testified that he returned to work on August 11, 2014. (Tr. 31). Petitioner testified that since his return to work, he has received a promotion to the dish room supervisor. (Tr. 31). Petitioner also testified that since his return to work he has had one evaluation and was given a good evaluation. (Tr. 31). Petitioner testified that he has not received any complaints about his job performance since his return to work. (Tr. 32). Petitioner testified that he is not taking any prescription medication and is not required to wear any type of brace or protective device. (Tr. 31-32).

Petitioner testified that the last time he treated with Dr. Brown for his left shoulder was in February 2012 and he has not seen him since that time, nor has he treated with any other doctor for his left shoulder. (Tr. 32-33).

Dr. Treg Brown testified via evidence deposition on April 21, 2015. (PX4). Dr. Brown testified that Petitioner was originally treated and underwent surgery by a partner in his office, Dr. Young, prior to being referred to him. (PX4, pg. 5-6). Dr. Brown testified that the first time he saw Petitioner was February 24, 2009. (PX4, pg. 6). Dr. Brown testified that Petitioner told him he injured his left shoulder when he pulled a heavy object out of the oven and experienced

pain. (PX4, pg. 6). Dr. Brown testified that he performed a second surgery in April 2009 to address adhesive capsulitis and possible rotator cuff re-tear. (PX4, pg. 8-10). Dr. Brown also testified he found a biceps tendon tear but could not say if this was a new issue as he was not present at the time of Petitioner's first surgery, but believed it was related to the initial injury. (PX4, pg. 9-10). Dr. Brown testified that he performed another surgery in February 2010 and at that time Petitioner's rotator cuff looked healed and Dr. Brown was able to achieve full motion of Petitioner's shoulder. (PX4. Pg. 11). Dr. Brown testified that in June 2011, an ultrasound was performed that showed an intact rotator cuff and Petitioner's biceps tenodesis had healed. (PX4, pg. 13). Dr. Brown testified that Petitioner ultimately regained his motion, but had some residual pain and slight weakness. (PX4, pg. 13). Dr. Brown testified that at that time he released Petitioner at MMI and recommended an FCE. (PX4, pg. 13). Dr. Brown testified that he agreed with the work restrictions outlined in the FCE. (PX4, pg. 15). Dr. Brown testified that he believed that Petitioner's left shoulder condition and the surgeries he underwent were related to the alleged April 16, 2008 work injury. (PX4, pg. 14-15). Dr. Brown testified that Petitioner could have some improvement of his symptoms over time and it would not shock him to learn that Petitioner had returned to his old position and was working. (PX4, pg. 15-16).

On cross-examination, Dr. Brown admitted that he did not know how much the object Petitioner pulled out of the oven weighed. (PX4, pg. 18). Dr. Brown testified that a biceps tendon tear would typically be something he would find during surgery in Mr. Inchcliff's first surgery. (PX4, pg. 20). Dr. Brown admitted that rotator cuff tears can be degenerative and also occur idiopathically. (PX4, pg. 20-21). Dr. Brown admitted that lack of blood supply is a theory for some rotator cuff tears and that smoking affects the blood supply in a person and the healing process of rotator cuffs. (PX4, pg. 21). Dr. Brown testified that Petitioner indicated that he smoked a pack of cigarettes a day for 40 years. (PX4, pg. 21). Dr. Brown testified that smoking could be a risk factor in developing rotator cuff tears, as well as Petitioner's age. (PX4, pg. 22). Dr. Brown admitted that if a person has a degenerative tear in one shoulder, they are at a greater risk to have a tear in the other shoulder. (PX4, pg. 23). Dr. Brown testified that the last time he saw Petitioner was February 1, 2012 and he told Petitioner to follow up as needed, and Petitioner had not followed up with him in over three years. (PX4, pg. 23). Dr. Brown admitted that he has no idea what Petitioner's current condition is. (PX4, pg. 24).

Dr. Richard Lehman testified via evidence deposition on September 24, 2014. (PX4).Dr. Lehman testified that he is a board certified orthopedic surgeon with a sub qualification in sports medicine. (RX7, pg. 5-6). Dr. Lehman testified that Petitioner gave a history of an alleged work injury that occurred on April 23, 2008 with respect to his left shoulder. (RX7, pg. 10). Dr. Lehman testified that Petitioner indicated that over a period of time he started having discomfort in his shoulder while working in the kitchen for Respondent, and that he did not have a specific incident or injury, that it occurred over a period of time. (RX7, pg. 11). Dr. Lehman testified that Petitioner gave him an overview of his job duties, including lifting food trays, cleaning kitchen equipment, and general activities consistent with a kitchen environment. (RX7, pg. 11-12). Dr. Lehman testified that he reviewed the films from Petitioner's June 9, 2008 left shoulder MRI and it was consistent with long term and chronic impingement syndrome. (RX7, pg. 13-14). Dr. Lehman testified that he did not identify a rotator cuff on the MRI film. (RX7, pg. 14). Dr. Lehman testified that he reviewed the MRI of Petitioner's right shoulder and it also showed impingement syndrome and basically the same underlying pathology. (RX7, pg. 15-16). Dr.

Lehman testified that Petitioner's left shoulder condition was not related to an alleged work injury on April 23, 2008 or to his work duties. (RX7, pg. 19-20). Dr. Lehman testified that Petitioner has similar pathology in both of his shoulders that indicates a pre-existing or congenital issue, as well as there was nothing on the MRI films to suggest an acute injury or something activity-related. (RX7, pg. 20). Dr. Lehman testified that MRIs make it very clear that Petitioner's conditions in his left and right shoulders are degenerative conditions; further, Petitioner's age and predisposing factors are indicative of a degenerative condition. (RX7, pg. 22).

Dr. Lehman also testified that Petitioner's subjective complaints did not match his objective findings. (RX7, pg. 22). Dr. Lehman testified that there really should not be skin tenderness in the shoulder as it is not a very sensitive part of the body, and that Petitioner's symptoms were in excess of what Dr. Lehman would expect given Petitioner's physical exam and the pathology noted in his medical records. (RX7, pg. 22-23). Dr. Lehman believed there was symptom magnification on Petitioner's part. (RX7, pg. 23).

Dr. Lehman testified that smoking a pack of cigarettes a day for 40 years could affect Petitioner's shoulder conditions as tobacco use is one of the greatest risk factors for rotator cuff tear, impingement syndrome, and frozen shoulder, according to orthopedic literature. (RX7, pg. 23). Dr. Lehman testified that smoking a pack of cigarettes a day for 40 years

> greatly increases his [Petitioner's] chances of having virtually every degenerative process in the shoulder, and that would be consistent with a degenerative rotator cuff tear, degenerative labral tear, impingement syndrome, frozen shoulder. So those numbers go sky high after about 10 years, and then just continue to climb as pack of cigarettes in terms of what we call pack years increase. (RX7, pg. 23-24).

Dr. Lehman testified that Petitioner had other risk factors that could affect his shoulder conditions. (RX7, pg. 24). Dr. Lehman testified that Petitioner had had a heart attack which is blood flow problem and issues with vascularity. (RX7, pg. 24). Dr. Lehman testified that have vascular issues do have degeneration secondary to a lack of blood flow at the insertion site of the rotator cuff. (RX7, pg. 24). Dr. Lehman also testified that Petitioner had bladder cancer in the past and the chemotherapeutic treatment for cancers have a significant effect on vascularity and healing, as such, would also be a factor that could affect Petitioner's shoulder conditions. (RX7, pg. 24).

Dr. Lehman testified that he did not believe any of the treatment Petitioner received for his left or right shoulder was related to his alleged work injury. (RX7, pg. 25). Dr. Lehman testified that Petitioner did not need any work restrictions and was at MMI. (RX7, pg. 25).

There was no cross examination. (RX7).

CONCLUSION OF LAW

ISSUE (C): Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

The Arbitrator finds that Petitioner did not sustain an accident arising out of and in the course of his employment with Respondent on April 16, 2008, to his left shoulder.

The Petitioner lacks credibility because of the many inconsistencies contained in his accounts of how and when his alleged accident occurred. He testified that he was injured on April 16, 2008, which is his birthday. He said that he was removing a large pan of potatoes from an oven, holding the pan with his left arm underneath, as the handle of the pan was broken. He said his shoulder locked up on him and popped as he lifted the pan. He did not report his accident until May 1, during which time he continued to work with increasing discomfort in the shoulder.

When he finally reported the accident, he filled out an Employee's notice of injury which he signed. He wrote that he was loading, not unloading, potatoes into the oven and he said that he was injured at 3:00 p.m. on April 23. At arbitration he was shown his statement and asked to explain the date discrepancy. He gave no response. The Arbitrator believes that if he was injured at work on his birthday, April 16 while removing potatoes from the oven in a pan with a broken handle, he would have remembered those facts two weeks later when he completed his report.

Additionally, the Form 45 prepared by Caresys on the same date with information provided by the Petitioner states he was loading, not unloading potatoes. Interestingly, it lists the accident date as April 16. The supervisor's report of May 8 indicates the accident occurred on April 23. In short, these accounts of accident by the Petitioner a relatively short time after his alleged accident fail to provide corroboration for his testimony.

Medical corroboration is also lacking. Dr. Lehman testified that the MRI films done on June 9, 2008 fail to reveal any acute pathology in the Petitioner's left shoulder. He said the findings were consistent with long term and chronic impingement. He also noted similar pathology in the Petitioner's right shoulder. While Dr. Brown, the Petitioner's second surgeon, testified that a causal relationship existed between the accident and the conditions which he treated, he did not base his opinions on anything other than the petitioner's account of the accident. He made no mention of the initial MRI referenced above.

Finally, the Petitioner presented no lay witnesses to support his claim. He testified that he was working with Ms. Burrows prior to his alleged accident, and that he continued to perform his regular job for several weeks thereafter. The Arbitrator wonders why Ms. Burrows or some other co-worker was not subpoenaed or called to testify as to their observations of the Petitioner as he worked with a weak left shoulder.

The Petitioner has the burden of proving the elements of his claim. If there was just one discrepancy between his testimony and what was reported, a different result might have followed. Here, however, there were multiple inconsistencies. When coupled with an injury

which Dr. Lehman credibly explained was old, the result is a failure of satisfying his burden. The claim is denied. All other issues become moot.

STATE OF ILLINOIS	)	☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF KANE	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Urbano Villasano,

Petitioner,

vs.

NO. 09WC024430

16IWCC0174

Armour Eckrich Meats, LLC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review under §19b having been filed by the parties herein and proper notice given, the Commission, after considering the issues of accident, temporary disability, causal connection, medical expenses, prospective medical care, penalties, attorney fees and credit and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 21, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

16IWCC0174

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $19,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 1 1 2016
SJM/sj
o-2/25/2016
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

VILLASANO, URBANO
Employee/Petitioner

Case# **09WC024430**

11WC030948

ARMOUR ECKRICH MEATS LLC
Employer/Respondent

16IWCC0174

On 1/21/2015, 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 0.07% 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:

5317 JOHN J CASTANEDA PC
47 DuPAGE COURT
ELGIN, IL 60120

2461 NYHAN BAMBRICK KINZIE & LOWRY
HEATHER BOYER
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

16IWCC0174

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

Urbano Villasano,
Employee/Petitioner

v.

Armour Eckrich Meats, LLC.
Employer/Respondent

Case # 09 WC 24430

Consolidated cases: 11 WC 30948

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 **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **Geneva**, on **7/14/14** and **10/16/14.** 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. [x] 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. [x] 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. [x] 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. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[x] TPD [ ] Maintenance [x] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **2/21/09**, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**39,111.28**; the average weekly wage was $**752.14**.

On the date of accident, Petitioner was **44** years of age, ***married*** with **1** dependent child.

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

Respondent shall be given a credit of $**0.00** for TTD, $**3,168.32** for TPD, $**0.00** for maintenance, and $**2,276.40** for other benefits, for a total credit of $**5,444.72**.

Respondent is entitled to a credit of $**778.40** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $19,906.02, as provided in Sections 8(a) and 8.2 of the Act. These expenses can be broken down as follows: Athletic Therapeutic Institute ($12,154.55), Chicago Pain & Orthopedic Institute ($425.66), Accredited Ambulatory Care ($2,300.27), Hinsdale Orthopaedics ($4,845.74) and Windy City Anesthesia ($179.80). (Arb.Ex.#3).

Respondent shall be given a credit of $778.40 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act. (Arb.Ex.#1).

Respondent shall pay to Petitioner penalties of $**0.00**, as provided in Section 16 of the Act; $**0.00**, as provided in Section 19(k) of the Act; and $**0.00**, as provided in Section 19(l) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

Signature of Arbitrator

1/15/15
Date

ICArbDec19(b)

JAN 21 2015

STATEMENT OF FACTS:

Petitioner testified through Spanish interpreters at the arbitration hearings held on July 14, 2014 and October 16, 2014. At the time of trial, Respondent conceded that Petitioner sustained a lumbar strain injury as a result of the incident on February 21, 2009 (09 WC 24430) but disputed Petitioner's claim that said incident resulted in an injury to the cervical spine. (Arb.Ex.#1). In addition, Petitioner alleges a date of accident of June 15, 2011, the subject of claim 11 WC 30948. (Arb.Ex.#2). The parties also noted that a third claim (11 WC 21010), involving the bi-lateral upper extremities, is still pending and not presently in dispute.

Petitioner testified that he began working for Respondent on September 2, 2003. Petitioner worked various positions for Respondent that required him to operate a forklift, place packages of meat into a box, and move packages with a hand jack. Petitioner had no physical limitations when he began his employment with the Respondent nor was he treating with any physician for back or neck pain. Petitioner denied he took any medication for pain or discomfort before he started working. Petitioner also denied prior symptoms of back or neck pain.

On Saturday February 21, 2009 (09 WC 24430), Petitioner was working in the "aging" department where he had been assigned for three or four years. His job activities included washing ovens and bending over to pick up sausages. Petitioner testified that on that date he bent over to pick up a sausage when he felt pain in the lower part of his back. On cross examination, Petitioner agreed that he only picked up five (5) pieces of meat that day and that he did so separately. He indicated that his shift on the day in question was from 5:00 a.m. until 1:30 p.m., and that he thought the incident occurred at 10:30 a.m. He noted that before his shift ended he told his supervisor about his low back. Petitioner left work, went home and informed his son, who was 22 years old at the time, that his back was hurting. Petitioner requested that his son retrieve medication for him. The next day, Sunday, Petitioner stayed home. He indicated that he was taking Tylenol three times a day.

The following Monday, February 23, 2009, Petitioner returned to work to his regular job. Petitioner had constant pain in his back. Petitioner continued working with a forklift to move pallets. That day after work Petitioner presented at the Dreyer Medical Clinic. The medical records of Dreyer Medical Clinic reflect that on Saturday (2 days prior) Petitioner was doing a lot of lifting when his pain started in the "lumbar/sacral" area of his back. (PX10). Petitioner advised the clinic that his pain was aggravated with bending and twisting. (PX10). It was noted that he had had prior recurrent limited episodes of low back pain. (PX10). On cross examination, Petitioner claimed that he had not experienced the complained of pain before. Petitioner was diagnosed with a lumbar strain and placed on light duty of no bending at the waist, no lifting greater than 15 lbs., and no overhead lifting. (PX10). Petitioner subsequently returned to work within his restrictions.

On February 24, 2009, Petitioner visited his family physician, Dr. Cristina Brotea. (PX1). Petitioner advised Dr. Brotea that he had an injury at work, that he had pain in his lower back, and that he tried to return to work. (PX1). Petitioner denied any radiation to the lower extremities or numbness or tingling. (PX1). Dr. Brotea diagnosed a back strain and recommended that Petitioner not work. (PX1).

On February 25, 2009, Petitioner was sent to Tyler Medical Services by Respondent's corporate health and safety manager, E.J. Klages. (PX2). At Tyler Medical Services, Petitioner described his injury to Dr. Robert Long, D.O. stating that "he was at work performing his usual job responsibilities of cleaning an oven, operating a forklift, and also carrying buckets of meat that weighed between 15 to 20 lbs. repetitively to the oven" and that "[w]hen he began performing this responsibility he developed soreness involving his low back that progressed to pain... States he was asymptomatic up until that time." (PX2). Petitioner denied any previous back history or injury to Dr. Long. (PX2). Dr. Long diagnosed a lumbar strain and spasm. (PX2). Dr. Long

recommended therapy for six (6) sessions and prescribed light duty restrictions of no lifting, pushing, pulling more than 10 lbs., stoop/bend as tolerated, alternate sitting/standing, no operation of forklift, limited climbing of stairs and no reaching or lifting above the shoulder. (PX2).

Petitioner attended physical therapy from March 3, 2009 through April 13, 2009. (PX2). He continued to work during this period, cleaning the ovens, picking up meat off the floor and cleaning the department. Petitioner's symptoms persisted after his completion of physical therapy. On April 13, 2009, Tyler Medical ordered an MRI of the lumbar spine without contrast. (PX2). On April 24, 2009, Petitioner underwent the MRI which was interpreted as evidencing "disc degeneration at L5-S1 with small to moderate disc protrusion, which is somewhat broad base and asymmetric to the right. Disc is noted ventral to both nerve roots at this level." (PX3).

At the follow up visit with Dr. Pappas at Tyler Medical, Petitioner complained of persistent low back pain with radiation into the gluteal region. (PX2). Dr. Pappas noted on examination that Petitioner had a "spasm of the lumbar paravertebral musculature with tenderness of the spinous process region." (PX2). Dr. Pappas diagnosed persistent low back pain secondary to L5-S1 protrusion and recommended that Petitioner attend a pain clinic. (PX2). As a result, Petitioner was referred to Dr. James Kelly. (PX2).

On May 7, 2009, Petitioner consulted with Dr. Kelly for a pain clinic evaluation. Dr. Kelly noted that Petitioner "strained his lower back while engaged in repetitive activity" on February 21, 2009. (PX2). Dr. Kelly also noted that Petitioner "... denies any specific incident such as a fall or any particular incident of heavy lifting or any accident, etc. that he can point to. He states that by the end of the day and from that point forward he has been experiencing severe pain, which he describes a virtually always presents, although of somewhat variable intensity." (PX2). Petitioner denied any radiation of pain in the lower extremities and any numbness, tingling or weakness. (PX2). Dr. Kelly also recorded that "[a]t times the pain seems to radiate upwards along the spine towards the base of the neck." (PX2). Upon examination it was noted that Petitioner had one positive Waddell's sign. (PX2). Dr. Kelly opined that the Petitioner had pain of possible radicular etiology. (PX2). Dr. Kelly recommended an epidural steroid injection. (PX2). Petitioner underwent the injection on June 2, 2009 at the DuPage Pain Center. (PX4). Petitioner returned to Dr. Kelly on June 11, 2009. At that time, Petitioner indicated that he still had pain in his lower back and that he had not even experienced temporary relief from the injection. (PX2). Dr. Kelly thereupon recommended facet injections. (PX2).

On August 28, 2009, Petitioner visited Dr. Jesse Butler at the request of Respondent for purposes of a §12 examination. (RX9). Dr. Butler reviewed the MRI and opined that it revealed a "degenerative protrusion of the disc at L5-S1 without any acute findings." (RX9). Dr. Butler's impression was lumbar strain with a central lumbar disc herniation. (RX9). Dr. Butler noted that there did not appear to be a history of prior injury or pre-existing condition and that "[t]he mechanism of injury is difficult to state as a reasonable cause for the patient's current symptomatology. The degenerative disc findings clearly predate this incident, and it is very difficult to state that the simple act of lifting these sausages as is described is enough to cause an aggravation of his underlying degenerative condition. While on the quick report I checked the box that there does appear to be a causal connection between his injury and the history provided, having had the opportunity to further review the medical records available with this case, my opinion is that there is not likely to be a causal relationship between his complaints of pain and the workplace exposure. The patient, in my opinion, is not currently disabled relative to the incident of February 21, 2009." (RX9). Dr. Butler felt that Petitioner did not require any additional treatment, had reached maximum medical improvement ("MMI") and should be able to return to regular-duty capacity. (RX9).

On September 24, 2009, Petitioner visited Dr. Mark Lorenz at Hinsdale Orthopaedic Associates pursuant to a referral by his family physician, Dr. Brotea. (PX1; PX5). At that time, Petitioner advised Dr. Lorenz that he was lifting up packages of meat and throwing them and in the process developed neck pain, arm pain, back pain and leg pain. (PX5). This would appear to be the first reference to any neck pain in the medical record. Petitioner testified that he could not remember when he started having problems with his cervical spine. Dr. Lorenz reviewed the MRI and noted mild spondylosis at L4-L5, moderate spondylosis at L5-S1 with a central disk herniation. (PX5). Dr. Lorenz diagnosed cervical pain and an L5-S1 central disk herniation. (PX5). Dr. Lorenz recommended an MRI of the cervical spine, an FCE, and allowed Petitioner to work sedentary duty with no lifting. (PX5). In addition, Dr. Lorenz referred Petitioner to Dr. Steven G. Bardfield, also at Hinsdale Orthopaedics, "... in followup to see if there is any further rehabilitation that would be beneficial." (PX5). Finally, Dr. Lorenz noted that "... the patient's subjective findings are consistent with cervical pain, low back pain, arm pain and leg pain and an L5-S1 disk herniation emanating out of an injury where he was lifting on February 21, 2009." (PX5).

Petitioner underwent an MRI of his cervical spine on October 2, 2009. The MRI report noted a mild C5-C6 central left paramedian focal disk protrusion and bony spondylotic changes with spurring at C3. (PX5). Petitioner also underwent a functional capacity evaluation ("FCE") on October 8, 2009. The FCE was reported as a valid test consistent with Petitioner performing at the light duty level. (PX6). Petitioner described his activities of a forklift driver as medium duty.

On October 30, 2009, Petitioner visited Dr. Bardfield. Dr. Bardfield diagnosed Petitioner as having a cervical/lumbar strain injury with L5-S1 central disc protrusion and mild disc bulges in the cervical spine. (PX5). Dr. Bardfield referred Petitioner for physical therapy, work conditioning and light duty. (PX5).

Petitioner attended physical therapy at ATI from November 9, 2009 through December 20, 2009. (PX6). However, Petitioner's complaints of back and neck pain persisted. On December 28, 2009 Dr. Bardfield recommended another FCE. On January 7, 2010, Petitioner underwent a second FCE at ATI which was noted to be invalid. (PX6). The therapist at ATI noted that since the evaluation was invalid, Petitioner might be capable of more than the medium capacity noted. (PX6). On January 18, 2010, Petitioner returned to see Dr. Bardfield who noted that Petitioner had reached maximum medical improvement and released petitioner from care with a restriction of no lifting over 20 lbs. (PX5).

On May 10, 2010, Respondent's §12 examiner, Dr. Butler, issued an addendum based upon a review of records. (RX10). Dr. Butler noted that "[t]he medical records accurately describe his reports of low back pain as a result of lifting at work. The date of injury is February 21, 2009." (RX10). However, Dr. Butler goes on to note that subsequent to his own examination in August 2009, Petitioner visited Dr. Lorenz with complaints that were "... markedly different from that demonstrated to me at the time of the independent medical exam." (RX10). Along these lines, Dr. Butler indicated that Petitioner reported neck, arm, thoracic, low back and bilateral knee pain at that time and that this was "... the first mention of any cervical pain syndrome throughout his care and treatment." (RX10). Dr. Butler also noted that "[n]owhere in [Petitioner's] work history was there an injury to his cervical spine document" and that "[e]ven after [his previous §12 examination] there is no documentation to my knowledge of any specific injury to his neck." (RX10). As a result, Dr. Butler indicated that his opinion had not changed since his previous report, and that "[t]he additional medical records, if anything[,] further support that there is some degree of symptom magnification present in this patient. The lack of response to physical therapy and injections indicate that the patient is not a surgical candidate and the progressive deterioration even with appropriate physical therapy, work conditioning and medical management clearly indicates to me that this patient has secondary gain issues at hand." (RX10). Dr. Butler concluded that Petitioner "should easily be able to perform the job of a fork lift driver" and that "... his permanent restrictions are somewhere between the full

duty level and the restrictions that are currently indicated." (RX10). More to the point, Dr. Butler stated that it was "... not unreasonable to expect [Petitioner] to be able to perform at the medium physical demand level, which would be consistent with his occupational title and therefore, he could return back to work in a regular duty capacity." (RX10).

Petitioner returned to Dr. Bardfield on July 19, 2010, approximately six (6) months since his last appointment on January 18, 2010. At that time, Dr. Bardfield recorded that Petitioner "... has a flareup in symptoms involving the neck and low back. He did have to do more work activities and at a heavier rate than his 20-pound limit because other employees were out of town. This flared up his symptoms in the low back greater than the neck..." (PX5). Dr. Bardfield's impression was "[f]lareup of neck and low-back pain with primarily myofascial symptoms and history of L5-S1 disc protrusion." (PX5). Dr. Bardfield recommended another course of physical therapy, medication and provided restrictions of no lifting over 20 pounds. (PX5).

Petitioner attended physical therapy again at ATI from July 22, 2010 through October 1, 2010. On October 1, 2010, Dr. Bardfield prescribed a third FCE that Petitioner underwent on October 14, 2010. (PX5). The therapist noted that the FCE was a valid representation of Petitioner's capabilities and placed him at the medium level work capacity. (PX5). On October 29, 2010, Dr. Bardfield reviewed the FCE with Petitioner and released him back to work with a 30 pound lifting restriction and the ability to drive a forklift. (PX5).

Petitioner did not see another physician again until five (5) months later when he returned to Dr. Lorenz on March 21, 2011. On that date, Dr. Lorenz noted Petitioner continued to complain of pain. (PX5). Dr. Lorenz diagnosed Petitioner as suffering from aggravations of cervical and lumbar herniations. (PX5). Dr. Lorenz recommended an epidural injection for his cervical spine but otherwise discharged him from further follow up. (PX5). On May 17, 2011, Petitioner visited Dr. Morgan at the Chicago Pain & Ortho Institute via referral from Dr. Lorenz. (PX7). On May 24, 2011, Dr. Morgan administered an epidural injection to Petitioner's cervical spine. (PX7). On May 31, 2011, Dr. Morgan noted that Petitioner had "zero percent improvement" referred him back to Dr. Lorenz and Dr. Barfield. (PX7).

Petitioner testified that on June 15, 2011 (11 WC 30948), he was taking meat from a cart and putting it on a line when another employee struck him in the stomach with a cart he was pushing. Petitioner noted that the cart struck him underneath his stomach towards the right side and he was pushed backwards into a woman working next to him. Petitioner indicated that they hit each other "back to back" and that he did not go all the way to the floor. He stated that the incident occurred between 9:30 p.m. and 10:00 p.m. and that his shift ended at 11:00 p.m. Petitioner testified that he reported the incident to his supervisor and finished working that day. He noted that at the end of his shift he could not tolerate the pain in his back and neck.

Petitioner returned to see Dr. Lorenz on June 29, 2011 at which time he informed the latter that he had had a new injury. (PX5). Dr. Lorenz examined Petitioner and noted that he was still complaining of neck and upper extremity pain. (PX5). Dr. Lorenz mentioned a discography, which Petitioner declined. (PX5). Dr. Lorenz thereupon referred Petitioner back to Dr. Bardfield and took Petitioner off work. (PX5).

On July 8, 2011, Petitioner returned to Dr. Bardfield at which time it was noted that Mr. Villasano "had a new injury, which has flared up his lower back pain..." (PX5). Dr. Bardfield's impression was a lumbar strain and contusion with flare-up symptoms secondary to a work-related injury. (PX5). Dr. Bardfield also ordered physical therapy and order Petitioner off work. (PX5). Petitioner attended physical therapy at ATI from July 1, 2011 through September 2, 2011. (PX6).

On August 31, 2011, Petitioner visited Dr. Butler for another §12 examination. (RX11). Following his examination and review of the records, Dr. Butler opined that Petitioner's complaints of lower back pain were not causally related to his accident of February 21, 2009. (RX11). Instead, Dr. Butler related Petitioner's complaints to pre-existing disc degeneration at L5-S1. (RX11). Dr. Butler also noted that cervical complaints were not documented after the injury of February 21, 2009 until seven (7) months later. (RX11). Thus, Dr. Butler opined that the cervical complaints are not related to the accident of February 21, 2009. (RX11). Dr. Butler did opine that treatment for the lumbar spine had been reasonable and necessary up through the functional capacity evaluation of October 2009. (RX11).

On September 2, 2011, Dr. Bardfield noted that Petitioner did not improve with additional therapy and continued to have the same complaints of neck and low back pain. (PX5). Dr. Bardfield's impression was cervical and lumbar strain injury with contusions and history of L5-S1 disc herniation and C5-C6 bulge. (PX5). Dr. Bardfield recommended another FCE once Petitioner completed treatment for his wrist condition. (PX5). Dr. Bardfield also maintained Petitioner's off work restriction. (PX5).

At the request of Respondent, Petitioner visited Dr. Edward Goldberg on February 22, 2012 for purposes of a §12 examination. The report of Dr. Goldberg was not offered into evidence by either party.

On March 26, 2012, Petitioner underwent surgery for another condition [presumably the wrist] not related to the neck or lower back condition at issue in the present claims.

Petitioner did not return to Dr. Bardfield until July 18, 2012. By this date, Petitioner had returned to light duty work with Respondent doing the same work he currently performs – namely, putting labels on boxes; erasing the bar code on packages; and moving meat that may get stuck as it proceeds on the conveyor line. Petitioner could also alternate between sitting and standing. On the date of this examination, Dr. Bardfield noted Petitioner had increased pain in the neck, low back, arms and legs. (PX5). Dr. Bardfield diagnosed cervical and lumbar radiculopathy with underlying myofascial pain and recommended repeat a MRI of both the cervical and lumbar spine. (PX5).

On July 16, 2012, Petitioner underwent an MRI of the lumbar spine and cervical spine. (PX5). The lumbar spine MRI revealed a "stable appearance of L5-S1 broad-based central disc protrusion . . . abutting bilateral S1 nerve roots in the lateral recesses." (PX5). The cervical MRI revealed a C4-C5 shallow posterior central disc protrusion, a C5-C6 broad-based posterior left paracentral protrusion indenting the anterior left thecal sac, a C6-C7 minimal disc bulge and a T2-T3 small posterior disc protrusion that slightly indents the anterior thecal sac. (PX5). On August 1, 2012, Dr. Bardfield recommended a lumbar epidural injection that Petitioner underwent on September 6, 2012 at Salt Creek Surgery Center. (PX9).

Petitioner recalled telling Dr. Bardfield that the injection did not help his pain. Dr. Bardfield noted this lack of improvement at the time of his November 1, 2012 examination. (PX5). Dr. Bardfield thereupon recommended that Petitioner return to Dr. Lorenz. (PX5).

At the request of Respondent, Petitioner visited Dr. Jay Levin on January 7, 2013 for purposes of yet another §12 examination. (RX12). Following his examination and review of the voluminous records, Dr. Levin noted that he did see anything "... to support that this examinee sustained an injury to his lumbar spine on February 21, 2009" and that "... this examinee did not sustain an injury to the cervical spine from the February 21, 2009 occurrence." (RX13). Dr. Levin also indicated that he agreed with Dr. Butler's assessment that Petitioner's "... degenerative disk changes predated the incident and it would be very difficult to state that a simple act of lifting sausages that was described ... was enough to cause an aggravation of underlying degenerative condition."

(RX13). Finally, Dr. Levin opined that since Petitioner did not sustain any injury to his cervical spine as a result of the February 21, 2009 occurrence, given that he was totally asymptomatic for months thereafter, "... [Petitioner] did not require any care or treatment to the cervical spine from that event." (RX13).

Petitioner underwent surgery for his other condition, said condition not currently in dispute, and did not return to Dr. Lorenz until January 13, 2014. (PX5). At that time Dr. Lorenz recommended repeat MRIs of the cervical and lumbar spine. (PX5). Petitioner underwent the MRIs on February 21, 2014. The MRI of the lumbar spine indicated a "broad-based disc bulge and superimposed 5 mm central disc protrusion at the L5-S1 level slightly effaces the ventral aspect of the thecal sac but does not cause significant stenosis." (PX5). The cervical MRI indicated "scattered levels of degenerative disc disease and cervical spondylosis present throughout the cervical spine..." (PX5). On February 27, 2014, Dr. Lorenz recommended a myelogram and CT scan. (PX5). Dr. Lorenz noted the cervical spine images were "very hard to interpret due to a very grainy picture." (PX5).

On April 7, 2014, Dr. Lorenz examined Petitioner and reviewed the MRIs. Dr. Lorenz noted that the CT scan showed very minor degenerative changes. (PX5). Dr. Lorenz noted that Petitioner had a chronic neck and back strain not amenable to surgical intervention and referred Mr. Villasano to pain management specialist Dr. Jain. (PX5). Petitioner did not go to Dr. Jain but instead saw another physician, Dr. Theodore Fischer, on his own for a second opinion. Petitioner has not seen any other physicians since that time.

Petitioner testified that he has not suffered any other accidents or injuries to his neck or his back. Petitioner also noted that currently his neck hurts when he turns it and that his lower back hurts when he sits, stands, walks or sleeps. Petitioner takes Norco and Naprosyn for his pain complaints.

Petitioner agreed that he received his regular pay from the date of his initial injury of February 21, 2009 through February 7, 2011 at which time he was placed in a slicing line operator position. He indicted that when he switched positions his rate of pay changed and that Respondent paid the difference for two months. Petitioner acknowledged that while he is assigned to the slicing line department he is not working on the slicing line but instead is doing other jobs – namely, watching product to ensure there is no jam-up, assisting in completing inspection sheets, and wiping off codes and applying labels to single packages.

Petitioner testified that he is currently working the same light duty position as in 2012 earning $16.70 per hour. He indicated that Respondent has accommodated his restrictions but claimed that they still wanted him to do a job that required him to do activities contrary to his restrictions. However, Petitioner admitted that his supervisor, Ray Gonzalez, instructed him to have someone else pick up meat that fell on the floor. He indicated that he has not worked overtime since 2012.

Respondent's corporate safety and health manager, E.J. Klages, confirmed that Petitioner is currently working in the slicing line operator position on restrictions doing other tasks within the department. Those restrictions are related to his bilateral upper extremity claim that is not being litigated at this trial. Ms. Klages confirmed that the slicing line operator position to which Petitioner is presently assigned meets the restrictions imposed by Dr. Bardfield in October of 2010.

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner testified that on February 21, 2009 he was washing the ovens and that when he bent over to pick up sausage he felt pain in his lower back. He indicated that meat would constantly fall on the floor

and that sometimes he would use his hands or else a shovel to put it in the tank. He acknowledged on cross examination that on the date in question he only picked up five (5) pieces of meat and that he did so separately. He indicated that the five (5) pieces of meat came out of the casings. However, he could not recall what he put in the report or said to Ms. Klages.

The "Workers[']] Compensation – First Report of injury or Illness" submitted into evidence shows a date of injury of February 21, 2009 and indicates that Petitioner was "was lifting product, when he felt pain in the lower back. The [employee] sustained a strain to the lower back." (RX3). This form shows that it was prepared by E.J. Klages on February 25, 2009.

Ms. Klages agreed that she completed the above form, after Petitioner's supervisor did the initial reporting. She also noted that her understanding was that Petitioner was picking up five (5) pieces of product that had fallen on the floor and that he felt pain in his lower back while picking up one such item. She indicated that Petitioner did not say he was constantly picking up meat that day or that he was using a shovel.

While there appears to be some references in subsequent medical histories to a possible repetitive trauma basis to his lower back complaints, the record appears to be consistent to the extent that the Petitioner experienced an acute onset of pain in his lower back while performing his work duties on February 21, 2009. Furthermore, in Request for Hearing form, Respondent conceded that Petitioner sustained a lumbar strain on the date in question, ostensibly disputed Petitioner's claims with respect to his cervical spine. (See Arb.Ex.#1). In doing so, Respondent essentially acknowledged that Petitioner sustained accidental injuries arising out of and in the course of his employment on that date.

Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner sustained accidental injuries arising out of and in the course of his employment on February 21, 2009, at least as it pertains to his lower back. The real question is whether Petitioner's current conditions of ill-being relative to his lower back and/or neck are causally related to said accident.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

As previously noted, Petitioner reported experiencing low back pain at work on February 21, 2009 after picking up a sausage from the floor. There is no evidence to suggest that Petitioner also experienced any neck complaints at that time as well. Petitioner immediately reported his complaints to his supervisor and an incident report was completed several days later. The incident report essentially substantiated Petitioner's claim along these lines, noting that he reported he was "lifting product, when he felt pain in the lower back." (RX3). Respondent's witness, Ms. Klages, who filled out this report, likewise related that Petitioner claimed he had felt pain in his low back after picking up a piece of product on the floor.

Petitioner sought treatment at Dreyer Medical Clinic. The medical records of Dreyer Medical Clinic reflect that two days earlier Petitioner was doing a lot of lifting when his pain started in the "lumbar/sacral" area of his back. (PX10). Petitioner advised the clinic that his pain was aggravated with bending and twisting. (PX10). It was noted that he had had prior recurrent limited episodes of low back pain. (PX10). On cross examination, Petitioner denied experiencing similar complaint of pain before. However, Dreyer Medical Clinic records dated April 26, 2005 show that he presented at that time with complaints of back pain in the lumbar/sacral area and that he could not recall any injury to the area. (RX8). At the time of this previous visit, Petitioner was diagnosed with a lumbar strain and was instructed to return if his symptoms worsened. (RX8). There is no

evidence that Petitioner sought or received additional treatment relative to his lower back during the ensuing almost four (4) years leading up to the date of the incident on February 21, 2009.

Following his visit to Dreyer Medical Clinic on February 23, 2009 Petitioner was diagnosed with a lumbar strain and placed on light duty of no bending at the waist, no lifting greater than 15 lbs., and no overhead lifting. (PX10). Petitioner subsequently returned to work within his restrictions.

On February 24, 2009, Petitioner visited his family physician, Dr. Cristina Brotea. (PX1). Petitioner advised Dr. Brotea that he had had an injury at work, that he had pain in his lower back and that he tried to return to work. (PX1). Petitioner denied any radiation to the lower extremities or numbness or tingling. (PX1). Dr. Brotea diagnosed a back strain and recommended that Petitioner not work. (PX1).

On February 25, 2009, Petitioner visited Tyler Medical Services at which time it was noted "he was at work performing his usual job responsibilities of cleaning an oven, operating a forklift, and also carrying buckets of meat that weighed between 15 to 20 lbs. repetitively to the oven" and that "[w]hen he began performing this responsibility he developed soreness involving his low back that progressed to pain... States he was asymptomatic up until that time." (PX2). Petitioner denied any previous back history and was diagnosed with a lumbar strain and spasm. (PX2). Petitioner was also prescribed physical therapy and given light duty restrictions of no lifting, pushing, pulling more than 10 lbs., stoop/bend as tolerated, alternate sitting/standing, no operation of forklift, limited climbing of stairs and no reaching or lifting above the shoulder. (PX2).

Petitioner continued to work within his restrictions and treat conservatively thereafter. A subsequent MRI of the lumbar spine performed on April 24, 2009 revealed "disc degeneration at L5-S1 with small to moderate disc protrusion, which is somewhat broad base and asymmetric to the right. Disc is noted ventral to both nerve roots at this level." (PX3).

Petitioner was subsequently referred to a pain management clinic. On May 7, 2009, Dr. Kelly noted that Petitioner "strained his lower back while engaged in repetitive activity" on February 21, 2009. (PX2). Petitioner denied any radiation of pain in the lower extremities and any numbness, tingling or weakness. (PX2). Upon examination it was noted that Petitioner had one positive Waddell's sign. (PX2). Dr. Kelly opined that the Petitioner had pain of possible radicular etiology. (PX2). Dr. Kelly recommended an epidural steroid injection. (PX2). Petitioner underwent the injection on June 2, 2009 at the DuPage Pain Center. (PX4). Petitioner returned to Dr. Kelly on June 11, 2009. At that time, Petitioner indicated that he still had pain in his lower back and that he had not even experienced temporary relief from the injection. (PX2). Dr. Kelly thereupon recommended facet injections. (PX2).

On August 28, 2009, Petitioner visited Dr. Jesse Butler at the request of Respondent for purposes of a §12 examination. (RX9). Dr. Butler reviewed the MRI and opined that it revealed a "degenerative protrusion of the disc at L5-S1 without any acute findings." (RX9). Dr. Butler's impression was lumbar strain with a central lumbar disc herniation. (RX9). Dr. Butler noted that there did not appear to be a history of prior injury or pre-existing condition and that "[t]he mechanism of injury is difficult to state as a reasonable cause for the patient's current symptomatology. The degenerative disc findings clearly predate this incident, and it is very difficult to state that the simple act of lifting these sausages as is described is enough to cause an aggravation of his underlying degenerative condition. While on the quick report I checked the box that there does appear to be a causal connection between his injury and the history provided, having had the opportunity to further review the medical records available with this case, my opinion is that there is not likely to be a causal relationship between his complaints of pain and the workplace exposure. The patient, in my opinion, is not currently

disabled relative to the incident of February 21, 2009." (RX9). Dr. Butler felt that Petitioner did not require any additional treatment, had reached maximum medical improvement ("MMI") and should be able to return to regular-duty capacity. (RX9).

On September 24, 2009, Petitioner visited Dr. Mark Lorenz at Hinsdale Orthopaedic Associates pursuant to a referral by his family physician, Dr. Brotea. (PX1; PX5). At that time, Petitioner advised Dr. Lorenz that he was lifting up packages of meat and throwing them and in the process developed neck pain, arm pain, back pain and leg pain. (PX5). This would appear to be the first reference to any neck pain in the medical record. Petitioner testified that he could not remember when he started having problems with his cervical spine. Dr. Lorenz reviewed the MRI and noted mild spondylosis at L4-L5, moderate spondylosis at L5-S1 with a central disk herniation. (PX5). Dr. Lorenz diagnosed cervical pain and an L5-S1 central disk herniation. (PX5). Dr. Lorenz recommended an MRI of the cervical spine, an FCE, and allowed Petitioner to work sedentary duty with no lifting. (PX5). In addition, Dr. Lorenz referred Petitioner to Dr. Steven G. Bardfield, also at Hinsdale Orthopaedics, "... in followup to see if there is any further rehabilitation that would be beneficial." (PX5). Finally, Dr. Lorenz noted that "... the patient's subjective findings are consistent with cervical pain, low back pain, arm pain and leg pain and an L5-S1 disk herniation emanating out of an injury where he was lifting on February 21, 2009." (PX5).

Petitioner underwent an MRI of his cervical spine on October 2, 2009. The MRI report noted a mild C5-C6 central left paramedian focal disk protrusion and bony spondylotic changes with spurring at C3. (PX5). Petitioner also underwent a functional capacity evaluation ("FCE") on October 8, 2009. The FCE was reported as a valid test consistent with Petitioner performing at the light duty level. (PX6). Petitioner described his activities of a forklift driver as medium duty.

On October 30, 2009, Petitioner visited Dr. Bardfield who diagnosed a cervical/lumbar strain injury with L5-S1 central disc protrusion and mild disc bulges in the cervical spine. (PX5). Dr. Bardfield referred Petitioner for physical therapy, work conditioning and light duty. (PX5).

On January 7, 2010, Petitioner underwent a second FCE at ATI which was noted to be invalid. (PX6). The therapist at ATI noted that since the evaluation was invalid, Petitioner might be capable of more than the medium capacity noted. (PX6). On January 18, 2010, Petitioner returned to see Dr. Bardfield who noted that Petitioner had reached maximum medical improvement and released Petitioner from care with a restriction of no lifting over 20 lbs. (PX5).

On May 10, 2010, Respondent's §12 examiner, Dr. Butler, issued an addendum based upon a review of records. (RX10). Dr. Butler noted that "[t]he medical records accurately describe his reports of low back pain as a result of lifting at work. The date of injury is February 21, 2009." (RX10). However, Dr. Butler goes on to note that subsequent to his own examination in August 2009, Petitioner visited Dr. Lorenz with complaints that were "... markedly different from that demonstrated to me at the time of the independent medical exam." (RX10). Along these lines, Dr. Butler indicated that Petitioner reported neck, arm, thoracic, low back and bilateral knee pain at that time and that this was "... the first mention of any cervical pain syndrome throughout his care and treatment." (RX10). Dr. Butler also noted that "[n]owhere in [Petitioner's] work history was there an injury to his cervical spine document" and that "[e]ven after [his previous §12 examination] there is no documentation to my knowledge of any specific injury to his neck." (RX10). As a result, Dr. Butler indicated that his opinion had not changed since his previous report, and that "[t]he additional medical records, if anything[,] further support that there is some degree of symptom magnification present in this patient. The lack of response to physical therapy and injections indicate that the patient is not a surgical candidate and the progressive deterioration even with appropriate physical therapy, work conditioning and medical management clearly indicates to me that this

patient has secondary gain issues at hand." (RX10). Dr. Butler concluded that Petitioner "should easily be able to perform the job of a fork lift driver" and that "... his permanent restrictions are somewhere between the full duty level and the restrictions that are currently indicated." (RX10). More to the point, Dr. Butler stated that it was "... not unreasonable to expect [Petitioner] to be able to perform at the medium physical demand level, which would be consistent with his occupational title and therefore, he could return back to work in a regular duty capacity." (RX10).

Petitioner returned to Dr. Bardfield on July 19, 2010, approximately six (6) months since his last appointment on January 18, 2010. At that time, Dr. Bardfield recorded that Petitioner "... has a flareup in symptoms involving the neck and low back. He did have to do more work activities and at a heavier rate than his 20-pound limit because other employees were out of town. This flared up his symptoms in the low back greater than the neck..." (PX5). Dr. Bardfield's impression was "[f]lareup of neck and low-back pain with primarily myofascial symptoms and history of L5-S1 disc protrusion." (PX5). Dr. Bardfield recommended another course of physical therapy, medication and provided restrictions of no lifting over 20 pounds. (PX5).

Petitioner attended physical therapy again at ATI from July 22, 2010 through October 1, 2010. On October 1, 2010, Dr. Bardfield prescribed a third FCE that Petitioner underwent on October 14, 2010. (PX5). The therapist noted that the FCE was a valid representation of Petitioner's capabilities and placed him at the medium level work capacity. (PX5). On October 29, 2010, Dr. Bardfield reviewed the FCE with Petitioner and released him back to work with a 30 pound lifting restriction and the ability to drive a forklift. (PX5).

Petitioner did not see another physician again until five (5) months later when he returned to Dr. Lorenz on March 21, 2011. On that date, Dr. Lorenz noted Petitioner continued to complain of pain. (PX5). Dr. Lorenz diagnosed Petitioner as suffering from aggravations of cervical and lumbar herniations. (PX5). Dr. Lorenz recommended an epidural injection for his cervical spine but otherwise discharged him from further follow up. (PX5). On May 17, 2011, Petitioner visited Dr. Morgan at the Chicago Pain & Ortho Institute via referral from Dr. Lorenz. (PX7). On May 24, 2011, Dr. Morgan administered an epidural injection to Petitioner's cervical spine. (PX7). On May 31, 2011, Dr. Morgan noted that Petitioner had "zero percent improvement" referred him back to Dr. Lorenz and Dr. Barfield. (PX7).

Petitioner testified that he eventually suffered another alleged accident on June 15, 2011, the subject of companion claim 11 WC 30948, when another employee struck him in the stomach with a cart he was pushing.

On January 7, 2013, Petitioner was examined by Dr. Jay Levin at the request of Respondent pursuant to §12 of the Act. (RX12). Following his examination and review of the records, Dr. Levin noted that he did see anything "... to support that this examinee sustained an injury to his lumbar spine on February 21, 2009" and that "... this examinee did not sustain an injury to the cervical spine from the February 21, 2009 occurrence." (RX13). Dr. Levin also indicated that he agreed with Dr. Butler's assessment that Petitioner's "... degenerative disk changes predated the incident and it would be very difficult to state that a simple act of lifting sausages that was described ... was enough to cause an aggravation of underlying degenerative condition." (RX13). Finally, Dr. Levin opined that since Petitioner did not sustain any injury to his cervical spine as a result of the February 21, 2009 occurrence, given that he was totally asymptomatic for months thereafter, "... [Petitioner] did not require any care or treatment to the cervical spine from that event." (RX13).

As far as the Arbitrator can tell, the only medical opinion offered by any of the treating physicians on the issue of causation can be found in the initial progress note by Dr. Lorenz dated September 24, 2009 wherein he stated that "[i]t is of medical and surgical certainty the patient's subjective findings are consistent with cervical pain, low back pain, arm pain and leg pain and an L5-S1 disk herniation emanating out of an injury where he was

lifting on February 21, 2009." (PX5). Needless to say, this opinion was offered at the commencement of Dr. Lorenz's treatment, and well before Dr. Bardfield's eventual release of Petitioner with permanent restrictions in October of 2010.

Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner sustained a lumbar strain as a result of the accident on February 21, 2009, and that said lumbar strain was causally related to the accident in question up through the date of Dr. Bardfield's release from care with restrictions on October 29, 2010. It is interesting to note that Dr. Bardfield had previously found Petitioner to be at MMI at the time of his January 18, 2010 visit, and had released Petitioner to return to work with a 20 pound lifting restriction, only to have Mr. Villasano return six (6) months later with complaints of continued back and neck pain. Thereafter, Petitioner underwent additional physical therapy and yet another FCE, this one on October 14, 2010, which was found to be valid and which determined that Petitioner was capable of medium duty work. Petitioner subsequently continued to work and did not seek treatment again until five (5) months later when he returned to Dr. Lorenz on March 21, 2011. Prior to that, Petitioner had been examined by Dr. Butler at the request of Respondent on August 28, 2009. At that time, Dr. Butler opined that it was not likely that a causal relationship existed between Petitioner complaints of pain and "the workplace exposure." (RX9). Dr. Butler also felt that Petitioner did not require any additional treatment, had reached maximum medical improvement ("MMI") and should be able to return in a regular-duty capacity. (RX9). In addition, Dr. Butler raised the possibility of symptom magnification and secondary gain in a subsequent report dated May 10, 2010. (RX10). However, Dr. Butler did opine that treatment for the lumbar spine had been reasonable and necessary up through the functional capacity evaluation of October 2009. (RX11).

Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner reached maximum medical improvement with respect to his lumbar condition as of his release by Dr. Bardfield on October 29, 2010, and that as a result Petitioner failed to prove that his current condition of ill-being with respect to his lumbar spine is causally related to the accident on February 21, 2009.

Furthermore, the Arbitrator finds that Petitioner failed to prove by a preponderance of the credible evidence that any condition of ill-being with respect to his cervical spine was causally related to the accident on February 21, 2009. The record shows that the first reference to any real neck complaints was when Petitioner visited Dr. Lorenz on September 24, 2009, or more than seven (7) months following the accident in question. While Dr. Kelly, in his chart dated May 7, 2009, recorded that "[a]t times the pain seems to radiate upwards along the spine towards the base of the neck", this would appear to have been more of a comment with respect to possible radiating symptoms relating to the lumbar spine and not any cervical complaints per se. (PX2). This is evidenced by the fact that Dr. Kelly's examination and treatment thereafter, in the form of epidural steroid and then facet injections, addressed the lumbar spine exclusively. Furthermore, Petitioner himself testified that he did not know when his cervical symptoms began, much less provide adequate testimony as to a possible cause of his neck complaints. Along these lines, the Arbitrator finds the fact that Petitioner continued to work in a light duty capacity, without further evidence as to the specific amounts, frequency and positional requirements associated with his job activities, to be wholly inadequate to support a claim with respect to the cervical spine. Likewise, Drs. Butler and Levine, who examined Petitioner on behalf of Respondent, both opined that Petitioner's cervical condition was not related to the accident of February 21, 2009. (RX11; RX12).

Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner failed to prove that his current condition of ill-being with respect to his cervical spine is causally related to the accident on February 21, 2009. Accordingly, Petitioner's claim for same is hereby denied.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

The parties submitted into evidence an agreed stipulation setting forth the amount of medical expenses that would be due and owing pursuant to the fee schedule in regards to claim 09 WC 24430 in the event this matter was found compensable, with Respondent maintaining any objection it may have to liability, reasonableness and necessity. (Arb.Ex.#3).

In light of the Arbitrator's determination as to accident and causation (issues "C" and "F", supra), the Arbitrator finds that Petitioner is entitled to reasonable and necessary medical expenses totaling $19,906.02 pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act. These expenses can be broken down as follows: Athletic Therapeutic Institute ($12,154.55), Chicago Pain & Orthopedic Institute ($425.66), Accredited Ambulatory Care ($2,300.27), Hinsdale Orthopaedics ($4,845.74) and Windy City Anesthesia ($179.80). (Arb.Ex.#3).

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Given the Arbitrator's determination that Petitioner's lower back condition relative to the accident on February 21, 2009 had stabilized or reached MMI as of the date of Dr. Bardfield's release on October 29, 2010, the Arbitrator finds that Petitioner failed to prove his entitlement to any additional care or treatment. Accordingly, Petitioner's claim for prospective medical treatment with respect to claim 09 WC 24430 is hereby denied.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY AND TEMPORARY PARTIAL DISABILITY, THE ARBITRATOR FINDS AS FOLLOWS:

Given that Petitioner continued to work for Respondent in an accommodated position within his restrictions from the date of the initial accident on February 21, 2009 (09 WC 24430) through the date of the second alleged accident on June 15, 2011 (11 WC 30948), the Arbitrator finds that Petitioner failed to prove his entitlement to temporary total disability and/or temporary partial disability benefits as they relate to the February 21, 2009 accident. Accordingly, said benefits are hereby denied.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that issues of law and fact existed between the parties and that Respondent's defense of this claim was neither unreasonable nor vexatious so as to warrant the imposition of penalties. Accordingly, Petitioner's claim for additional compensation pursuant to §19(k) and §19(l) as well as attorneys' fees pursuant to §16 of the Act is hereby denied.

STATE OF ILLINOIS)	☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
JEFFERSON		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Hart,
Petitioner,
vs.

16IWCC0171

NO: 09 WC 34436

Illinois Department of Natural Resources,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of nature and extent of Petitioner's permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 3, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

MAR 11 2016

DATED:
KWL/vf
O-3/8/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0171

HART, MICHAEL
Employee/Petitioner

Case# **09WC034436**

ILLINOIS DEPT OF NATURAL RESOURCES
Employer/Respondent

On 9/3/2015, 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 0.27% 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:

1413 BRAD L BADGLEY PC
26 PUBLIC SQUARE
BELLEVILLE, IL 62220

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9208

0375 SAM C MITCHELL & ASSOC
115 E MAIN
WEST FRANKFORT, IL 62896

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

4948 ASSISTANT ATTORNEY GENERAL
WILLIAM H PHILLIPS
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

SEP 3 - 2015

RONALD A.RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

☐ 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 16IWCC0171

Michael Hart
Employee/Petitioner

v.

Illinois Department of Natural Resources
Employer/Respondent

Case # 09 WC 34436

Consolidated cases: _____

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 **Michael Nowak**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **3-4-15**. 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 _____

16IWCC0171

FINDINGS

On **7/23/09**, 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 **$48,695.92**; the average weekly wage was **$936.46**.

On the date of accident, Petitioner was **57** years of age, ***married*** with **0** children under 18.

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 **$134,335.28** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$134,335.28**.

Respondent is entitled to a credit for any medical expenses paid directly or by the group insurance carrier under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $624.31/week for 267 2/7 weeks, commencing 7/23/09 through 9/4/14, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $407,582.46, as set forth in Petitioner's exhibits, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $561.88/week for 137.65 weeks, because the injuries sustained caused the 5% loss of the left foot, 10% loss of the right index finger, as provided in Section 8(e) of the Act, and 25% loss of the person as a whole, as provided in Section 8(d)2 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.

Signature of Arbitrator

8/21/15
Date

ICArbDec p. 2

SEP 8 - 2015

16IWCC0171

FINDINGS OF FACT

On July 23, 2009 Petitioner was employed with Respondent as a Site Tech II, a position which required heavy outdoor work maintaining State property and grounds. Petitioner had been employed by the Respondent for 23 years. He had injured his low back several years before. That injury resolved without surgery and he had suffered no further problems within the five years preceding the accident. During the course of his duties on July 23, 2009 Petitioner was struck in the head by a falling portion of a tree that he was attempting to remove. Petitioner remained conscious, but sustained injuries to his right index finger, head, neck, both hips, left leg, and left foot.

Petitioner was admitted to St. Mary's Good Samaritan Hospital on the date of his accident and remained in the hospital until July 31, 2009. (Px 11, p. 179) The hospital took imaging studies of Petitioner's head, eyes, chest, back, pelvis, and femur. (Id) Petitioner was diagnosed with a subdural hematoma of the posterior falx, a herniated nucleus pulposus of the thoracic spine, a contusion of the back, a sprain of the left thigh and groin, a lacerated left index finger, and multiple abrasions. (Id)

After his discharge from the hospital, Petitioner treated with Dr. Richard Garretson who utilized narcotic pain medication to alleviate Petitioner's back pain, and headaches. (Px 18) During the next several years, Petitioner had a number of out-patient admissions for various diagnostic testing associated with his head, neck, low back and hips.

Petitioner underwent further evaluation for a subdural hematoma between March 23, 2010 and July 19, 2013 at Mt. Vernon Neurology. He also received physical therapy at Crossroads Community Hospital between October 27, 2009 and November 17, 2009, NovaCare between July 18, 2011 and August 25, 2011 and Mulvaney Rehabilitation Services between May 3, 2011 and October 24, 2012.

On April 8, 2010 Petitioner was assessed by Heidi Prather D.O., at the referral of Dr. Garretson. Dr. Prather diagnosed him with posterior pelvic girdle pain, status post trauma, and back pain. (Px 27, p. 510) Dr. Prather treated Petitioner with both sacroiliac joint injections and lumbar spine injections over the following year. (Id)

In January of 2011 Petitioner was examined by Lydia Williams Ph.D who assessed his cognitive functioning. That evaluation documented some short term memory problems and deficits in cognitive skills. However she felt that his IQ of 87 did not appear to constitute a decline in "overall" functioning when compared to his preinjury status. (Px 25, p. 491)

On June 29, 2011 Petitioner was assessed by Dr. Lukas Zebala, an orthopedic surgeon, to whom he was referred by Dr. Prather. Dr. Zebala ordered physical therapy and medication through June of 2011 and a Functional Capacity Evaluation on August 23, 2011. The functional capacity evaluation was performed on October 12, 2011 and found that Petitioner was capable of working at the light demand level. (Px 32)

On September 19, 2012 an MRI was taken of Petitioner's lumbar spine which revealed a disc protrusion at L5-S1 and a concentric bulge at L4-5. (Px 17)

Petitioner was next referred to Dr. Gornet by Dr. Garretson. He saw Dr. Gornet on October 29, 2012. (Px 1b) Petitioner remained under the doctor's care between October 29, 2010 and January 6, 2015. At the time of the first visit the injury with respect to Petitioner's index finger had healed, however, he still complained of foot pain, headaches and short term memory loss in addition to bilateral low back pain, hip pain, numbness in the left hip and lateral side of his knee. Petitioner also had neck pain radiating into both shoulders and significant headaches. The doctor's physical examination and diagnostic work-up revealed a central disc herniation at L5,S1 which correlated with his symptoms and small degenerative disc herniations at C3,4, C4,5 and C6,7. The doctor believed that these symptoms were connected to the work accident and suggested surgery following Petitioner being weaned off narcotic pain medication. Petitioner was referred to Dr. Kaylea Boutwell to wean him off his medication. That was accomplished by Dr. Boutwell between November 1, 2012 through December 18, 2012.

Petitioner was examined by Dr. David Robson on 7/29/10, 11/14/12, and 9/31/14. (Rx 1, 2) The first two visits were with respect to the low back. The third focused on the cervical spine. Dr. Robson did not believe Petitioner required low back surgery. Dr. Robson conceded, however that physicians may have differing opinions as to the appropriate treatments for a patient. When specifically asked if performing the surgery Dr. Gornet recommended would be a deviation from standards of care Dr. Robson responded "It's certainly not a standard of care issue....It would be a difference of opinion." (Rx 1, p. 23) Dr. Robson agreed with the limitations demonstrated by the FCE. Dr. Robson further agreed that the accident had resulted in injury to both Petitioner's low back and cervical spine.

Dr. Gornet performed surgery on August 21 and August 23, 2013 performing a lumbar inter body fusion with a fixation device screws. Petitioner did very well postoperatively and was ultimately able to return to his habit of walking three miles per day. (Px 3, p. 147). He was released to light duty on December 5, 2013 with a 20 pound weight restriction which was increased to a 25 pound weight restriction on August 21, 2014.

Petitioner's cervical spine was then assessed on October 23, 2014 and Dr. Gornet decided no further treatment was required. Dr. Gornet released Petitioner to return to work on January 26, 2015 without restrictions.

Petitioner had previously returned to his former employment on September 4, 2014. Petitioner has continued to work without incident. At arbitration, Petitioner indicated he experiences occasional headaches, memory loss and complaints of neck pain and in his lumbar spine. He still complains of occasional pain with respect to his left foot. Petitioner denied any ongoing issues with his finger and denied having any visible scars from the injury.

CONCLUSIONS OF LAW

Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?

Although Petitioner had experienced low back symptoms in the past, he was symptom free and not undergoing any active treatment in the 5 years preceding the accident. The medical evidence submitted in this record, including the opinions of Respondent's §12 examiner, indicate that Petitioner's condition of ill being is causally related to the accident. The real dispute centers on the choice of treatment to address the condition.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner's condition of ill being is casually related to the accident.

Issue (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?

Respondent does not dispute that on July 23, 2009, Petitioner sustained a significant injury consisting of a subdural hematoma, injury to his cervical spine, lacerated left index finger, left foot and injury to his lumbar spine, nor does Respondent dispute over three (3) years of intense medical treatment of a conservative nature. Rather, based upon the November 14, 2014 second examination by Dr. David Robson, Respondent terminated Petitioner's temporary total disability benefits and disputed whether the surgeries performed by Dr.Gornet on August 21, 2013 and August 23, 2013 were reasonable and necessary.

Dr. Gornet opined that Petitioner sustained a structural injury to the disc at the L5,S1 level with an annular tear and small herniation which resulted in discogenic lowback pain. These conclusions were supported by diagnostic testing. Dr. Gornet indicated the fusion he performed was reasonable and necessary to cure and correct that condition. Respondent's examining physician, Dr. Robson, characterized the disc at that level as bulging, and not requiring surgery. Dr. Robson would not characterize the performance of the surgery as inappropriate, stating specifically that he was not arguing with the decision rather, he just would not have done it. Further, he acknowledged that in evaluating treatment options for a chronic low back condition, one must consider the nature and type of conservative treatment the person had under gone, his response, and the remaining options available. The Arbitrator notes that Petitioner underwent an intense course of conservative treatment over a three year period, consisting of therapy, medication and injections all of which failed to relieve his symptoms. Further, Petitioner weaned himself off significant narcotic medication at the instruction of Dr. Gornet in order to proceed with surgery.

Prior to surgery, Petitioner's treating physicians and Dr. Robson, the examining physician, believed Petitioner was limited to work of a light duty nature as per the Functional Capacity Evaluation. Following surgery, he obtained a good result which eventually permitted Petitioner to return to his prior employment.

The Arbitrator finds the testimony and opinions of Dr. Gornet regarding the appropriate manner in which to address Petitioner's condition more persuasive. His opinion is vindicated by the successful response Petitioner had to the surgery and his ultimate return to his regular occupation.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that the surgical procedures performed by Dr. Gornet were both reasonable and necessary.

Petitioner has incurred the following medical expenses: $71,952.33 to Dr. Matthew Gornet; $136,795.74 to St. Louis Spine & Orthopedic Surgery Center; $3,870.00 to Premier Anesthesia; $43,919.00 to The Orthopedic Center of St. Louis; $8,672.00 to CT Partners; $4,450.00 to MRI Partners; $6,317.59 to West County Care Center; $1,153.00 to Dr. Kaylea Boutwell; $26,233.60, $1,499.00; $9,888.00; $2,655.00; $4,899.00; $3,717.00 and $3,239.00 to St. Mary's Good Samaritan Hospital; $4,926.18 to Mid America Radiology; $2,132.00 to Irvington Friendly Care/Dr. Richard Garrettson; $1,371.00 to Good Samaritan Physicians; $1,315.00 to Dr. Alan Froehling; $17,075.00 to Mt. Vernon Neurology; $8,794.00 to Mulvaney Rehabilitation Services;

$900.00 to Integrity Clinical Networks/Dr. Lydia Williams; $1,055.00 to Washington University Physicians Radiology; $3,712.00 to Dr. Heidi Prather; $219.00 to Dr. Luke Zebala; $3,709.66 to Barnes Jewish West County; $410.00; $1,137.00; $1,976.00; $1,856.00; $2,496.00; $1,541.50; $1,445.50; $717.00; $6,020.00 and $975.00 to Barnes-Jewish Hospital; $894.40; $2,187.12 and $1,009.84 to Crossroads Community Hospital; $10,448.00 to NovaCare - - TOTAL: $407,582.46.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Respondent shall pay medical expenses totaling $407,582.46 as provided in Sections 8(a) and 8.2 of the Act. Respondent shall have credit for any and all medical bills previously paid.

Issue (K): What temporary benefits are in dispute?

Petitioner was temporarily totally disabled from July 23, 2009 through September 4, 2014, a period of 227 2/7 weeks. Respondent did not dispute the period of time Petitioner was off work, but rather, disputed its obligation to pay temporary total disability benefits on or after November 14, 2012. For the reasons setforth above, the Arbitrator concludes that Petitioner is entitled to temporary total disability benefits for the above period. Respondent shall be given a credit of $134,335.28 for benefits previously paid,

Issue (L): What is the nature and extent of the injury?

Petitioner is employed by Respondent as a Site Technician. His job requires heavy, physical labor. Petitioner was 57 years old at the time of his injury. Petitioner does not plan to retire. Although Petitioner has returned to work without restrictions, he still complains of short term memory loss, headaches, pain in his left foot, neck and low back. His finger laceration resolved without residual impairment. There is no x-ray in the record to confirm a fractured left foot. Treatment to the cervical spine was of a conservative nature. Surgery to the lumbar spine was much more invasive. It was a two part surgery which involved decompression, laminectomy, utilization of graft, stabilization device, and pilot screws to stabilize the injury site.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner is entitled to permanent partial disability to the extent of 5% of the left foot; 10% of the right index finger; 23% of the person as a whole relative to the low back; 1% of the person as a whole relative to the cervical spine; and 1% of the person as a whole relative to the head injury. Therefore Respondent shall pay Petitioner permanent partial disability benefits of $561.88/week for 137.65 weeks.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kenneth Gardner,
Petitioner,
vs.

NO: 08 WC 39886

Buske Lines,
Respondent,

16IWCC0140

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue(s) of accident, causal connection, temporary total disability, medical, permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 20, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 1 - 2016
o121015
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

DO NOT COPY

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GARDNER, KENNETH
Employee/Petitioner

Case# **08WC039886**

16IWCC0140

BUSKE LINES
Employer/Respondent

On 5/20/2015, 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 0.08% 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:

4364 LAW OFFICE OF THOMAS SCHOOLEY
2038 EDISON AVE
PO BOX 1289
GRANITE CITY, IL 62040

0507 RUSIN & MACIOROWSKI LTD
DANIEL EGAN
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

16IWCC0140

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

☐ 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

Kenneth Gardner
Employee/Petitioner

v.

Buske Lines
Employer/Respondent

Case # 08 WC 39886

Consolidated cases: _____

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 **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **March 17, 2015**. 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 June 10, 2008, 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 not* 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 not* causally related to the accident.

In the year preceding the injury, Petitioner earned $31,252.00; the average weekly wage was $601.

On the date of accident, Petitioner was 68 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 $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00.

Respondent is entitled to a credit of $306,569.26 ($149,806.06 in payments and $156,763.20 in write offs) under Section 8(j) of the Act.

ORDER

Petitioner's claim for benefits is denied. Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment by Respondent. Petitioner failed to prove his condition of ill being is causally related to a claimed accident.

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.

Signature of Arbitrator

5/11/15
Date

MAY 20 2015

STATEMENT OF FACTS

Petitioner testified that on June 10, 2008, he was employed by Respondent as a truck driver (Transcript hereinafter T. p. 5). He had worked for Respondent for nine years prior to that date (T. p. 5). Petitioner testified his job as a truck driver would be to hook up trailers, drive them to various places and unhook the trailer. He did not have any loading or unloading responsibilities with respect to the trailer (T. p. 6).

Petitioner described the process of hitching and unhitching a tractor from the trailer. Petitioner testified he would back up to the trailer, get out of the truck, look at the fifth pin to make sure the trailer was not too high, hook up the trailer, crank up the legs using a dolly crank, hook up the air hose, hook up the service line and hose for lights and everything (T. p. 7). Petitioner described the legs or dollies as the support for the front end of the trailer when they were not hooked up to a truck (T. p. 7-8).

Petitioner testified that on June 10, 2008, he was in Carlisle, Pennsylvania. He was supposed to bring a load back from Carlisle to Greenville, Illinois. He testified that the trailer was too high and he could not hook up the truck to the trailer. Petitioner testified he had to crank the dolly down to where he could match the fifth wheel and go ahead and hook it up. Petitioner testified there was 44,800 pounds on the trailer. When he cranked on the handle, he felt something in his back pop. At that time, he thought he had pulled a muscle. He finished cranking the dolly down, hooked up the trailer, hooked all of the hoses up and proceeded to drive to the first rest area (T. p. 18-19).

At the rest area, petitioner laid down for four hours to sleep. When he woke up, he was not able to stand on his right leg (T. p. 19-20).

Petitioner testified that he was able to drive home. He drove to Greenville, Illinois, dropped his trailer, and took a trailer back to the Granite City yard where he spoke with his supervisor, Glenda. Petitioner testified that Glenda filled out an accident report, and sent him to Midwest Medical (T. p. 21).

Petitioner acknowledged having a history of prior problems with his low back. Petitioner acknowledged treating with Dr. Jalal starting on July 30, 2007, or a little over ten months before the claimed instant accident (Px. 1).

On July 30, 2007, petitioner presented complaining of low back discomfort. It radiated into the right buttock area and had been of three to four days duration. He reported taking ibuprofen every day with modest relief. On this visit, Dr. Jalal diagnosed petitioner as having low back pain, most likely due to degenerative joint disease of the lumbar spine with mild sciatic symptoms. He was given a prescription for Ultram. If symptoms remained uncontrolled, they would plan on radiologic evaluation after completion of his cardiac work up (Px. 1).

Petitioner returned to Dr. Jalal on November 7, 2007. His chief complaint was low back pain which had been going on for the last two to three weeks. It would radiate to the back of his buttock on the left side and go down to his ankle sometimes. He reported having pain in the groin as well. Dr. Jalal felt petitioner had degenerative joint disease of the lumbar spine with radicular symptoms. Petitioner also reported back pain with sitting and with walking. An MRI of the lumbar spine was ordered (Px. 1).

The MRI was performed on November 26, 2007. The radiologist described multi-level disk disease with moderate lumbar spondylosis with marked lower lumbar facet arthropathy. The radiologist noted moderate central canal stenosis at L4-5 and mild central stenosis at L5-S1.

Also noted was multi-level foraminal stenosis with the left L4 nerve root and both L5 nerve roots contacting disk bulges in the foramen noted to be possible sources for radiculopathy/back pain.

The radiologist also noted anterior disk protrusion at L5-S1 which could be a source for back pain (Px. 1).

On November 28, 2007, petitioner saw Dr. Jalal again. Dr. Jalal noted that the MRI confirmed moderately severe spinal stenosis. Petitioner was told to use Lortab for pain relief. Petitioner was told to follow up in six weeks at which time referring him for surgery versus a pain clinic would be considered if pain control remained poor.

Petitioner testified that he did not return to the doctor thereafter because he felt no further pain in his back (T. p. 13).

Petitioner saw Dr. Dirkers at Midwest Occupational Medicine on June 10, 2008. Significantly, petitioner told Dr. Dirkers that he never had any back problems (Px. 2).

Petitioner told Dr. Dirkers he was cranking the landing gear to lower a trailer when he felt a pop in his right lower back. Petitioner indicated that he wished to treat elsewhere. Dr. Dirkers felt petitioner had low back pain likely due to some underlying spinal stenosis based upon the fact that he was better sitting and worse with walking and based upon being 68 years of age. The event that petitioner described would not cause spinal stenosis in Dr. Dirkers' opinion. He was not sure what a chiropractor would be able to do for him. Petitioner was given a light duty restriction (Px. 2).

On June 30, 2008, Dr. Dirkers authored a response to Jake Heins, a workers' compensation claim representative for Cottingham & Butler Claim Services. Dr. Dirkers

reviewed prior records. He noted petitioner's misrepresentation to him that petitioner had never had any prior back problems based upon the prior physician records and MRI. It is noted that petitioner clearly had longstanding symptoms of spinal stenosis. Dr. Dirkers noted that petitioner clearly from his previous records had longstanding symptoms of spinal stenosis and had been told by his doctor he needed to see a neurosurgeon or other specialists for evaluation prior to June 10, 2008. Dr. Dirkers concluded that petitioner did not sustain any aggravation of his pre-existing medical condition. Dr. Dirkers believed that petitioner's medical condition was significant and serious far prior to June 10, 2008. Dr. Dirkers did not believe that work caused him any worsening of his condition. Dr. Dirkers believed petitioner was suffering solely from spinal stenosis (Px. 2).

Petitioner found his way to Chiropractor Kevin Winkle (Px. 3). It does not appear that these records are complete. It is not clear whether petitioner shared his prior condition with Dr. Winkle. Dr. Winkle ordered x-rays which were performed on June 13, 2008. The radiologist described degenerative disk changes at L5-S1 with slight space narrowing. There were degenerative changes in the epiphyseal joints at L5-S1 with slight anterior listhesis at L5 on S1. There were anterior osteophytes described at several levels.

Petitioner then found his way to St. Francis Medical Center (Px. 4). Again it does not appear that these records are complete. There on June 20, 2008, petitioner underwent an MRI. The radiologist described mild facet joint arthropathy at L3-4 causing mild narrowing of the central canal. There was mild narrowing of the neuroforaminal bilaterally. At L4-5 was noted diffuse disk bulge and moderate facet joint arthropathy resulting in moderate central canal and lateral recess stenosis bilaterally. There was mild neuroforaminal stenosis at this level bilaterally left greater than right. There was a prominent left sided facet joint effusion at L4-5.

At L5-S1 was described moderate fact joint arthropathy, disk bulge causing mild narrowing of the central canal. There was mild narrowing of the lateral recess. There was mild neuroforaminal stenosis bilaterally right greater than left (Px. 4). The arbitrator notes the description of the MRI on June 20, 2008 to be similar to the description of the MRI on November 26, 2007. The arbitrator notes there to be nothing acute noted on either MRI.

Eventually, petitioner came under the care of Dr. Fonn, a neurosurgeon (T. p. 27, Px. 5). Dr. Fonn eventually performed surgery on petitioner on July 8, 2008 involving a fusion from L4 through S1.

On July 16, 2008, petitioner's medical records were studied by Dr. Soriano (Rx. 1). Dr. Soriano concluded that petitioner's incident of June 10, 2008 did not cause any aggravation of his underlying medical condition. He further did not believe that petitioner would have improvement in lumbar stenosis as it is a chronic longstanding problem. The very nature of this condition would be expected to worsen regardless of occupation or activity. Moreover, Dr. Soriano disagreed with the surgical recommendation for a fusion. He felt petitioner would benefit more from foraminal and bilateral hemilaminotomies. Nevertheless, Dr. Soriano opined Dr. Fonn's recommendation for surgery had no relationship to the alleged work injury.

Moreover, Dr. Soriano noted discrepancies in the histories that petitioner had provided. Petitioner told an emergency room on June 23, 2008 that he injured his back at work about eight months previous. He then noticed he lifted something at work the week before and developed a foot drop on the right (Rx. 1). Dr. Soriano noted petitioner to be inconsistent in that regard in his histories leading Dr. Soriano to question the mechanism of, and timing of, the injury in and of

itself. The arbitrator notes petitioner did not offer complete records into evidence and therefore has to rely upon Dr. Soriano's interpretation of same as accurate.

After surgery, petitioner remained under Dr. Fonn's care. On October 15, 2008, Dr. Fonn discharged petitioner from his care (Px. 5, p. 14). In fact, Dr. Fonn on that date released petitioner to return to work as an over the road truck driver without restriction. Dr. Fonn believed petitioner had a very good outcome from his surgery with good resolution of his pre-operative symptoms, and petitioner was in a good condition and safe to be released without restriction (Px. 5, p. 15).

After Dr. Fonn released petitioner to return to work, petitioner did not go back to work (T. p. 30). Petitioner underwent arthroscopic surgery on his right knee on October 8, 2008. Petitioner then had a right total knee replacement by Dr. Lentz in 2009 (T. p. 30 and 31).

Petitioner testified that from October 2008 until March 11, 2010, he did not see Dr. Fonn (T. p. 32).

Petitioner testified that he developed pain in his back, and he did not know exactly why, so he decided to return to Dr. Fonn (T. p. 32). Petitioner denied any additional injury or accident to his low back during that 17 month gap (T. p. 32).

Petitioner testified that Dr. Fonn ordered a myelogram and performed a series of epidural steroid injections on petitioner (T. p. 33). Petitioner testified the last course of shots was some time in September or October 2014 (T. p. 34).

At petitioner's request, he was examined by Dr. Dwight Woiteshek (Px. 7).

At Respondent's request, petitioner was examined by Dr. Rutz (Rx. 3).

The arbitrator notes that despite the treatment rendered by Dr. Fonn beginning again in March 2010, he never placed restrictions on petitioner (Px. 5, p. 26).

CONCLUSIONS OF LAW

C. Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

F. Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner bears the burden of proving by a preponderance of the credible evidence all the elements of his claim in order to recover benefits under the Workers' Compensation Act; this burden of proof cannot be based upon imagination, speculation or conjecture. *Illinois Bell Telephone Co. v. Industrial Commission*, 265 Ill.App.3d 681 (1994). This includes whether a claimant's condition is causally connected to a work accident. *Brady v. Louis Ruffolo & Sons Construction Co.*, 143 Ill.2d 542 (1991).

For the reasons that follow, the Arbitrator concludes that petitioner failed to meet his burden of proof as to either accident or causal connection, and therefore denies petitioner's claim for benefits in its entirety.

Prior to the claimed accident of June 10, 2008, petitioner had problems involving his low back over the span of at least five months that caused him to seek treatment (Px. 1). On November 28, 2007, Dr. Jalal's notes indicate petitioner to have an MRI scan confirming some

moderately severe spinal stenosis (Px. 1). Dr. Jalal told petitioner he might require surgery or pain management if pain control remained poor (Px. 1). The Arbitrator notes the testimony of Dr. Woiteshak (Px. 7, p. 28) and Dr. Rutz (Rx. 3, p. 11) in particular who note petitioner's low back condition to be degenerative and in addition progressive. The Arbitrator finds it incredible for Petitioner to claim that after November 28, 2007, his low back complaints somehow disappeared until he had the instant claimed work injury. Such a representation is inconsistent with the nature of stenosis and degenerative disk disease.

The Arbitrator also finds it significant that when petitioner first sought medical care at Midwest Occupational Health, he denied any history of prior low back problems (Px. 2).

The Arbitrator notes he is not required to side with the petitioner's physicians. The Arbitrator notes he is able to weigh the relative qualifications of the doctors along with the doctor's testimony. *Prairie Farms Dairy v. Industrial Commission*, 279 Ill.App. 3d 546 (1996).

The Arbitrator is not persuaded by the deposition testimony of Dr. Fonn (Px. 5) as to accident and causal connection. The Arbitrator notes the doctor's testimony, particularly on cross-exam, to be evasive. Dr. Fonn either could not, or would not, respond to questions during cross-exam.

The Arbitrator is not persuaded by the testimony of Dr. Woiteshek (Px. 7). Dr. Woiteshek is a retired general orthopedic surgeon who had not actively practiced medicine since the summer of 2008 (Px. 7, p. 22-23).

The Arbitrator is persuaded by the evidence from Dr. Dirkers (Px. 2), Dr. Soriano (Rx. 1) and Dr. Rutz (Rx. 3).

Dr. Dirkers, in a report dated June 12, 2008, before ever seeing Petitioner's records noted:

> He has bilateral symmetrical leg symptoms, so the chance of a significant rupture are slim, as this would be unilateral. He may have some underlying spinal stenosis based on the fact that he is better sitting and worse with walking and based on his advanced age of 68, the event would not cause spinal stenosis...

Dr. Dirkers on June 30, 2008, noted that in fact petitioner had significant prior low back problems, studied petitioner's prior MRIs and noted long standing spinal stenosis (Px. 2). Dr. Dirkers further noted that petitioner did not sustain any aggravation of his pre-existing medical condition on June 10, 2008. Dr. Dirkers felt petitioner to be suffering solely from spinal stenosis (Px. 2).

Dr. Soriano (Rx. 1) concluded that:

1. Petitioner described three different work injuries to three different providers;
2. Petitioner sustained no aggravation of a pre-existing condition on June 10, 2008. Lumbar stenosis does not improve and by its very nature would be expected to worsen regardless of occupation or activity (Rx. 1).

Finally, Dr. Rutz, a board certified orthopedic surgeon specializing in spinal surgery (Rx. 3, p. 6). Dr. Rutz concluded petitioner had severe spinal stenosis in November 2007, which took years to develop. The MRI from June 2008, per Dr. Rutz' reading of it, did not show any worsening or acute findings; petitioner had a severe degenerative condition which would become symptomatic one way or the other sooner or later (Rx. 3, p. 10-11).

As support for the conclusion of no accident and, in particular, no causal connection, the Arbitrator relies on the rationale expressed in *Nagle v. Taylorville Memorial Hospital*, 12 IWCC

349. In *Nagle*, the claimant suffered from a severe degenerative condition, similar to petitioner herein. Claimant alleged a work injury that aggravated her condition. The Commission adopted the Arbitrator's conclusion that a degenerative condition could wax and wane, but inevitably the condition itself would progress until surgery was necessarily similar to herein.

Based upon all of the foregoing, petitioner's claim for compensation is denied.

J. Where the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

Although moot, the Arbitrator notes the group health insurer for Respondent addressed medical totalling $306,569.26, with payment of $149,806.96 and write-offs of $156,763.20 (Rx. 2). Respondent is entitled to a credit for same. Based upon the Arbitrator's decision as to accident and causal connection, however, petitioner's claim for medical benefits is denied.

K. What temporary benefits are in dispute?

Again, although moot, the Arbitrator notes petitioner claimed entitlement to TTD benefits again starting March 11, 2010 (Arb. Ex. 1). However, Dr. Fonn testified he never placed any work restriction on petitioner after petitioner returned to him on that date (Px. 5, p. 26). It is incongruous for petitioner to be entitled to TTD benefits (or even PTD benefits) absent some sort of off work authorization. TTD is only appropriate when a person is disabled from work. *Manis v. Industrial Commission*, 230 Ill.App.3d 657 (1992). It is not enough for petitioner to show he did not work; he must show also that he was unable to work. *Gallentine v. Industrial Commission*, 201 Ill.App.3d 880 (1990). Petitioner failed to meet this burden Petitioner would

not be entitled to TTD or maintenance benefits after March 11, 2010, even if this matter were compensable.

STATE OF ILLINOIS	)	☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF WILL	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Anabel Cortez n/k/a Anabel Moore,
Petitioner,

vs.

NO: 09 WC 45589

Menards Inc.,
Respondent.

16IWCC0151

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of nature and extent and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 22, 2014, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $50,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 3 - 2016
o2/24/16
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

16IWCC0151

CORTEZ, ANABEL N/K/A MOORE, ANABEL Case# 06WC045589
Employee/Petitioner

MENARDS INC
Employer/Respondent

On 12/22/2014, 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 0.11% 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:

0190 LAW OFFICES PETER F FERRACUTI
JENNIFER KIESEWETTER
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1296 CHILTON YAMBERT PORTER LLP
DANIEL T CROWE
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CHICAGO, IL 60606

16IWCC0151

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

- ☐ 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
CORRECTED ARBITRATION DECISION

Anabel Cortez n/k/a Anabel Moore
Employee/Petitioner

v.

Menards, Inc.
Employer/Respondent

Case # **06** WC **45589**

Consolidated cases: _____

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 **Gerald Granada**, Arbitrator of the Commission, in the city of **New Lenox**, on **10/8/14**. 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 **7/21/2006**, 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 $**19,919.64**; the average weekly wage was $**383.07**.

On the date of accident, Petitioner was **27** years of age, ***single*** with **3** dependent children.

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0** **The parties stipulated at hearing that all TTD has been paid and any underpayment will be resolved directly by Respondent.**

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $251.32/week for 200 weeks, because the injuries sustained caused the 40% loss of the person as a whole, as provided in Section 8(d)2 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.

Signature of Arbitrator

12/18/14
Date

DEC 22 2014

FINDINGS OF FACT

This case was previously tried on a Section 19(b) petition on March 6, 2009. The Arbitrator's Decision, filed on March 26, 2009, found that Petitioner sustained a compensable accident; that her current low back pain with radiculopathy was causally connected to the accident; that she was entitled to temporary total disability compensation for the period of time she was prescribed off work; and that she was entitled to a discogram as prescribed by Dr. Mark Lorenz, treating orthopedic spine surgeon. Upon review, the Commission reduced the period of TTD because it found that the Respondent had offered modified duty. The Respondent subsequently paid the award and the case was remanded to the Arbitrator.

On April 7, 2010, the case was again tried on a Section 19(b) petition. The Arbitrator's Decision, filed on April 26, 2010, found that Petitioner was entitled to the fusion surgery as prescribed by Dr. Mark Lorenz and denied further temporary total disability benefits prior to surgery. The Commission affirmed and adopted the Decision on December 5, 2011.

While the appeal was pending, Petitioner returned to Dr. Lorenz on October 19, 2011. He continued to recommend the L5-S1 decompression and fusion and continued to recommend pain medication and that she remain off work. (P3, p.28)

Following the Commission Decision, the Petitioner underwent the lumbar fusion on April 27, 2012 at Adventist Hinsdale Hospital. (P2; p.3, p.48) The postoperative diagnosis was L5-S1 central disk herniation with left radiculopathy and L5-S1 lumbar spondylosis with axial instability. She returned to Dr. Lorenz on May 9, 2012 for a follow up visit. At that time, he noted moderate surgical pain. He continued to recommend that the Petitioner remain off work and on pain medication. (P3, p.23)

From July 2012 through September 2012, Petitioner underwent physical therapy at ATI. (P4) She continued to complain of pain particularly at the surgical site and hardware removal was recommended.

On January 11, 2013, Petitioner returned to Adventist Hinsdale Hospital for hardware removal surgery with Dr. Lorenz and Dr. Stanley Fronczak. (P2; P3, p.40) The history noted that she had undergone local injection at the hardware sites and had complete relief of her symptoms so that she was being admitted for removal of the previously placed instrumentation. At this time, she was in general experiencing low back pain, somewhat greater on the left side than the right side. The postoperative diagnosis was status post L5-S1fusion with retained hardware. (P3, p.35)

Petitioner returned to Dr. Lorenz on January 23, 2013 with lower left side back pain and swelling and discomfort when walking. She further did complain of some pain sensation in the lower extremities. Dr. Lorenz recommended that she remain off work and on pain medication. (P3, p.30)

Petitioner underwent a Functional Capacity Evaluation on May 1, 2013. The evaluation was determined to be a valid representation of her present physical capabilities. (P4, p.9) The test demonstrated that she was capable of a 1 to 2 hour work day and that her physical tolerances were sitting for 1 to 2 hours per day but for a 25 minute duration, standing 1 to 2 hours per day with a 15 minute duration, and waking 1 to 2 hours per day but occasional short distances. Further, she was able to occasionally lift 17 lbs. bilaterally from desk to chair or

above shoulders but not from chair to floor. (P4, p.10)

On June 24, 2013, Petitioner returned to Dr. Lorenz for a follow up. At that time, he indicated that she had reached maximum medical improvement and that he would recommend vocational rehabilitation as she could not return to her previous medium level duty job. (P3, p.27) He further released her to modified work of a 2 hour work day with no lifting greater than 17 pounds, alternate sitting, standing, and walking every 30 minutes, sedentary work only. He also recommended continued medications. (P3, p.21)

Dr. Mark Lorenz, treating orthopedic surgeon, testified via evidence deposition on June 3, 2014. He testified that the Petitioner's restrictions were permanent and were related to her work accident. (P5, p.9-10) He further indicated that he recommended pain management. (P5, p.10) On cross-examination, Dr. Lorenz also performed Waddell testing on the petitioner, which he admitted was positive. Dr. Lorenz explained that the Waddell testing was designed as social testing for Anglo-Saxons so he did not document which signs may have been positive for the Petitioner. (P5, p.12) However, Dr. Lorenz could not provide any authority for his statement regarding the inapplicability of the Waddell testing to Hispanics (P5, p.12) He further explained that the hardware injection performed did resolve Petitioner's pain for a period of time so that was suggestive that the hardware was causing inflammation. (P5, p.13) Dr. Lorenz admitted that all of the physical examinations he performed on the Petitioner after the hardware removal were normal. (P5, p.14) Dr. Lorenz also admitted that the MRI that was performed after the hardware removal was normal; he stated that the MRI showed some mild degenerative changes, but they were of no consequence. (P5, p.15) The straight leg raising tests performed were normal. (P5, p.15) Her strength was normal. (P5, p.15) She was neurologically fine. (P5, p.15) The Petitioner complained of numbness and tingling on June 24, 2013; Dr. Lorenz testified that he did not find any objective basis to support this claim. (P5, p.15)

Petitioner was evaluated by Dr. Steven Mather of M&M Orthopedics, on January 13, 2014 at the request of the Respondent for a repeat Independent Medical Examination. Dr. Mather testified via evidence deposition on July 11, 2014. Dr. Mather reviewed all of the petitioner's medical records and diagnostic films. To Dr. Mather the Petitioner stated that she did not get any relief from the fusion surgery, and that her left leg was more numb after the surgery. She also told Dr. Mather that her left leg was weak and that she could barely walk. Dr. Mather performed a physical examination. He noted that the diffuse tenderness she complained of across the lumbar region of her spine was nonphysiologic. Dr. Mather noted several positive Waddell findings. Dr. Mather noted that her reflexes were normal. Dr. Mather testified that the petitioner was magnifying symptoms; that she was malingering. Dr. Mather stated a diagnosis of status post L5-S1 fusion and hardware removal with significant functional overlay. Dr. Mather opined that the petitioner did not sustain any permanent disability as a result of the accident of July 21, 2006. Dr. Mather was of the opinion that the petitioner could return to work with a forty-pound lifting restriction. These opinions were based on several reasons: The only findings the petitioner had on MRI were age-appropriate degeneration at L5-S1; if this was the cause of her pain, the L5-S1 fusion would have provided her with excellent relief, which, per the petitioner, it did not. If she had hardware pain, its removal would have provided her with relief, which it did not. Thus, Dr. Mather opined that the petitioner's original pathology was not L5-S1. In addition, the petitioner had several nonorganic pain findings and she demonstrated these on each examination performed. Thus, Dr. Mather concluded the petitioner's complaints cannot be taken at face value.

Petitioner testified at hearing that she was granted social security disability benefits and continues to receive those benefits. Other than her low back condition, she is not under treatment for any other conditions of ill-

being. She has low back pain often and experiences numbness and loss of feeling in her legs. She testified that she is on pain medications including Morphine which she receives from a pain management doctor that she sought out on her own for care.

She testified that she did apply for jobs prior to her surgery but has not applied for any jobs within the past two years. It is her understanding that she was only released to work two hours per day. She testified that when she left her employment with Menards they had offered her work but they were not honoring her restrictions and were having her do activities which she was unable to do.

The parties stipulated at hearing that Respondent would resolve any underpayment of temporary total disability and would resolve the unpaid anesthesia bill without the necessity of an award on either of the issues.

CONCLUSIONS OF LAW

1. With regard to the issue of causation, the Arbitrator finds that the Petitioner has met her burden of proof. This findings is based on both the "law of the case" and the fact that there was no evidence of any intervening incident or condition that could have broken the causation chain. Under the "law of the case," this Arbitrator is bound by the prior decisions in this case in which the issue of causation has already been resolved in favor of the Petitioner. There was no evidence presented to suggest the Petitioner's condition is due to anything other than her original work accident. Therefore, the Arbitrator finds that the Petitioner's current condition of ill-being is causally related to her July 21, 2006 accident.

2. Regarding the issue of the nature and extent of the Petitioner's injuries, the Arbitrator finds that the Petitioner has sustained injuries resulting in 40% loss of use of the person as a whole. In support of this finding, the Arbitrator relies on the medical evidence, which show that the Petitioner sustained a back injury requiring her to undergo surgery involving an L5-S1 fusion. Petitioner underwent a subsequent surgery to remove the hardware in her spine. The medical evidence shows that her objective tests were normal, despite Petitioner's continued complaints of pain. Petitioner's normal medical findings are at odds with her current complaints, as both Dr. Mather and Dr. Lorenz could not pinpoint an explanation for these complaints. It is also difficult to reconcile these normal findings with the limitations set forth in the FCE, which indicates Petitioner cannot work more than 2 hours per day. The evidence appears to indicate that the Petitioner is no longer working for Respondent in order to take care of her three small children, and that the Petitioner is currently on social security disability. It is more likely that these additional factors are why the Petitioner has not sought employment in the last 2 years. Despite the questions regarding the Petitioner's credibility, the Arbitrator finds that she is still entitled to permanency as indicated above.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lance Fancher,
Petitioner,
vs.

NO: 09WC 49710
11WC 32739

Big Muddy River Correctional Center,
Respondent,

16IWCC0128

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical, temporary total disability, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 14, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

DATED: FEB 23 2016
o020916
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FANCHER, LANCE
Employee/Petitioner

Case# **09WC049710**
11WC032739

BIG MUDDY RIVER CORRECTIONAL CENTER
Employer/Respondent

16IWCC0128

On 4/14/2015, 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 0.10% 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:

0969 THOMAS C RICH PC
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FAIRVIEW HTS, IL 62208

4948 ASSISTANT ATTORNEY GENERAL
WILLIAM H PHILLIPS
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

CERTIFIED as a true and correct copy pursuant to 820 ILCS 305/14

APR 14 2015

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

1350 CENTRAL MANAGEMENT SYSTEMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

16IWCC0128

STATE OF ILLINOIS)
)SS.
COUNTY OF **Jefferson**)

- ☐ 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

Lance Fancher
Employee/Petitioner

v.

Big Muddy River Correctional Center
Employer/Respondent

Case # **09** WC **49710**

Consolidated cases: **11 WC 32739**

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 **Mt. Vernon**, on **February 6, 2015**. 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 (CASE 09 WC 49710)

On **11/25/09**, 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 not* 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 not* causally related to the accident.

In the year preceding the injury, Petitioner earned $**57,825.04**; the average weekly wage was $**1,112.02**.

On the date of accident, Petitioner was **39** years of age, *married* with **2** dependent children.

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

Respondent *has* paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**any amounts paid** for TTD, $- for TPD, $- for maintenance, and $- for other benefits, for a total credit of $**any amounts paid**.

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

ORDER (CASE 09 WC 49710)

Petitioner failed to prove he sustained an accident on November 25, 2009 that arose out of and in the course of his employment with Respondent or that his condition of ill-being in his right elbow was causally related to his injury. Petitioner's claim for compensation is denied and no benefits are awarded.

FINDINGS (CASE 11 WC 032739)

On **8/17/11**, 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 not* 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 not* causally related to the accident.

In the year preceding the injury, Petitioner earned $**57,825.04**; the average weekly wage was $**1,112.02**.

On the date of accident, Petitioner was **40** years of age, *married* with **2** dependent children.

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

Respondent *has* paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**any amounts paid** for TTD, $- for TPD, $- for maintenance, and $- for other benefits, for a total credit of $**any amounts paid**.

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

ORDER (CASE 11 WC 032739)

Petitioner failed to prove he sustained an accident on August 17, 2011 that arose out of and in the course of his employment with Respondent or that his condition of ill-being in his left elbow was causally related to his injury. Petitioner's claim for compensation is denied and no benefits are awarded.

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.

Henry Lindsay
Signature of Arbitrator

April 3, 2015
Date

APR 14 2015

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner filed two separate claims for his injuries, which were consolidated and tried as one before the Arbitrator. The parties requested that one decision issue for both cases. Claim 09 WC 49710 alleges repetitive trauma to Petitioner's hands, right wrist, and right elbow. Claim 11 WC 32739 alleges repetitive trauma to Petitioner's left elbow. Each claim has its own Petitioner's Exhibit List and labeled group exhibits, beginning with Petitioner's Exhibit 1. These lists and their corresponding group exhibits were entered into evidence as Arbitrator's Exhibits 4 and 5. Respondent does not dispute notice/manifestation date or the dates of temporary total disability, but disputes accident, causation, liability for medical expenses and temporary total disability benefits, and the nature and extent of the injuries.

Two witnesses testified at the hearing: Petitioner and Respondent's representative, Lt. Harold Schuler.

The Arbitrator Finds:

Petitioner began working for Respondent in 1999. According to Respondent's Time Sheets, Petitioner worked for Respondent as a "Dietary Officer" from April 20, 2009 through May 9, 2009. He was then a "Relief 7" Officer from May 15, 2009 through September 17, 2009. Beginning on September 18, 2009 Petitioner continued working as a "Relief 7" Officer on Wednesdays, a "R-1 A & B" Wing Officer on Sundays and Mondays, a "R1 & 2 Escort" Officer on Tuesdays and an "R-2 Control" Officer on Saturdays. This continued through October 21, 2009. Petitioner was off work on Thursdays and Fridays. Beginning on October 22, 2009 Petitioner began working in the Infirmary. (RX 3)

According to the medical records, Petitioner sought treatment with Dr. David Brown on November 25, 2009. As part of the examination Petitioner completed a questionnaire acknowledging he had already retained an attorney and that he believed he had a work-related injury. Petitioner described his symptoms as "Hands wrist, numb. Elbow numb, comes and goes, but happens when turning keys, and writing reports, driving." (AX 4 -PX 3) He described his job as follows: "My job consists[s] of security of inmates which includes, turning keys to doors, hand cuffs, waist chains, leg restraints, control buttons, doors & cells, writing, I/M disciplinary reports, shake down reports, incident reports, [?] every 30 min., tower logs, control logs, tool log boos, hunger strike log every 15 min., suicide logs every 10 min. My current job, Infirmary Office, turning keyes [sic] , and writing is continuous." (AX 4- PX 3)

Petitioner told Dr. Brown that he was right hand dominant and worked as a correctional officer for Respondent over the preceding ten years. Petitioner worked eight hours a day, forty

hours per week. He told Dr. Brown his job involved the opening and closing of cell doors fifty times per hour and raps bars during the course of his work at Big Muddy River Correctional Center. Petitioner further represented to Dr. Brown that he did not participate in any hobbies or sports. Dr. Brown's note indicates that Petitioner's problems in his hands had evolved over the preceding two years with some pain over the medial aspect of both elbows (right more than the left) and some right wrist pain. He recalled no traumatic injury. On examination Dr. Brown noted good active range of motion of both elbows, wrists, and all digits of his hands. Petitioner was noted to have a partial subluxing ulnar nerve over both elbows but negative Tinel's signs at his elbows. Tinel's was painful over the carpal tunnels bilaterally. Phalen's tests were negative bilaterally. Direct compression produced some discomfort bilaterally. Dr. Brown suspected Petitioner had some symptoms and findings consistent with a "bilateral peripheral compression neuropathy." He recommended a nerve conduction test. In the interim, Dr. Brown suggested Petitioner wear pillow splints at night and take nonsteroidal anti-inflammatory medication. He was to return after the studies were completed. Dr. Brown further noted his belief that Petitioner's work duties for Respondent were in part a contributing and/or aggravating factor in the development of a "possible peripheral compression neuropathy such as carpal tunnel syndrome and/or cubital tunnel syndrome." Petitioner was allowed to continue working full duty without any restrictions. (PX 3)

Petitioner underwent nerve conduction studies with Dr. Phillips on November 25, 2009. They were within normal limits. Petitioner had completed a Patient Questionnaire as part of the exam/testing process. He indicated symptoms of numbness, right and left hands and elbow. His pain drawing reflected these complaints, too. (PX 3, PX 4) After reviewing these studies, Dr. Brown recommended splinting, anti-inflammatory medications and observation. (PX 3)

Petitioner signed his Application for Adjustment of Claim in 09 WC 49710 on November 30, 2009, alleging bilateral hand, right wrist and right elbow injuries. (AX 2)

On January 14, 2010 Petitioner was no longer assigned to the Infirmary and he began working in "Segregation Control." He stayed there until February 3, 2010. (RX 3)

As of February 4, 2010 Petitioner began working as a "Dietary Officer" and he remained in that position through April 7, 2010. (RX 3)

Petitioner returned to Dr. Brown on April 7, 2010, with ongoing complaints of numbness and tingling in both of his hands. All testing was negative except for some discomfort on direct compression. Dr. Brown again suspected Petitioner's symptoms were consistent with a possible peripheral compression neuropathy. A repeat nerve conduction study was ordered and Petitioner was again allowed to continue working full duty without any restrictions. (AX 4- PX 3)

Repeat studies were performed on April 7, 2010 by Dr. Phillips and were normal. As part of the test Petitioner completed a Patient Questionnaire and drawing. Petitioner's symptoms included numbness, right hand and elbow, pain in right elbow, and left hand numbness. His left

elbow was not marked on the pain drawing. (PX 4) After reviewing the repeat testing, Dr. Brown wrote, "At this point I have no further recommendations from a hand surgical point of view." (AX 4-PX 3) Petitioner was to return as needed. (AX 4- PX 3)

As of April 8, 2010 Petitioner was assigned to "R-4 Escort." (RX 3)

Petitioner returned to see Dr. Brown on June 16, 2010 with the primary complaint of ongoing numbness and tingling in the right hand, mainly the little and ring fingers and some right medial elbow pain. Petitioner had good range of motion of his right elbow with partial subluxation of his ulnar nerve. Tinel's induced some discomfort. Dr. Brown felt Petitioner had symptoms consistent with an ulnar neuropathy and again noted he had a partial subluxing ulnar nerve. He recommended continued conservative treatment. No work restrictions were given. Petitioner was to return in three months. (AX 4 -PX 3)

On June 30, 2010 Petitioner began working in the "Visiting Room." (RX 3) He remained there until August 7, 2010. (RX 3)

Petitioner took a leave of absence from his job beginning on August 17, 2010. This continued through May 31, 2011. (AX 5 - PX 7) According to Respondent's Time Sheets (RX 3) Petitioner was not assigned to any position between August 7, 2010 and November 16, 2010. (RX 3)

On September 15, 2010, Petitioner again presented to Dr. Brown with complaints of numbness and tingling in his right little and ring fingers with medial elbow pain. (AX4 -PX3, 9/15/10). On examination, Petitioner continued to have a subluxing ulnar nerve as well as positive Tinel's and direct compression test over the right elbow. *Id.* As Petitioner was recovering from knee surgery Dr. Brown again recommended conservative care. *Id.*

On October 26, 2010, Petitioner saw Dr. Brown with continued complaints of pain and popping over the medial aspect of his right elbow, associated with numbness and tingling in his right little and ring fingers. (AX4 -PX3, 10/26/10). Petitioner continued to show signs of his subluxing ulnar nerve in the right elbow, a positive Tinel's sign, and positive direct compression and elbow flexion tests. Dr. Brown noted that when Petitioner flexed his elbow, his ulnar nerve moved/subluxed out of the condylar groove across the medial epicondyle, causing irritation of his nerve. *Id.* Dr. Brown's impression was chronic ulnar neuropathy of the right elbow with an associated subluxing ulnar nerve. Dr. Brown further noted that this was a "dynamic ulnar neuropathy" that would not necessarily be identified on a nerve conduction study. *Id.* Since Petitioner suffered had from this condition for over three years and failed a year of conservative measures, Dr. Brown recommended surgery. *Id.*

Petitioner was assigned to "R-3 A & B" on November 17, 2010. The next day he was assigned to "Tower 3." (RX 3)

A copy of the communication from Respondent dated November 18, 2010, approving surgery was entered into evidence as Petitioner's Exhibit 6. This correspondence from Respondent's adjustor, Sue Zellers, stated:

> Fyi.....we had previously denied Mr. Lance Fancher's repetitive motion claim (date of injury: 11/25/09). After reviewing Dr. Brown's report, we have changed it to a compensable claim. Work Comp will pay for treatment related to this injury. (AX4 - PX6).

On December 7, 2010, Petitioner underwent a right cubital tunnel release with anterior submuscular transposition of the ulnar nerve and myofascial lengthening of the flexor pronator tendon origin. (AX4 -PX5). Objective intra-operative findings included tight fascial bands at the proximal edge of the cubital tunnel. *Id.* Petitioner's myofascial flaps had to be sutured in a lengthened, loosened fashion over the ulnar nerve to keep the nerve anterior to the medial epicondyle. *Id.* Dr. Brown noted that Petitioner had a good recovery and referred him for physical therapy. (AX4 -PX3, 12/20/10, 1/19/11). Petitioner was off work as of December 7, 2010 until December 20, 2010 when he was released with restrictions. (AX 4 - PX 3)

Petitioner underwent therapy at DuQuoin Health Center for his right elbow beginning December 10, 2010 and ending on January 14, 2011. (AX 4 - PX 7)

Petitioner returned to see Dr. Brown on January 19, 2011. He reported the numbness was gone, he had no pain, and he was doing well. He had good active range of motion of the elbow, wrists, and all digits as well as good grip strength and sensation. He was to continue with his home therapy for an additional four to six weeks and return to full duty work as of January 24, 2011. Petitioner was otherwise released from care with instructions to return on an as needed basis. (AX 4 - PX 3)

According to RX 3, Petitioner did not return to work until January 25, 2011 at which time he was assigned to "Leave Relief 11." He remained in that position through February 18, 2011. (RX 3)

Petitioner did not work between February 18, 2011 and March 1, 2011. As of March 1, 2011 Petitioner worked "R-4 C & D" on Saturdays and Sundays, "R-4 Escort" on Wednesdays, and "R- 4 A & B" on Thursdays and Fridays. He had Mondays and Tuesdays off. This schedule remained in effect through April 10, 2011. (RX 3)

As of April 12, 2011 Petitioner worked the following schedule: "R-4 Escort" on Thursdays; "R-3 Escort" on Sundays and Mondays; and "R-4 Control" on Fridays and Saturdays. Tuesdays and Wednesdays were his days off. This schedule remained in effect through July 27, 2011. (RX 3)

Effective July 29, 2011 Petitioner worked as an "R1 Escort" officer through August 15, 2011. (RX 3)

On August 17, 2011 Petitioner presented to Dr. George Paletta. According to the doctor's notes, Petitioner was a correctional officer for Respondent, having been there for twelve years. Dr. Paletta wrote:

> . . . His job involves the typical duties of a correctional officer including cuffing and un-cuffing inmates, locking and unlocking cell doors, opening and closing cell doors, and at times having to restrain inmates. He presents for evaluation of a chief complaint of left elbow pain as well as numbness and tingling into the lateral digits of the hand. He has a significant past medical history that this has been going on for at least three years. He initially saw Dr. David Brown several years ago. He had initial EMG and nerve conduction studies that were negative. Dr. Brown treated him conservatively, but ultimately he had continued complaints particularly with regard to the right elbow. He underwent ulnar nerve transposition of the right elbow in December 2010. He returned to work after about six weeks. He has done well on the right side. However, he has had continued symptoms on the left side. (AX5 - PX3, 8/17/11).

Petitioner complained of medial elbow pain as well as pain and numbness radiating down into the ulnar border of his hand and into the lateral fingers. Petitioner reported that his symptoms were aggravated by repetitive use of his hand, particularly his job duties, and that he was taking over-the-counter medication as necessary to manage his symptoms. (AX5 -PX3, 8/17/11).

Physical examination of Petitioner's left elbow revealed tenderness at the cubital tunnel, positive Tinel's sign, positive ulnar nerve compression test and positive elbow flexion test. *Id.* Grip strength in Petitioner's left upper extremity was 60 versus 110 on his right surgically repaired side. *Id.* Pinch strength on his left side was also reduced as opposed to his right side. *Id.* Dr. Paletta noted Petitioner had evidence of a "clearly hypermobile subluxing nerve." Petitioner's right elbow was noted to be fine. Dr. Paletta's impression was recurrent left ulnar neuritis in the setting of a hypermobile subluxing ulnar nerve, which he believed was aggravated by Petitioner's repetitive job duties. *Id.* Dr. Paletta made the following recommendations based on his impression:

> Clearly the patient has had persistent ongoing symptoms secondary to hypermobile subluxing ulnar nerve. His previous EMG and nerve conduction studies done a year-and-a-half ago were normal. I recommend that he undergo repeat EMG and nerve conduction studies. However, I would recommend that he consider ulnar nerve transposition irregardless [sic] of what the nerve conduction study show [sic]. This is a mechanical issue due to instability of the ulnar nerve. The ulnar nerve is repeatedly irritated based on his reparative [sic] work activities. The purpose of the EMG and nerve conduction studies is to document whether there has been any interval change in the nerve and to

> document that preoperatively. This would help predict potential recovery. Nonetheless, irregardless [sic] of what the nerve conduction study show [sic], I would recommend he undergo ulnar nerve transposition similar to what was performed on the opposite site [sic]. . . *Id.*

Dr. Paletta stated that Petitioner's left elbow complaints were causally related to Petitioner's job activities, and noted that Petitioner's left elbow condition and symptoms was almost identical to what Petitioner suffered in his right upper extremity. *Id.* Dr. Paletta recommended that Petitioner proceed with surgery, based in part on the success Petitioner had in obtaining relief from his right-sided complaints with same. *Id.* Petitioner was allowed to continue working full duty. *Id.*

Petitioner underwent an EMG and Nerve Conduction Study with Dr. Phillips on August 17, 2011. They were normal. Dr. Paletta reviewed the studies himself on August 25th. His diagnosis remained intermittent ulnar neuritis in the setting of a hypermobile subluxing ulnar nerve and he further described it as a mechanical problem. He again recommended surgery to eliminate the instability of the ulnar nerve and the tendency for recurrent irritation of the nerve. (AX 5 - PX 3)

On August 17, 2011 Petitioner also authored a letter "To Whom It May Concern" discussing his work duties in Dietary, Control Rooms, the Infirmary, the Visiting Room, and Administrative Back Room. He also mentioned writing of reports and cuffing of inmates. (AX 5 - PX 8)

Petitioner completed a Notice of Injury form on August 18, 2011 reporting an injury to his left elbow on August 17, 2011 due to correctional officer duties which had involved "twelve years of keying doors, pushing buttons, cuffing, writing reports and log books." A First Report of Injury form was completed by Respondent on August 18, 2011. (AX 5 - PX 7)

On August 19, 2011 a Demands of the Job form was completed for Petitioner's job. According to it, Petitioner used his hands for fine manipulation less than three times per week and for gross manipulation zero to two hours per day. (AX 5 - PX 7)

From August 19, 2011 through August 24, 2011 Petitioner was assigned to "Tower 3." (RX 3)

Petitioner signed his Application for Adjustment of Claim in 11 WC 032739 on August 23, 2011. (AX 3; AX 5 - PX 7)

On August 25, 2011, Petitioner underwent a subcutaneous ulnar nerve transposition. (AX5 -PX5, PX 6) Intra-operative findings noted a generally normal left elbow except for evidence of a "hypermobile snapping ulnar nerve" which snapped with every cycle of flexion and extension and subluxed over the medial epicondyle. *Id.* Petitioner was taken off work as of August 25, 2011.

Dr. Paletta's post-surgery follow-up note documented significant elbow pain with numbness and tingling into the lateral border of Petitioner's hand in the fourth and fifth fingers. (AX5 -PX3, 9/12/11). Dr. Paletta prescribed Lyrica and Vicodin and began Petitioner's physical therapy. *Id.* Petitioner was returned to full duty work on December 8, 2011, and released from care on January 11, 2012. At the time of his last visit with Dr. Paletta, Petitioner was doing "great" with no significant pain and only a "tiny bit" of numbness at the tip of his fifth finger. Any fourth finger numbness had completely resolved. Petitioner had no swelling and full range of motion. The ulnar nerve was nice and mobile. Dr. Paletta described Petitioner's outcome as "excellent." (AX5 -PX3, 11/30/11, 1/11/12).

Petitioner was off work from August 25, 2011 through January 28, 2012. He returned to work on January 29, 2012 as a "Gym Officer." He remained in that position through February 28, 2012. He was then off work until April 23, 2012 at which time he returned to the Infirmary where he worked through September 1, 2012. (RX 3)

Dr. Paletta testified by way of deposition on February 8, 2013. (AX5 -PX9). Dr. Paletta testified that he was beginning his 16th season as the team physician for the Cardinals, and that he has performed independent medical examinations at the request of the State of Illinois. (AX5 -PX9, p.4). Dr. Paletta testified that Petitioner suffered from irritation of the ulnar nerve as a result of friction caused by hypermobility, and recommended ulnar nerve transposition. *Id.* at 8, 10, 11. Dr. Paletta explained that Petitioner's nerve was slipping in and out of its "groove" and rolling over the medial epicondyle, the bony prominence on the inner side of the elbow. *Id.* 10, 11. Following the transposition, Petitioner suffered from post-surgical causalgia, which was resolved conservatively with Lyrica. *Id.* at 9.

Dr. Paletta described the difference between ulnar neuritis and ulnar neuropathy:

> The basic difference between the two is in ulnar neuritis there will not be EMG and nerve conduction study changes, whereas in ulnar neuropathy there will be abnormalities on the nerve conduction changes. The clinical symptoms will be identical – pain in the elbow, numbness and tingling in the ulnar nerve distribution – but the nerve has not been adversely effected from a functional perspective yet. *Id.* at 11, 12.

Dr. Paletta testified, however, that if left untreated Petitioner's condition could worsen and create chronic changes in the nerve, which would affect the ability of the nerve to conduct signal. *Id.* at 11. Dr. Paletta testified that the condition is aggravated by repetitive flexion and extension under load; and in Petitioner's case, his cuffing and uncuffing inmates, locking and unlocking cells, and opening and closing cell doors qualified as repetitive flexion-extension under load. *Id.* at 12, 13. Dr. Paletta explained that "under load" did not mean heavy weight or significant force, but meant resistance, which could be created with as little as one pound. *Id.* at 15-17.

On cross-examination Dr. Paletta testified that he most commonly sees ulnar neuritis in athletes but, of course, his practice is sports medicine based. He has also seen it in industrial workers and "everyday folks." It's really a consequence of friction on the nerve because of the underlying instability. He further testified that if one just bends and straightens one's arm with out any resistive force against it, the nerve may sublux. However, in his experience the nerve becomes symptomatic when the elbow is being bent and straightened with some type of resistance such as when one throws a baseball or repetitively pushes and pulls a dolly or repetitively opening and closing cell doors where there is some resistance or increased force besides the weight of just their arm or their hand. Dr. Paletta noted, "I see this in little leaguers, too, who don't throw the ball very hard." *Id.* at 16, 17.

Dr. Paletta testified that he reviewed Respondent's materials pertaining to the job duties of a Correctional Officer at Big Muddy Correctional Center, and based on Petitioner's history, clinical examination findings, intraoperative findings and his recovery following his bilateral elbow surgeries, Dr. Paletta opined that Petitioner's job duties did contribute to symptomatic ulnar neuritis of the left elbow. *Id.* at 10. On cross he acknowledged that he hadn't reviewed the aforementioned materials (job site analysis, DVD of Big Muddy) in the last couple of weeks; rather, it had probably been within the last year. *Id. at 18.*

Petitioner attended an examination with Dr. Anthony Sudekum at the request of Respondent on August 29, 2013. Dr. Sudekum testified by way of deposition on December 23, 2013, and began his testimony by pointing out three errors in his report, one of which was substantive. (RX5, p.5, 6). Petitioner testified that the test performed by Dr. Sudekum was vastly different from the one performed by Dr. Phillips. (T.39). Unlike Dr. Brown and Dr. Paletta, Dr. Sudekum believed that evidence of a hypermobile/subluxing nerve should show up on electrodiagnostic studies. (RX5, p.11).

Dr. Sudekum's physical examination findings demonstrated positive Tinel's sign bilaterally over Petitioner's wrists, positive Tinel's sign over Petitioner's left elbow, and borderline Phalen's and grind test over the left wrist. (RX4, p.10). Dr. Sudekum stated that hypermobility and/or subluxation of the ulnar nerve was not caused by any specific accident, repetitive motion or work activity, and that usually, the condition is asymptomatic. (RX4, p.45). He acknowledged, however, that subluxation of the nerve from significant elbow movement can become symptomatic as a result of irritation inflammation and produce elbow pain and paresthesia in the ulnar nerve distribution. (RX4, p.45; RX5, p.7, 8, 11). He indicated that, "The more subluxation, potentially, the more likely the patient is to become symptomatic." (RX5, p.7, 8). Dr. Sudekum stated that very few patients are symptomatic and even fewer patients fail to improve with conservative measures and require surgery. (RX4, p.45-46).

Dr. Sudekum was under the impression that most of the opening and closing of cell doors at Big Muddy River Correctional Center was done electronically through the control pod rather

than manually by Correctional Officers. (RX4, p.13). Dr. Sudekum also indicated that he visited Respondent's Big Muddy facility and observed Correctional Officers performing their job duties; however, he did not indicate whether this was done during the busy day shift or one of the other shifts with less movement. (RX4, p.13, 17; RX5, p.16, 17, 19). Dr. Sudekum also indicated that he performed some of the tasks repeatedly performed by Correctional Officers; however, he failed to indicate how many times he did so or which areas of Respondent's facility he opened doors/chuckholes, turned keys or lifted property boxes. *Id.*

Based on Respondent's exhibits, his review of the video and his visit, Dr. Sudekum did not believe Petitioner's job activities caused or aggravate ulnar subluxation, or resulted in the need for any treatment for same. (RX4, p.50; RX5, p.20, 21). Dr. Sudekum suggested that Petitioner's condition could be related to his cervical spine. Despite stating that he believed Petitioner's persistent left-sided complaints were related to his cervical spine, he testified that they could also be related to the type of surgery performed on Petitioner's left elbow (subcutaneous ulnar nerve transposition), which was different than the procedure performed on Petitioner's right side (submuscular ulnar nerve transposition). (RX4, p.48, 49; RX5, p.14, 15). Rather than recommending cervical intervention, Dr. Sudekum testified that he would recommend revision ulnar nerve surgery with submuscular transposition if Petitioner's left side worsened. (RX5, p.15, 16).

On cross-examination, Dr. Sudekum testified that in the past 3 years, he has performed 138 IMEs, given 71 depositions, and made over $944,000.00 performing medical legal services for the State of Illinois. *Id.* at 21, 22. He testified that he did not believe that the fact that the video provided to him by Respondent was filmed on a different shift than the one worked by Petitioner would impact is causation opinion, even when provided with evidence that the Illinois Workers' Compensation Commission felt differently. *Id.* at 30, 37-40. However, given the fact that he believed that the video was an accurate representation of what he saw, and the testimony of Petitioner and Respondent's witness that the day shift is different than the other shifts, it is evident that Dr. Sudekum did not visit during Petitioner's day shift. *Id.* at 39. He acknowledged that sticking doors would be difficult to operate and pull open, that property boxes are often heavy, and that repetitive motion of the arms and hands is needed to perform property box searches. *Id.* at 26-28. Dr. Sudekum was unaware that the strength demands in Respondent's Job Site Analysis indicated that Petitioner frequently lifted up to 25 pounds, frequent being defined as up to 5 ½ hours per day. *Id.* at 33. He admitted to opining in the case of *Branden Schrader v. SOI/Big Muddy River Corr. Ctr.* that the job duties of a Correctional Officer did not contribute "significantly" to the etiology or exacerbation of bilateral repetitive injury. *Id.* at 36.

Dr. Brown testified by way of deposition taken on February 25, 2014 (09 WC 49710). (AX4-PX8) Dr. Brown trained under Dr. Susan Mackinnon, an internationally recognized expert in the field of peripheral nerve injury and head of the plastic surgery program at Washington University, and Dr. David Green, president of the Hand Society and senior editor of the

international standard textbook on hand surgery, Green's Operative Hand Surgery. (AX4-PX8, p.5). In addition to his practice, Dr. Brown currently serves as the hand specialist for the St. Louis Cardinals, and frequently lectures before medical facilities, judicial bodies, insurance agencies and both petitioner and respondent oriented groups. *Id.* at 6-8. Dr. Brown testified that 95% of his patient referrals come from insurance companies, employers, occupational medical clinics or defense attorneys. *Id.* at 8, 9. Dr. Brown also performed IMEs at the request of the State of Illinois. *Id.* at 9, 10.

Dr. Brown further explained the etiology of a symptomatic subluxing ulnar nerve:

> Subluxing ulnar nerve. Another word for subluxation is dislocation, and if you look at the literature on the subject, sixteen to twenty percent of the population actually has subluxing ulnar nerves. And what that is is the ulnar nerve runs along the inside of the elbow and it runs in a groove between two bones at the elbow and that groove is called the condylar groove. It's between the medial epicondyle and a piece of the olecranon and it is an actual groove. And patients with subluxing ulnar nerves, when they move from extension to flexion, the nerve will actually move out of that groove or dislocate and go over the bony prominence called the medial epicondyle. . . *Id.* at 10, 11.

Dr. Brown testified that there are no comorbid risk factors that can lead to the development of subluxing ulnar neuropathy. *Id.* at 12. The condition is an anatomical abnormality. *Id.* at 12. Hence, his opinion focuses on the specific common factors that exist in the patients that become symptomatic as a result of the condition. *Id.* at 10-12.

Dr. Brown testified that while the majority of patients with this condition are asymptomatic, "A smaller percentage of them are symptomatic and it's a dynamic process that is activity related." *Id.* at 11. He testified that the patients that come to him with symptomatic subluxing ulnar nerves "are either athletes or they're in arm-intensive type jobs." *Id.* at 11. He stated, "They're doing something that is causing it to become symptomatic and so those are the patients that I see with symptomatic subluxing ulnar nerves." *Id.* at 11. When asked what specific type of motion caused the condition to become symptomatic, he stated:

> It's moving from extension to flexion and the nerve will then sublux or dislocate out of the condylar groove over the medial epicondyle and that causes trauma to the nerve, and if they're doing that on a frequent basis, it becomes symptomatic. . . *Id.* at 11, 12.
>
> . . . I see it in athletes or I see it in the industrial Work Comp setting in individuals who are doing arm-intensive type of activities. The come in with symptomatic subluxing ulnar nerves from using their arms all day long. *Id.* at 12.

Dr. Brown testified that Petitioner's attorney's office furnished him with a two page handwritten job description with additional details concerning Petitioner's job. *Id.* 23, 26. He also

reviewed a Job Site Analysis and some videos. The latter items were not that significant to him as they didn't provide much useful information pertaining to Petitioner's job. They did not address the frequency of the activities Petitioner stated he repetitively performed -- key turning and cell door opening/closing. They were silent as to the forces involved also. *Id. 24 - 26.*

Although Dr. Brown testified that this condition in symptomatic form is seen in patients who perform frequent strenuous activities, Dr. Brown did not indicate that the arm-intensive activity had to be forceful activity, and he also indicated that it is seen in individuals who simply use their arms repetitively. *Id.* at 12, 41. Dr. Brown testified that the relevant factors were activity, frequency and duration of exposure. *Id.* at 54, 55. He testified, however, that resistance or added force would add to the irritation sustained. *Id.* at 56.

Dr. Brown also testified that symptomatic nerve irritation resulting from hypermobility of the ulnar nerve does *not* typically show up on nerve conduction studies:

> His answer to paraphrase is basically he's saying that you typically expect to see a nerve conduction study would be positive for changes on it and that's absolutely not true. He doesn't know the medical literature on the subject. As I stated before, in the published series on subluxing ulnar nerves, all of the patients in the most recent series had completely normal nerve conduction studies, so it's extremely uncommon for them to have a positive nerve conduction study no matter how symptomatic they are because it's a dynamic process. It's a dynamic pathology where the nerve is subluxing out of the condylar groove, being irritated by the medial epicondyle and that produces symptoms, so it's very uncommon for them to have positive nerve conduction studies . . . so that statement in his answer is just not true. It's not – it's not consistent with what the medical literature says. *Id.* at 34-35.

Dr. Brown explained why the nerve conduction studies obtained were reasonably necessary:

> . . . The reason I obtained them in this case is basically a way to monitor the patient and if I see any changes on the nerve conduction studies when I'm treating them conservatively, I will tend to operate on them sooner, but in this case, they were negative, so I felt I had time to treat this gentleman conservatively for a whole year, but he failed the year of conservative treatment so we eventually offered him surgery, but normally they're going to be normal. . . *Id.* at 34-35.

Dr. Brown testified that Dr. Phillips did not physically examine Petitioner for a subluxing ulnar nerve because it is an uncommon diagnosis and that was not the indication for the referral. *Id.* at 17, 18.

Dr. Brown found it significant that Respondent's video was taken on a different shift than the day shift which Petitioner most frequently worked, because more activity occurs during the first/day shift. *Id.* at 25. Dr. Brown testified that there were no other activities performed on a frequent enough basis to aggravate his subluxing ulnar nerve outside of his employment

activities, which Petitioner frequently performed for more than 10 years. *Id.* at 27. Hence, Dr. Brown concluded that Petitioner's employment was the only plausible explanation for Petitioner's subluxing ulnar nerve, which is typically asymptomatic, becoming symptomatic and requiring surgical intervention. *Id.* at 27. Dr. Brown noted that the arm-intensive activity performed by Petitioner at Big Muddy River Correctional Center throughout his work day as he repeatedly lifted/flexed his arm to turn keys, open and close doors and cuff and uncuff inmates was beyond the normal "everyday" level of activity, and when done over a prolonged period of time, would aggravate a subluxing ulnar nerve. *Id.* at 43, 44, 53.

Dr. Brown disagreed with Dr. Sudekum's testimony that the procedure performed by Dr. Paletta was somehow inferior to the procedure which he performed, and stated that it was simply a matter of personal preference. *Id.* at 29. Dr. Brown also pointed out that the Neurometrix test performed by Dr. Sudekum was substandard and does not even measure nerve conduction across the elbow. *Id.* at 30-32. He also noted that Dr. Sudekum did not offer a credible explanation for the symptomatic manifestation of a typically asymptomatic condition. *Id.* at 33.

On cross-examination Dr. Brown acknowledged that Dr. Sudekum's Neurometrix testing results were normal as were Dr. Phillips. He also stated that Petitioner's nerve is an anatomical variant that he was born with. He typically sees it in athletes or workers with arm-intensive types of jobs. It's also prevalent with weight lifters. Dr. Brown acknowledged that Petitioner denied any sports activities or hobbies outside of work. *Id. 39 - 42* Dr. Brown felt Petitioner's job was fairly arm intensive in that he turned locks several hundred times a day, pushed and pulled on doors to sure they were locked several hundred times a day, cuffed and uncuffed inmates that were struggling throughout the day and over a prolonged period of time could aggravate someone with a subluxing ulnar nerve. Dr. Brown was told by Petitioner that he turned keys to open and close doors fifty times an hour but based upon Petitioner's handwritten description he didn't think it was every hour. He thought it was 200 to 300 times per day. *Id. at 44.* Dr. Brown agreed that there are various different job assignments with Respondent and that the hand intensity of the assignments could vary. He agreed that there wouldn't be turning of 300 keys per hour on tower duty. Dr. Brown testified that when he saw Petitioner Petitioner was working in the Infirmary on the first shift where he was turning keys fifty times and an hour. Dr. Brown didn't think that was inconsistent with what he read in other reports, referencing the Job Site Analysis in which it was noted that was one of the areas where keys were manually turned. He had also worked in dietary where he turned a lot of keys and did morning counts and property box checks with keying of two hundred cells per day. Petitioner didn't include tower work in the written job description. *Id. 44, 45* Dr. Brown further acknowledged that when he first saw Petitioner, Petitioner provided him with a general job description. Thereafter, Petitioner provided him with more details but he didn't go through an exhaustive, detailed list of every activity he has done for the past ten years with Respondent. Dr. Brown testified that Petitioner gave him a general description that he turned keys and opened/closed cell doors. Petitioner also denied any outside activities or hobbies. He was generally healthy. *Id. 47-48.*

With regard to Petitioner's case, Dr. Brown did not know how Petitioner turned the keys; however, his understanding from other officers was that it was commonplace to use both arms. *Id. 48-49.* He believed different types of keys were used at Respondent's facility and that chuckholes are found in segregation and in the infirmary. Bar rapping is found in segregation and the showers. Petitioner would not have been rapping bars in the infirmary. Dr. Brown was unaware of any bars in the Infirmary. He did not know how long Petitioner had worked in segregation. Dr. Brown felt it took more force to open the chuckholes with the Folger Adams keys. *Id. 49 - 54*

Dr. Brown further testified that the only plausible explanation he had for Petitioner's subluxing ulnar nerve was his work activity because there was nothing non-occupational he could point to as an aggravating factor. *Id. 54* Dr. Brown also testified that any activity, whether at work or weight lifting, can have the same effect on the nerve so it becomes important how frequent one performs the activity and what's the exposure. He explained that his daughter is a volleyball player and has a subluxing ulnar nerve that bothers her when she's playing and then stops after she quits playing. *Id. 55*

At the arbitration hearing Petitioner testified that he began his career with the State of Illinois on September 27, 1999, as a Correctional Officer at Big Muddy River Correctional Center. Petitioner testified that neither his job title nor his job duties have changed in any way since he was hired in 1999. Prior to 2010, Petitioner never missed any time from work because of a workers' compensation injury for his hands or elbows, nor did he require any care or treatment for his hands, wrists or elbows. Petitioner's weight has been consistent for the last 10 to 15 years, and that he does not suffer from diabetes, gout, hypothyroidism or rheumatoid arthritis.

Petitioner testified that he has spent the overwhelming majority of his time working Respondent's 7 to 3 shift, working in the infirmary unit (35%) and in the housing gallery unit (40%). Petitioner testified that there is a distinction between the healthcare unit and the infirmary. The infirmary, which is located in the back part of the unit, is where inmates are kept because of illness or disability. Petitioner used the remaining percentage of his time working as a relief officer in other positions, including segregation (an isolation wing) and dietary. Petitioner testified that working dietary also requires that he open "quite a few doors with bigger keys," because of frequent inmate movement from the kitchen, dish room and bathrooms. Petitioner testified that Respondent's job post roster was not an accurate representation of his actual assignment history, because shift commanders frequently change the assignments indicated on the roster.

Petitioner testified that he reviewed the video of a Big Muddy Correctional Officer offered into evidence by Respondent and testified that it was not taken on the day shift which he most frequently worked. Petitioner testified that most of the movement in Respondent's facility

takes place on the day shift, and the video did not depict any of the activity occurring on the 7-3 day shift.

Petitioner testified that the keys used at the facility were approximately 3 inches in length, which is smaller than a Folger Adams key, but larger than the regular key used by the general public. Petitioner testified that the keys are large enough to require all 5 of his fingers to turn them.

The first thing Petitioner did when he arrived on day shift while working in the infirmary was key open all of the doors for count. When working on the gallery, Petitioner began his day by keying open doors for property box checks. Petitioner described opening the locks as, "You put in the key, and you've got to twist almost 180 degrees, sometimes sticking and then turning it back trying to get that door to unlock." Petitioner testified that the doors at the facility are hinged doors made of heavy steel. Petitioner testified that the doors and locks stick, and on occasions require both hands to open. Petitioner testified that he opens over 100 doors in the first 90 minutes of his shift alone on his gallery assignment. Petitioner testified that he was individually responsible for two wings, each containing 50 cells.

After opening the doors, Petitioner performed property box checks, which involved lifting up the boxes and searching its contents using his upper extremities. Petitioner testified that the property boxes are heavy, because all of the inmates' items are stored in them, including food, clothes, legal materials, magazines and books. Petitioner also lifts mattresses and moves furniture during his search for contraband.

After compliance checks are complete, and he has confirmed that the inmate counts check, Petitioner began running lines for gym, school, and work assignments. Petitioner testified that inmates are sometimes searched and cuffed, and the destination of each inmate must be logged. Petitioner testified that he cuffs and uncuffs inmates on a daily basis, and that it takes 5 separate motions with his upper extremities to do so. Petitioner testified that the locks do not work all of the time, and when they do not work he has to try operating the lock in different positions and/or put in a work order to get the equipment replaced. Respondent employs a full-time locksmith at its Big Muddy River correctional facility. Petitioner also performed wing checks every 30 minutes. Petitioner testified that he pulled on the doors to open them and make sure the inmates were compliant, confirmed the doors were secure, and logged the results.

Petitioner testified that he operated chuckholes on a daily basis throughout the course of his career while working in the infirmary and segregation units. Petitioner testified that the chuckholes at Big Muddy are opened by Folger Adams keys. Petitioner testified that the Folger Adams keys must be turned 180 degrees and require force and grip to operate. Petitioner testified that the chuckholes work "sometimes," but fail to work on other occasions due to paint, rust or inactivity. Petitioner used chuckholes to deliver food and mail, and in the infirmary, for the psychiatrist or staff could talk to the inmate through the chuckhole. Petitioner also restrained

inmates as necessary. Petitioner testified that there was no part of his job as a wing officer that does not involve the use of his arms and hands. Petitioner testified that he has never had a negative performance review in his 15 years of employment. Petitioner testified that the heaviest thing he had to lift was actual inmates.

Petitioner testified that despite the improvement resulting from surgery, he continues to experience symptoms depending on his level of activity. Petitioner testified that his elbows are bothered by performing lengthy chores around the house and driving for long distances. Petitioner testified that he begins to experience pain after driving more than an hour and a half. Petitioner takes Ibuprofen and/or Aspirin as needed for his symptoms. Petitioner testified that his hobbies of archery and fishing have been adversely affected. Petitioner testified that he continues to fish since his surgeries, but that he finds himself having to switch hands a lot. The pictures submitted by Respondent show Petitioner fishing and hunting. (RX6). Petitioner testified that his loss of strength has forced him to change the type of bow he uses.

Petitioner testified that he improved following his right elbow surgery, and returned to work performing the same job duties responsible for his right elbow injury. After returning to work from his right elbow surgery and working full duty for some time, Petitioner began to notice an increase in the intensity of the same symptoms in his left upper extremity. When these increased over time, Petitioner sought treatment with Dr. George Paletta.

On cross-examination Petitioner acknowledged that Respondent's facility opened in 1992 and is 20 - 23 years old. He also voiced no disagreement with RX 3, his staff assignment history. Petitioner agreed that he had probably worked every assignment in Respondent's facility at one time or another and that his job duties varied with some jobs involving more upper extremity activity than others. Petitioner believed that his job as a wing officer was the most hand intensive duty with it taking up approximately 30 to 40 percent of his time. The "Tower Officer" position was only hand intensive ten percent of the time as it mainly involves standing and watching for security breaches. As a "Dietary Officer" Petitioner explained that he maintained the safety and sanitation of the dietary and helped the lieutenants with chow lines. He would open quite a few doors with bigger keys to the dish room and to let inmates go to the bathroom. He worked solely in the dietary unit when assigned there.

Petitioner testified that his work as a "Relief Officer" was the most varied because he would be substituting for someone who was sick or off work. "Escort Officers" help the wing officers if requested and involves staging, walking and escorting inmate lines to and from the housing unit to the gym, yard, school, or health care. Doors at the beginning and end of the line would need to be unlocked but sometimes that was handled by buzzers in the Control Room. According to Petitioner, he primarily walked, used his eyes, and maintained good order in the line. It could be hand intensive if there was a physical altercation but on a day to day basis Petitioner agreed that it did not involve repetitive upper extremity motions.

Petitioner also testified that when working in "R2 Control" he would be the "bubble officer" in a housing unit/control room and keep an eye on the wings and control the panel's toggle switches for opening and closing doors. He agreed that it takes about four ounces of force to push one of the toggle switches which isn't a significant amount of force and he usually pushed it with his thumb.

When assigned to the Visiting Room Petitioner monitored visits between inmates and visitor and provided security. It, too, involves no significant amount of repetitive upper extremity use. Petitioner also explained that as a "Gym Officer" he was essentially providing security within the gym and involved no intensive upper extremity activity.

Petitioner called Lieutenant Harold Schuler, who was present on behalf of Respondent, to testify. Lt. Schuler testified that although he has worked on the same shift as Petitioner, he never worked as Petitioner's supervisor. Lt. Schuler worked in a separate division, internal affairs. Lt. Schuler agreed with Petitioner's testimony that the 7 to 3 shift is a lot busier than the 3 to 11 shift. He also agreed that it takes significantly more wrist turning movement to perform a 180 degree key turn. He also agreed that some of the locks and/or keys and chuckholes stick. Lt. Schuler clarified that the infirmary contains an open ward where the majority of the inmates/patients stay as well as three isolation cells for inmates/patients in segregation status. He further testified that an officer assigned to segregation control would be assigned to a control room and would not open/close chuckholes. Lt. Schuler also testified that he does not trust or respect Petitioner.

Results for the Illinois Team Trail were marked as RX 7. They are not dated. (RX 7)

Respondent's Job Site Analysis dated December 17, 2010 shows that Correctional Officers perform frequent lifting up to 50 pounds and frequent carrying of up to 25 pounds (frequent being defined as up to 5 ½ hours per day); horizontal reaching up to 2 ½ hours per day; pulling up to 2 ½ hours per day; pushing up to 2 ½ hours per day; pinching up to 2 ½ hours per day; grasping up to 2 ½ hours per day; wrist turning up to 2 ½ hours per day; and frequent finger manipulation up to 5 ½ hours per day. The Analysis further notes that the physical work demands are going to vary depending upon shift and assigned position. For more specifics per employee, one is told to refer to their individual locations, job descriptions, and log sheets. The Analysis also indicates that Respondent's facility is a Level 3 high medium security facility in which the inmates are allowed to move freely in and out of their cells for approximately six hours every day to allow them to use facilities such as the yard, gym, school, dining hall and day room. (RX1).

Respondent's Exhibit 2 is compromised of various position description summaries for "SEG Control Officer," Health Care Unit Officer," "Housing Unit Control Officer," "Housing

Unit Wing Officer," "Housing Unit Escort Officer," "Infirmary Officer," "Receiving Wing Officer," and "Segregation Wing Officer." (RX 2)

With regard to Case # 09 WC 49710, The Arbitrator concludes:

Issue (C): Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner failed to prove he sustained an accident on November 25, 2009 that arose out of and in the course of his employment with Respondent or that his current condition of ill-being is causally related to that injury. In particular, Petitioner failed to prove that any accident "arose out of" his employment or that his right elbow condition was causally related to his employment duties for Respondent. While Petitioner's Application for Adjustment of Claim alleges bilateral hand and right wrist injuries, Petitioner failed to prove he sustained any injury to his bilateral hands or right wrist as a result of an alleged accident on November 25, 2009.

In cases such as this one where a claimant's theory of liability is based upon repetitive trauma, the claimant generally relies on medical testimony to establish a causal connection between the claimant's work and the claimed disability. When the question is one specifically within the purview of experts, expert medical testimony is mandatory to show the claimant's work activities caused the condition of which the employee complains. *Nunn v. Industrial Commission*, 157 Ill.App.3d 470, 478 (4th Dist. 1987), citing *Westinghouse Electric Co. v. Industrial Commission*, 64 Ill.2d 257 (1976)

Petitioner herein has failed to prove to a medical and surgical certainty via expert testimony that he suffered accidental injuries with a causal link to his duties as a correctional officer for Respondent. Petitioner's case relies upon the opinion of Dr. Brown who has relied on incomplete and incorrect information. Most significantly, Dr. Brown did no have a complete and accurate understanding of Petitioner's work assignments for Respondent. As Petitioner acknowledged on cross-examination he has worked almost all of the available jobs at Big Muddy. His assignments varied and his duties within those assignments varied. Petitioner readily acknowledged that many of them were not upper extremity intensive whatsoever. Looking at Petitioner's job assignments prior to his initial visit with Dr. Brown, it is clear that Petitioner worked as a dietary officer, relief officer, wing officer, escort officer, and control room officer. Some of these positions varied within the work week itself. When initially presenting to Dr. Brown, he was assigned to the Infirmary. Even if

one focuses on the job assignments that involved cell doors and keys, Dr. Brown did not have correct information. Dr. Brown was told that Petitioner opened fifty doors per hour throughout an average workday which is an assertion wholly absent from Petitioner's trial testimony. Dr. Brown related that Petitioner opened two hundred doors every morning as a wing officer, contrary to that of Petitioner at trial. Additionally, Petitioner testified about property box checks. He never discussed that job duty with Dr. Brown, however.

Further troubling is the fact that after the initial visit with Dr. Brown in November of 2009 Petitioner did not return to see him until April 7, 2010. At that time he was assigned as a "Dietary Officer." No definitive diagnosis was reached at either visit. Petitioner then returned to see Dr. Brown on June 16, 2010 at which time he was working as an "Escort Officer." Dr. Brown's records contain no discussion of the job duties associated with these positions. Interestingly, when Petitioner then returned to see Dr. Brown in September and October of 2010, Petitioner was not even working for Respondent as he was on a leave of absence beginning back in August of 2010.

While Respondent has contended in its proposed decision that Dr. Brown's opinion is further unpersuasive because the doctor was misled regarding Petitioner's activities outside of work, the Arbitrator notes that no direct evidence was presented showing that Petitioner was engaged in any recreational hobbies or pursuits during 2009 and 2010. While Petitioner acknowledged photographs of himself (RX 6) and acknowledged bow hunting and fishing, he testified that he did in 2012 and 2013. He was never asked if he was doing so prior to those years. Thus, she is unable to adopt Respondent's contention. However, the line of questioning and photographs did cast suspicion on Petitioner's credibility, especially when he testified that he had to "drop down" to a 50 lb. bow as a result of his surgery. Nevertheless, Dr. Brown's causation opinion in this case is not persuasive for the reasons outlined above. The multitude of assignments and duties performed by Petitioner is a compelling factor in assessing the repetitive nature of his duties for Respondent. The fact that Petitioner performed at least ten different assignments during the period of time in which his upper extremity complaints manifested suggests that his activities were not sufficiently repetitive to constitute an aggravating factor for his congenital condition.

Petitioner's claim for compensation in 09WC 49710 is denied. All remaining issues are moot. No benefits are awarded.

With regard to Case # 11 WC 32739, The Arbitrator concludes:

Issue (C): Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner failed to prove he sustained an accident on August 17, 2011 that arose out of and in the course of his employment with Respondent or that his current condition of ill-being is causally related to that injury. In particular, Petitioner failed to prove that any accident "arose out of" his employment or that his left elbow condition was causally related to his employment duties for Respondent.

In cases such as this one where a claimant's theory of liability is based upon repetitive trauma, the claimant generally relies on medical testimony to establish a causal connection between the claimant's work and the claimed disability. When the question is one specifically within the purview of experts, expert medical testimony is mandatory to show the claimant's work activities caused the condition of which the employee complains. *Nunn v. Industrial Commission*, 157 Ill.App.3d 470, 478 (4th Dist. 1987), citing *Westinghouse Electric Co. v. Industrial Commission*, 64 Ill.2d 257 (1976)

Petitioner herein has failed to prove to a medical and surgical certainty via expert testimony that he suffered accidental injuries with a causal link to his duties as a correctional officer for Respondent. Petitioner's case relies upon the opinion of Dr. Paletta who has relied on incomplete and incorrect information. Dr. Paletta's opinions were based upon a job history and understanding of duties that were not based upon full knowledge of the totality of Petitioner's job assignments and duties for Respondent. Dr. Paletta did not have a complete and accurate understanding of Petitioner's work assignments for Respondent. As Petitioner acknowledged on cross-examination he has worked almost all of the available jobs at Big Muddy. His assignments varied and his duties within those assignments varied. Petitioner readily acknowledged that many of them were not upper extremity intensive whatsoever. Looking at Petitioner's job assignments prior to his initial visit with Dr. Paletta, it is clear that Petitioner worked as a dietary officer, relief officer, wing officer, escort officer, and control room officer. Some of these positions varied within the work week itself. Additionally, the Arbitrator notes that while Petitioner alleges repetitive injury to his left, non-dominant elbow, there was very little clear testimony or evidence as to how Petitioner used his left arm/elbow in a repetitive fashion at work. A careful review of Dr. Paletta's office records shows a complete absence of any specific detailed information as to how Petitioner used his non-dominant left arm/elbow at work.

The multitude of assignments and duties performed by Petitioner is a compelling factor in assessing the repetitive nature of his duties for Respondent. The fact that Petitioner performed at least ten different assignments during the period of time in which his upper extremity complaints manifested suggests that his activities were

not sufficiently repetitive to constitute an aggravating factor for his congenital condition.

Petitioner's claim for compensation in 11WC 32739 is denied. All remaining issues are moot. No benefits are awarded.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☒ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify down	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CARLOS ALBERTO RIOS-OLIVARES,
Deceased, by and through
LUCIA LEON, Mother and Legal
Guardian of ALDO MANRIQUEZ,
LUCIA MANRIQUEZ, NICOLE RIOS,
and ANGIE RIOS,

Petitioner,

vs. NO: 10 WC 1548

U.S. STAFFING,

16IWCC0149

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of "Improper calculation of amount and duration of Death Benefits," and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission affirms the Arbitrator's finding that Lucia Leon is not a surviving spouse and that the only two surviving children of the Decedent who are entitled to death benefits are Nicole Danna Rios, born June 22, 2005, and Angie Dennise Rios Leon, born March 31, 2009. However, the Commission modifies the Decision to delete the finding on page three that the benefits shall be paid "until $500,000.00 has been paid, or 25 years, whichever is greater," since this is not an accurate statement of the law under the circumstances of this case. We also replace the Order section with the orders specified below, outlining the duration of benefits and deleting references to "surviving spouse."

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that under Section 7(a) of the Act, Nicole Danna Rios, born June 22, 2005, and Angie Dennise Rios Leon, born March 31, 2009, are the surviving children of the Decedent and are entitled to a combined death benefit, commencing January 10, 2010, of $466.13 per week to be used for their combined benefit and

support. Each surviving child's entitlement to the death benefit shall cease upon reaching 18 years of age, or 25 years of age if she is enrolled as a full-time student in an accredited educational institution. If one child is no longer entitled but the other child has not yet reached 18 years of age, or 25 years of age if she is enrolled as a full-time student in an accredited educational institution, then the death benefit shall be used solely for the remaining entitled child's benefit and support. The preceding age limitations notwithstanding, if any of the above children shall be physically or mentally incapacitated, the payments shall continue for the support of that child or children for the duration of such incapacity. However, pursuant to Section 8(b)4.2 of the Act, in no event shall the total benefits exceed the greater of $500,000.00 or 25 years.

IT IS FURTHER ORDERD BY THE COMMISSION that pursuant to Section 7(e) of the Act, these payments shall be made by Respondent to Lucia Leon, the natural parent and guardian of the minor children of the Decedent, on behalf of and for the support of said children until such time that the award may be modified by the Commission in its discretion with respect to the person to whom the payments shall be paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay $8,000.00 for burials expenses to the person(s) incurring the burial expenses, as provided in §7(f) of the Act, with Respondent receiving a credit of $9,140.63 for the burial expenses already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in §8(g) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner shall pay to her attorney $3,500.00 in attorney's fees and $725.00 in costs.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 3 - 2016

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

SE/
O: 2/24/16
49

Microfilm

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
FATAL

RIOS-OLIVARES, CARLOS ALBERTO DECEASED BY AND THROUGH LEON, LUCIA MOTHER AND LEGAL GUARDIAN OF ALDO MARIQUEZ, LUCIA MARIQUEZ, NICOLE RIOS & ANGIE RIOS
Employee/Petitioner

Case# 10WC001548

16IWCC0149

U.S. STAFFING
Employer/Respondent

On 3/30/2015, 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 0.10% 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.

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STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

☐ 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
FATAL

Carlos Alberto Rios-Olivares, deceased, by and through Lucia Leon, mother and Legal Guardian of Aldo Manriquez, Lucia Manriquez, Nicole Rios & Angie Rios
Employee/Petitioner

v.

U.S. Staffing
Employer/Respondent

16IWCC0149

Case # **10** WC **01548**

Consolidated cases: _____

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 **Brian Cronin**, Arbitrator of the Commission, in the city of **Wheaton**, on **March 13, 2014** and **September 9, 2014**. 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 Decedent's employment by Respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to Respondent?

F. ☐ Is Decedent's current condition of ill-being causally related to the injury?

G. ☐ What were Decedent's earnings?

H. ☐ What was Decedent's age at the time of the accident?

I. ☒ What was Decedent's marital status at the time of the accident?

J. ☒ Who was dependent on Decedent at the time of death?

K. ☐ Were the medical services that were provided to Decedent reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

L. ☐ What compensation for permanent disability, if any, is due?

M. ☐ Should penalties or fees be imposed upon Respondent?

N. ☐ Is Respondent due any credit?

16IWCC0149

O. ☒ Other: **Attorney's Fees**

FINDINGS

On the date of accident, **January 9, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Decedent's death ***is*** causally related to the accident.

In the year preceding the injury, Decedent earned $**474.00**; the average weekly wage was $**474.00**.

On the date of accident, Decedent was **30** years of age, ***single*** with **2** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**9,140.63** for other benefits, for a total credit of $**9,140.63**.

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

The Arbitrator finds that the Decedent died on **January 9, 2010**, leaving **2** survivors, as provided in Section 7(a) of the Act, including **Nicole Danna Rios** and **Angie Dennise Rios Leon**.

ORDER

Fatal

Respondent shall pay death benefits, commencing **January 10, 2010**, of $**466.13**/week to **Lucia Leon**, natural parent and guardian of the minor children of the Decedent: **Nicole Danna Rios**, born **June 22, 2005** and **Angie Dennise Rios Leon**, born **March 31, 2009**, until **$500,000.00 has been paid or 25 years,** whichever is greater, have been paid, because the injury caused the employee's death, as provided in Section 7 of the Act.

If the surviving spouse dies before the maximum benefit level has been reached, and the children herein named still survive, Respondent shall continue to pay benefits until the youngest child reaches 18 years of age; however, if such child is enrolled as a full-time student in an accredited educational institution, payments shall continue until the child reaches 25 years of age. If any child is physically or mentally incapacitated, payments shall continue for the duration of the incapacity. If no children named herein are alive upon the death of the surviving spouse, payments shall cease.

If the surviving spouse remarries, and no children remain eligible, Respondent shall pay the surviving spouse a lump sum equal to two years of compensation benefits; all further rights of the surviving spouse shall be extinguished.

Respondent shall make payments for not less than six years to any eligible child under 18 years of age at the time of death.

Respondent shall pay **$8,000.00** for burial expenses to the surviving spouse or the person(s) incurring the burial expenses, as provided in Section 7(f) of the Act. Respondent is entitled to a credit of **$9,140.63** for the burial expenses that they paid.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund*** , as provided in Section 8(g) of the Act.

Petitioner shall pay her attorney **$3,500.00** in attorney's fees and **$725.00** in costs.

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.

Signature of Arbitrator

March 27, 2015
Date

MAR 30 2015

16IWCC0149

CARLOS ALBERTO RIOS-OLIVARES, deceased, by and through LUCIA LEON, mother and Legal Guardian of ALDO MANRIQUEZ, LUCIA MANRIQUEZ, NICOLE RIOS & ANGIE RIOS

16IWCC0149

v. **IWCC CASE #: 10 WC 01548**

U.S. STAFFING

FINDINGS OF FACT:

The Application for Adjustment of Claim, filed on January 15, 2010, indicates, *inter alia*, that the Employer/Respondent is S & S International and U.S. Staffing, and that the Employee has 4 dependents under age 18.

In the Amended Application for Adjustment for Claim, filed on March 29, 2010, the Petitioner named only U.S. Staffing as the Employer/Respondent.

On March 13, 2014, Lucia Leon testified on behalf of the Decedent regarding his fatal injuries of January 9, 2010. Lucia Leon testified that she and Carlos Alberto Rios-Olivares were never formally married but had lived together for nine years before the date of accident. Lucia Leon testified that for employment purposes, Carlos Alberto Rios-Olivares also went by the name of Fernando Lugo. Lucia Leon testified that the Decedent had only been employed by the Respondent for two weeks prior to the date of death. Lucia Leon testified that she and the Decedent had two biological children together: Nicole Rios, born June 22, 2005, and Angie Rios Leon, born March 31, 2009.

Lucia Leon further testified that she had two additional children, Aldo Leon and Lucia Leon, who were not the Decedent's biological children. Lucia Leon testified that the Decedent financially supported the two children who were not the Decedent's biological children, and that she did not receive any financial support for Aldo Leon and Lucia Leon from

their biological father. However, Lucia Leon was not married to the Decedent, and the Decedent never formally adopted these two children.

The Petitioner offered into evidence Petitioner's Exhibit #7, which is the birth certificate of Nicole Danna Rios, and Petitioner's Exhibit #6, which is the birth certificate of Angie Dennise Rios Leon. Both documents confirm that the Decedent was the biological father of Nicole and Angie.

The Petitioner offered into evidence the January 9, 2010 Emergency Department Chart Notes of Central DuPage Hospital for Carlos Rios, which states, *inter alia*, the following: "found unresponsive at his place of work … pt. was pinned between a forklift and his load on the forklift forks. the load slid back and pinned him against the forklift. CPR started but arrives with no VS … pt. was working at ss international in carol stream." (PX 1)

The Petitioner also offered into evidence the Medical Examiner/Coroner Certificate of Death for Carlos Alberto Rios from the DuPage County Health Department. (PX 3)

The Respondent does not dispute that the Petitioner's work injury of January 9, 2010, resulted in his death.

Lucia Leon testified that she did not pay the funeral/burial expenses in the amount of $9,140.63. However, the parties have stipulated that the Respondent paid such amount in "other benefits." (AX 1, Section 9) Moreover, the Respondent provided a copy of a "screen shot" that shows that on June 15, 2010, Broadspire issued check # 25909553 in the amount of $9,140.63 to O'Connor-Leetz Funeral Home for funeral expenses for DOS 01/09/2010 - 01/11/2010. (RX 2)

The parties have agreed that the Decedent was earning $474.00 per week at the time of the injury/death, that he was 30 years of age, and single.

Petitioner's attorney claimed a fee in excess of the $100.00 statutory fee. Petitioner's attorney offered into evidence a Time Sheet in which he claimed that he spent 42.8 hours on this case. (PX 10)

CONCLUSIONS OF LAW:

In support of his decisions as to issues (I) "What was Decedent's marital status at the time of the accident?" and (J) "Who was dependent on Decedent at the time of death?", the Arbitrator concludes as follows:

Based on the testimony of Lucia Leon, as well as on the exhibits, the Arbitrator finds that the Decedent died on January 9, 2010, and, pursuant to Section 7(a) of the Act, left two survivors: Nicole Danna Rios, born June 22, 2005, and Angie Dennise Rios Leon, born March 31, 2009. Therefore, Respondent shall pay death benefits, commencing January 10, 2010, of $466.13 which is the applicable minimum death benefit rate based on the Decedent's date of death. Payments shall be made to Lucia Leon, the natural parent and guardian of the minor children of the Decedent, until $500,000.00 has been paid, or 25 years, whichever is greater, because the injury caused the employee's death, as provided in Section 7 of the Act.

In support of his decision as to issue (O) Attorney's Fees, the Arbitrator concludes as follows:

Petitioner's attorney offered into evidence a document entitled "Time Sheet" that purports to show the number of hours that he worked on this case. Petitioner's attorney claimed that he worked 42.8 hours on this case and used an hourly rate of $250.00/hour.

Petitioner's attorney stated that he has appeared before Arbitrator Fratianni, Arbitrator Carlson and Arbitrator Cronin on this case. Petitioner's attorney stated that he had difficulty collecting workers' compensation benefits since the third party attorney filed a lawsuit against the employer in which he alleged the employer committed an intentional tort. Briefs were filed for the third party case. Petitioner's attorney stated that Judge Flanagan later threw out this lawsuit.

Petitioner's attorney also claimed costs in the amount of $700.00 - $750.00 for the professional interpreting services of Mr. Noel Cortez.

Mr. Noel Cortez provided professional interpreting services on March 13, 2014.

Petitioner testified a second time on September 9, 2014. Lucia Leon testified that she reviewed the document entitled Time Sheet and understood that such document indicates the time that the Petitioner's attorney spent working on this case. Lucia Leon testified that she understood that the Petitioner's attorney is alleging he spent 42.8 hours on the case and that the total bill indicated on the Time Sheet is $10,700.00. Lucia Leon further testified that she understood that Petitioner's attorney was only asking for attorney's fees in the amount of $3,500.00 and testified that "we have no objection" to that amount. Lucia Leon testified that she understood that Petitioner's attorney made 13 appearances at the Commission (both in Wheaton and Chicago) on her behalf and that Petitioner's attorney spent time with her and with Mr. Richardson. Lucia Leon further testified that she understood that Petitioner's attorney is seeking to be reimbursed for the cost of Mr. Noel Cortez's interpreting services in the amount of $700.00 - $800.00.

The Arbitrator notes that there was also a dependency issue here.

Several factors are considered in determining the *quantum meruit* amount for services rendered, which include 'the time and labor required, the attorney's skill and standing, the nature of the cause, the novelty and difficulty of the subject matter, the attorney's degree of responsibility in managing the case, the usual and customary charge for that type of work in the community, and the benefits resulting to the client.' Will v. Northwestern University, 378 Ill. App. 3d 280, 304, 881 N.E.2d 481, 504-505, 317 Ill. Dec. 313 (2007)

Section 19(e) of the Act states, in pertinent part, the following:

Decisions rendered by the Commission and dissents, if any, shall be published together by the Commission. The conclusions of law set out in such decisions shall be regarded as precedents by arbitrators for the purpose of achieving a more uniform administration of this Act.

In Evangelina Gutierrez v. Doralco, Inc., 14 IWCC 0931, the Commission found that $200.00/hour is "a reasonable and customary rate" for attorneys' fees.

Based on the foregoing, the Arbitrator finds that, for the services Petitioner's attorney rendered to Petitioner, $3,500.00 is a reasonable amount of attorney's fees.

Moreover, Petitioner's attorney is entitled to reimbursement in the amount of $725.00 for the professional interpreting services that Mr. Noel Cortez provided.

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jose Luis Loeza,

Petitioner,

No. 10 WC 02366

16IWCC0141

Seven-D Construction Co.,

Respondent.

DECISION AND OPINION ON §19H/§8A PETITION

Petition for unpaid medical expenses under §8(a) of the Act, and the case having been filed by Petitioner's attorney herein and due notice given, this cause came before Commissioner Gore on July 7, 2015. The Commission having jurisdiction over the persons and subject matter and after being advised in the premise finds:

1. Petitioner was injured on August 18, 2009. Respondent referred him to Dr. Ghanayem. Subsequently, the insurance company referred Petitioner to all of his treating doctors. Eventually he underwent two back surgeries, and then two additional surgeries in order to have a stimulator installed.

2. On May 7, 2014 Dr. Buck noted improvement in Petitioner's back pain.

3. A May 21, 2014 CAT scan revealed bony fusion across bilateral sacroiliac joints with degenerative changes on the lumbar spine.

4. On July 1, 2014 Petitioner's complaints were "pretty much the same." His pain had improved to a 7 out of 10 from a previously recorded 8 out of 10. Petitioner's complaints were similar in October 2014 as well. Dr. Buck requested a CT scan during this visit.

5. In October 2014 Petitioner settled his claim with the insurance company, which carried a provision that medical benefits would remain open.

6. Petitioner continued treating with two doctors, Drs. Milagros and Villalobos.

7. Petitioner treated with Dr. Villalobos on January 30th, April 30th and July 6th of 2015 due to back pain and cholesterol problems. Petitioner complained of back stiffness, aches and pains and paraspinal tenderness. He also stated that he got cramping in his feet when he walked a lot, and complained of neck pain and hand numbness.

8. Due to his back pain Petitioner was prescribed Naprosyn and Lyrica, in addition to Norco.

9. On March 10, 2015 Petitioner visited Dr. Buck, who recommended a CT scan. Petitioner stated that his pain had mildly improved.

10. Petitioner takes Norco, Lyrica and Baclofen for his back pain. He takes Metformin for his diabetic condition.

11. Petitioner acknowledged that all of his accident-related treatment was to his low back.

12. Dr. Khoury is board certified in general physical medicine and rehabilitation, no fellowship. He performed a Utilization Review on October 31, 2014. He was asked to review the necessity of a lumbar CT scan. He reviewed progress notes from Dr. Buck from April and May of 2014. The purpose of the scan was to determine whether a caudal or transforaminal injection was needed.

13. Dr. Khoury stated that the criteria for determining the medical necessity of a diagnostic procedure or medical treatment are denoted in The Office of Disability Guidelines (ODG).

14. Dr. Khoury stated that the ODG recommends a CT scan for patients who have evidence of significant trauma, myelopathy(spinal cord injury with significant nerve compromise), or findings on physical exam that corroborate myelopathy or infectious disease processes such as bone infection of the spine.

15. Dr. Khoury noted that Petitioner had chronic back pain since 2009. He had failed conservative management through 2013, had underwent surgeries and taken medications, and had a spinal cord stimulator installed.

16. Based on his review, Dr. Khoury opined that an additional CT scan was not medically necessary at that time. He stated that there had been no significant change in Petitioner's condition since the May 2014 CT scan, in fact there was mild improvement. He had normal strength on physical examination, no evidence of severe nerve compromise, although he acknowledged moderate to severe spondylosis at some levels.

- The matter was taken under consideration by the Commission on January 21, 2016.

16IWCC0141

The Commission finds that Petitioner presented unrebutted testimony that he treated with Dr. Villalobos for his accident-related back pain in 2015. The records in evidence corroborate Petitioner's testimony, as his January 2015 records indicate back pain complaints, as well as prescribed medication for such pain. Accordingly, the Commission finds that Respondent is liable for Petitioner's 2015 accident-related medical expenses.

However, regarding the necessity for a second CT scan recommended by Dr. Buck, the Commission finds that Respondent is not liable for it. Petitioner underwent a CT scan in May of 2014, and subsequent medical records indicate no significant change in his condition since that time. Thus, no identified purpose would be served in performing a second CT scan only 5 months after the first with no circumstances calling for it. Accordingly, the Commission finds that Respondent is not liable for a second CT scan on behalf of Petitioner.

THEREFORE IT IS ORDERED BY THE COMMISSION that Petitioner's Petition for unpaid medical expenses under §8(a) of the Act is hereby granted, with the caveat that any expenses related to additional CT scans are not reasonably necessary with respect to Petitioner's current condition, and thus Respondent shall not be liable for them.

DATED: MAR 1 - 2016
DLG/wde
1/21/16
45

David L. Gore

Mario Basurto

Stephen Mathis

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RONALD YOUNG,

Petitioner,

vs. NO: 10 WC 34141

METROPOLITAN PIER & EXPOSITION AUTHORITY,

16IWCC0162

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical, and permanent partial disability, and being advised of the facts and applicable law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission has affirmed and adopted the Decision of the Arbitrator in all aspects expect as to the amount of the Section 8(d)(1) wage differential award. The Commission modifies said award from $800.00 per week to $764.50 per week.

To receive a Section 8(d)(1) wage-differential award "an injured worker must prove (1) that he or she is partially incapacitated from pursuing his or her usual and customary line of employment and (2) that he or she has suffered an impairment in the wages he or she earns or is able to earn." *Cassens Transport Co. v. Industrial Comm'n*, 218 Ill. 2d 519, 530-31, 844 N.E.2d 414, 422, 300 Ill. Dec. 416 (2006).

In support of its Decision, the Commission notes that Petitioner's exhibit 5 establishes that the hourly wage for a Union Painter, between June 1, 2013 and May 31, 2014, was $40.75 per hour. Petitioner's exhibit 7, the wage statement, further establishes that Petitioner earned $24,745.53 while working for Staff Source between December 3, 2012 and November 23, 2013.

16IWCC0162

The wage statement, however, reflects wages earned during regular and overtime hours. The Petitioner's testimony during direct examination and cross-examination establishes that any overtime hours worked were mandatory. Additionally, the wage statement establishes that Petitioner worked overtime during 47 of the 51 weeks worked, and listed in PX.7. Accordingly, the Commission finds the overtime hours are to be included at the straight time rate of $10.00 per hour.

Petitioner has offered little guidance relative to the importance of the wage statement. *See* PX.7. Accordingly, the Commission must analyze said exhibit and determine the true nature of the Petitioner's earnings in his current employment.

A careful review of Petitioner's Exhibit 7, the wage statement, demonstrates that Young worked 1999.5 regular hours and 465.10 hours of overtime, for Staff Source, during the 51 week period, prior to the hearing before Arbitrator Heubstch. Since the Commission has determined that the overtime hours were mandatory, and regular, the Commission finds that those hours of employment must be calculated into the Petitioner's earnings in the performance of his current employment.

Based upon the above conclusions, the Commission finds that the Petitioner's current work week is 48.325 hours. When multiplied by $10.00 per hour, the Petitioner has a current Average Weekly Wage of $483.25. In his prior employment, Petitioner could have earned $1,630.00 per week. This results in a weekly difference in earnings of $1,146.75.

Accordingly, since Petitioner has established an impairment in earnings of $1,146.75 and an entitlement to 2/3rds of that amount pursuant to Section 8(d)(1) of the Act, he is entitled to receive a weekly wage differential benefit of $764.50.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on February 9, 2015 is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent partial disability benefits commencing September 7, 2012, of $764.50 per week for the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)(1) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $3,528.43 for medical expenses under §8(a) of the Act and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

16IWCC0162

No bond is required for removal of this cause to the Circuit Court by Respondent. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 8 - 2016

MJB/tdm
O: 2-22-16
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

YOUNG, RONALD
Employee/Petitioner

Case# 10WC034141

METROPOLITAN PIER & EXPOSITION AUTHORITY
Employer/Respondent

16IWCC0162

On 2/9/2015, 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 0.06% 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:

1067 ANKIN LAW OFFICE LLC
DEREK S LAX
162 W GRAND AVE SUITE 1810
CHICAGO, IL 60654

2461 NYHAN BAMBRICK KINZIE & LOWRY
WILLIAM A LOWRY ESQ
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Ronald Young
Employee/Petitioner

v.

Metropolitan Pier & Exposition Authority
Employer/Respondent

Case # **10 WC 34141**

16IWCC0162

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 **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **February 5, 2014**. 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. [X] 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. [X] 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. [X] 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. [X] What temporary benefits are in dispute?
X TPD X Maintenance X TTD
L. [X] What is the nature and extent of the injury?
M. [X] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

16IWCC0162

FINDINGS

On **June 1, 2010**, 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 $**64,017.20**; the average weekly wage was $**1,231.20.**

On the date of accident, Petitioner was **56** years of age, ***single*** with **0** dependent children.

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

Respondent ***has***, in part, paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**72,224.24** for TTD, $**0** for TPD, $**6,565.84** for maintenance, and $**5,863.48** for other benefits, for a total credit of $**84,653.08.** The Parties agreed that all TTD and maintenance has been paid through July 8, 2012.

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

ORDER

Respondent shall pay Petitioner reasonable and necessary medical services of $**3,528.43**, as provided in Sections 8(a) and 8.2 of the Act for the bills awarded below.

Respondent shall pay Petitioner permanent partial disability benefits, commencing **9/7/2012**, of **$800.00/week** for the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in Section 8(d) 1 of the Act.

Respondent shall pay to Petitioner penalties of **$0**, as provided in Section 16 of the Act; of **$0**, as provided in Section 19(k) of the Act; and of **$0**, as provided in Section 19(l) of the Act.

Respondent shall pay Petitioner all compensation that has accrued from 6/1/2010 through 2/5/2014, and shall pay the remainder of the award, if any, in weekly benefits.

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.

Signature of Arbitrator

February 9, 2015
Date

FEB 9 - 2015

FINDINGS OF FACT

Petitioner was employed by Respondent as a union painter at Navy Pier for 14 years. He was a member of Painters' District Counsel #14. He did industrial, commercial and intricate painting. He worked outside with a helmet and safety harness, sometimes at heights between 80 and 200 feet in the air. He worked on the Ferris Wheel, the carousel and under Lake Shore Drive, along with interior and detail work. The majority of Petitioner's work was at heights and required overhead reaching and ladder climbing. He would carry 60 to 70 pounds up several flights of stairs and carry two 5-gallon buckets of heavy industrial grade paint at a time. He would also operate boom lifts. Previously, Petitioner had done commercial painting , such as bridges, overpasses and water towers, and also some residential painting.

On June 1, 2010, Petitioner was injured while driving a boom lift back to the loading dock at the Pier after finishing a painting assignment. Petitioner was holding the joystick inside the basket and the wheels locked up, causing Petitioner to lunge forward and backwards inside the basket. He injured his right shoulder and neck. Petitioner reported the injury to his foreman, who was leaving for the day at that time. Petitioner set an appointment with Hammond Clinic for the next day, through his group coverage (HMOI).

The first medical treatment was at Franciscan Hammond Clinic on June 2, 2010. Petitioner was seen by Dr. Gina Dudley and the history was of neck and shoulder pain for 3 months. The pain was said to be bilateral neck pain, with extension to the back of the neck and the right shoulder. The patient was said to be a painter with repetitive painting motions and using a "cherry picker". X-rays of the cervical spine and right shoulder were ordered. Flexeril and Naproxen were ordered and petitioner was taken off work June 2, 2010, to return to work on June 4, 2010. The cervical spine x-ray showed multilevel disc space narrowing with a congenital fusion of C4/5 and moderate to severe endplate sclerosis and osteophyte formation at C3/4 and C5/6, with mild to moderate changes at C6/7. The clinical indication was said to be "Neck pain x 5 months, no known trauma." The right shoulder x-ray showed degenerative findings and findings consistent with a rotator cuff abnormality.

Petitioner was seen by a NP on June 4, 2010 for neck and right shoulder pain. The neck pain was said to have begun in February and the right shoulder pain was said to have begun on Friday after a jerking motion. Petitioner had not started taking his medications. Petitioner was given limited duty work restrictions. (ResEx. 1)

Respondent could not accommodate restricted duty for Petitioner. An accident report was prepared by Petitioner's supervisor and was submitted to the Operations Manager, Austin Kelly. Petitioner gave a recorded statement to Barry Jenkins at CCMSI. Respondent began paying TTD.

Petitioner underwent a Cervical MRI on June 18, 2010. The study showed the congenital fusion at C4/5, with a large herniated disc at C3/4 causing severe spinal cord compression and mild degenerative changes at C5/6. A Right Shoulder MRI showed osteoarthritic changes of the AC joint, with a small tear in the rotator cuff. (PetEx. 12)

Petitioner began treatment with Dr. Kung for his right shoulder and with Dr. Tyndall for his neck on referrals from Hammond Clinic. Dr. Tyndall recommended an ACDF procedure, due to the severity of the disc herniation. Dr. Tyndall took Petitioner off work completely. Dr. Kung treated the shoulder nonoperatively and restricted Petitioner to limited duty work regarding the shoulder only. (PetExs. 12, 22 & 23)

Petitioner saw Dr. Mark Chang, on August 24, 2010, for a second opinion regarding neck surgery. The history charted by Dr. Chang was of almost 3 months of neck pain radiating to the right arm, due to an accident at work on June 2, 2010. The Patient Information Sheet filled out by Petitioner gave an accident date of June 1, 2010. The accident was said to have involved a violent shaking of a boom lift. Dr. Chang concurred with the surgery recommendation, due to the risk of catastrophic neurological injury if surgery was not performed. Petitioner was to remain off work. (PetEx. 14)

Petitioner had conservative care regarding his shoulder with Dr.Kung, pending the proposed neck surgery.

Petitioner was seen by Dr. Mirkovic for an IME at the request of Respondent on September 4, 2010. Dr. Mirkovic thought that the treatment that Petitioner had was reasonable and necessary and that the proposed neck surgery was warranted, but was not related to the accident of June 1, 2010. The right shoulder condition was causally related to the accident of June 1, 2010. Petitioner's cervical spine condition was chronic and the accident resulted in a transient aggravation of neck pain, with an eventual return to baseline. (ResEx. 2)

Petitioner was seen by Dr. Charles Carroll for an IME at the request of Respondent on October 27, 2010. Dr. Carroll evaluated Petitioner's right shoulder. Dr. Carroll thought that the shoulder condition was causally related, in part, to the injury of June 1, 2010. The recommended surgery was appropriate. Petitioner should be on light duty work restrictions. (PetEx. 20)

Dr. Chang authored a report, of December 22, 2010, responding to Dr. Mirkovic's report. Dr. Chang thought that the accident caused or aggravated the very large C3/4 disc herniation, leading to the need for expedited surgery. Petitioner followed up with Dr. Chang.

Dr. Mirkovic authored a supplemental report, of February 3, 2011, addressing Dr. Chang's of December 22, 2010. Dr. Mirkovic maintained his no causal connection opinion and was supportive of the proposed fusion procedure, should the patient so elect. The neck surgery should be done prior to any shoulder surgery.

Petitioner's attorney sent Petitioner for an IME with Dr. Alexander Ghanayem on February 4, 2011. Dr. Ghanayem examined Petitioner and reviewed the MRI scan. Dr. Ghanayem thought that the jolting accident while operating the boom on June 1, 2010 caused the cervical disc herniation at C3/4, more likely than not. The mechanism of injury could have caused both the cervical and shoulder pathology. The cervical surgery should be done first and it is related to the accident. (PetEx. 15)

On June 24, 2011, Petitioner was advised that his employment with Respondent was terminated, due to restructuring at the Pier.

Petitioner chose to have the cervical surgery done through his group insurance, so he went back to Dr. Tyndall. Dr. Tyndall ordered a new MRI of the C-spine and surgery was performed on June 28, 2011. The procedure included an anterior cervical discectomy and fusion at C3/4 with instrumentation and an iliac crest bone graft. Dr. Tyndall cleared Petitioner for shoulder surgery on August 8, 2011. (PetEx. 23)

On September 14, 2011, Dr. Kung performed surgery on Petitioner's right shoulder. The procedure was a right shoulder arthroscopy with extensive synovectomy, debridement of a type I flap lesion, subacromial decompression and rotator cuff repair. (PetEx. 22) Petitioner underwent therapy as recommended by Drs.Tyndall and Kung.

Petitioner was seen by Dr. Brian Cole for an IME, on April 16, 2012, at the request of Respondent. Dr. Cole thought that Petitioner's shoulder related treatment was reasonable, necessary and related to the injuries and recommended 3 to 4 weeks additional therapy and then an FCE. Dr. Cole did not know whether Petitioner would be able to return to his pre-injury job duties. (PetEx. 16)

On May 15, 2012, Petitioner underwent an FCE at Accelerated Rehab. The test was considered valid and classified Petitioner's abilities to be within the medium-heavy physical demand level, including floor to waist lifting of 60 pounds. Petitioner had limitations regarding frequent overhead lifting. (ResEx. 5)

Dr. Kung released Petitioner to return to work per the FCE, with restrictions on climbing ladders and additional restrictions relative to the cervical spine condition, effective June 5, 2012. Dr. Tyndall released Petitioner to go back to work with limitations on returning to work as a painter due to limited cervical extension, effective June 18, 2012.

Petitioner testified that he tried to paint some rooms at his sister's house in June of 2012 and experienced pain.

Respondent submitted a surveillance video of Petitioner from June 2, 2012. It shows Petitioner driving a van, closing the liftgate on the van (above shoulder height), going to Menards and carrying paint supplies. Petitioner is seen carrying parts of a ladder, paint supplies and tools into a house near 119th Place and Michigan Avenue. Later, Petitioner is seen unloading the van, which seems to be a clean (not cluttered) passenger van, indicating that Petitioner did not regularly use the van for painting jobs. (ResEx. 6)

Dr. Cole authored an addendum report of July 10, 2012. He reviewed the surveillance video and the FCE, along with updated medical records. Dr. Cole thought that Petitioner could likely perform more than 90% plus of the duties of his job, but it would not be reasonable to expect the patient to do so on a day in and day out basis without significant difficulty. Restrictions per the FCE and limited use of ladders would be reasonable. Petitioner was to be considered at MMI as of the June 5, 2012 visit with Dr. Kung. (ResEx. 3)

Petitioner was told by his business agent that there were no light duty jobs available for union painters. Petitioner began a job search and obtained employment at ERA Valdevia, where he worked from July 8, 2012 through October 17, 2012. Petitioner quit this job because he was being asked to perform physical activities beyond his restrictions and was concerned regarding inhaling fumes. Petitioner was making $10.00 per hour at this job.

The union scale rate for Petitioner at the time of trial was $40.00 per hour, per Petitioner's testimony and that of Joseph Rinehart, the Business Representative for Painters' District Council 14. Rinehart testified that there were no jobs available for painters with restrictions. Petitioner's restrictions would prevent him from working as a painter. (PetEx. 21)

Petitioner was last seen by Dr. Tyndall on November 12, 2012. Ongoing neck pain was noted and further therapy was recommended. Petitioner chose not to pursue more therapy.

Petitioner got a new job at Staff Source, a temp agency in Hammond. He currently makes $10.00 per hour as a shipping and receiving order picker for auto parts.

Petitioner testified that he had previously hurt his back and neck before, but had never lost time from work and there had never been any prior recommendation for neck surgery. The prior injuries included an incident

involving carrying a ladder at work and an incident where Petitioner lifted a small dog over his head in February of 2009.

Austin Kelly, the former Director of Operations at Navy Pier, testified at the request of Petitioner. Mr. Kelly worked for more than 20 years at the Pier. Kelly remembered Petitioner as a good worker. He recalled that Petitioner had an injury at the Pier, but was not certain that the date was June 1, 2010. Kelly did not recall a painter with permanent restrictions being returned to work at the Pier.

Kari Stafseth, CRC, testified at the request of Petitioner. She conducted two interviews with Petitioner. Petitioner had an 11th grade education and had twice been unsuccessful in obtaining a GED. Petitioner had trade skills related to painting and prior experience as a machine operator. Petitioner was enthusiastic about looking for work. Given Petitioner's age, education, work experience and restrictions, the jobs that Petitioner obtained on his own were appropriate. Ms. Stafseth was not hired to perform vocational services for Petitioner because he was already gainfully employed. (PetExs. 2 & 3)

Respondent retained Daniel Minnich, MS, CRC, LCPC, to prepare a Comprehensive Vocational Assessment. A transferable skills analysis and labor market survey was done, including an analysis of wages for available positions. It does not appear that a personal interview with Petitioner took place. It does not appear that Petitioner's lack of a high school education and lack of a GED was considered. Mr. Minnich did not think that vocational services were needed for Petitioner, based upon his National Tea analysis. (ResEx. 13) Mr. Minnich did not think that Petitioner's current employment was close to Petitioner's maximum vocational potential. Mr. Minnich reported that experienced potential wages in Petitioner's profile could range from $31.47 to $46.66 per hour. (ResEx. 15)

Petitioner submitted the Evidence Depositions of Dr. John Kung and Dr. Dwight Tyndall. (PetExs. 22 A-C & 23 A-D)
Respondent submitted the Evidence Depositions of Dr. Srjdan Mirkovic and Dr. Brian Cole. (ResExs. 2 & 3)

At trial, the Parties stipulated that TTD was claimed for the time period of June 2, 2010 through June 18, 2012, representing 106 and 2/7 weeks. Petitioner claimed Maintenance from June 19, 2012 through July 8, 2012, representing 2 and 3/7 weeks. The Parties agreed that all TTD and Maintenance had been paid through July 8, 2012.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below. Petitioner's testimony is found to be credible. Petitioner liked his job as a union painter for Respondent and he was good at his job, per the testimony of Mr. Kelly. Unfortunately, the sequelae of the injury prevents Petitioner from returning to his former trade.

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

While the histories given by Petitioner to the initial medical providers are inconsistent as to the exact mechanics of the accident and as to the date of the accident, the Arbitrator does not find the inconsistencies to be fatal to Petitioner's claim after consideration of all of the evidence. Petitioner testified that he reported the injury to his

foreman on the date of occurrence. An accident report was filled out and was given to the Director of Operations, Kelly. Kelly testified that he recalled that Petitioner had an injury working at the Pier, but could not recall the date. Petitioner also gave a recorded statement to Respondent's TPA. The accident report and the recorded statement were not submitted into evidence.

The Arbitrator observed Petitioner's credible testimony and demeanor and finds that Petitioner did sustain accidental injuries, arising out of and in the course of his employment by Respondent on June 1, 2010 when the boom lift that he was operating malfunctioned, causing Petitioner's right shoulder and cervical spine to be injured.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Petitioner's current condition of ill-being with respect to his right shoulder and neck are causally related to the injury.

Petitioner was able to perform his heavy and strenuous work for Respondent before the event of June 1, 2010. Petitioner did testify to prior incidents of neck pain, but there was no surgical recommendation before June 1, 2010 and the only evidence of prior treatment for the cervical spine was from February of 2009 when Petitioner was seen at Hammond Clinic for a pulled neck muscle after lifting a dog over his head a week before. Moist heat and Tylenol was prescribed and the patient was to return as necessary.

The x-ray and MRI findings show degenerative changes, which would be consistent with Petitioner's age and occupation.

The testimony of Drs. Kung (shoulder) and Tyndall (neck) on the issue of causal connection is credible, persuasive and best comports with the evidence.

Dr. Cole testified that there was a causal connection between the accident of June 1, 2010 and Petitioner's right shoulder condition. Dr. Carroll though that the shoulder was causally related, in part, to the injury.

Dr. Chang and Dr. Ghanayem thought that the cervical spine condition was causally related to the injury, with the pathology being consistent with the described mechanism of injury. Dr. Ghanayem thought that the mechanism of injury could have caused both the shoulder and the cervical spine pathology.

Dr. Mirkovic thought that the right shoulder condition was causally related to the accident, but the cervical spine condition was chronic and the accident resulted in a transient aggravation of neck pain, with an eventual return to baseline. Dr. Mirkovic's opinion regarding the cervical spine condition is not persuasive and does not comport with the Record. Petitioner testified that he had prior incidents of neck and back pain (as would be expected for an experienced painter). Only one incident of prior medical treatment for the neck was submitted (a single visit with no follow up). Petitioner was working his regular duties before the accident and he never was able to return to work for Respondent as a painter after the accident. The Record does not show that Petitioner's cervical spine condition returned to "baseline" after the accident, as Dr. Mirkovic suggests.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

The medical treatment that Petitioner had regarding his right shoulder and cervical spine is found to be reasonable and necessary. Petitioner's bills exhibit was PetEx. 4.

The bill from Midwest Spine Center had a zero balance and it appeared that payments were made by Respondent's TPA. No award is made for this bill.

The bill from Hammond Clinic appears to show that three dates of service for cervicalgia have not been paid (4/4/2011, $95.00; 4/15/2011, $1,875.00; and 5/2/2011, $95.00). These bills, totaling $2,065.00 are awarded.

The bill from Accelerated Rehab in the amount of $1,111.43 is awarded.

Franciscan Physicians Hospital bill is $352.00 for C-spine x-rays on 1/6/2012. This bill is awarded.

The bill from St. Margaret Mercy has a zero balance and is not awarded.

The Respondent is directed to hold Petitioner harmless for group payments by Aetna ($431.46) and Blue Cross Blue Shield of Illinois ($26,780.70), as submitted in Petitioner's Exhibit 4.

The award of medical expenses herein is to be in accordance with §§ 8(a) and 8.2 of the Act.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

At trial, the Parties stipulated that the period of TTD was June 2, 2010 through June 18, 2012, representing 106-2/7 weeks and the Maintenance period was June 19, 2012 through July 8, 2012, representing 2-3/7 weeks. Further, the Parties agreed that all TTD and Maintenance benefits had been paid. The Parties further agreed that $72,224.24 in TTD benefits, $6,565.84 in Maintenance benefits (a total of $78,790.08) and $5,863.48 in other benefits had been paid. (ArbEx. 2)

108-5/7 weeks of compensation benefits amounts to $89,224.81, but the Parties stipulated that all TTD and Maintenance has been paid. The Arbitrator finds that the issues of TTD and Maintenance were resolved by the stipulation of the Parties.

Temporary Partial Disability was not in issue, so no award for TPD is made.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner claims that he is entitled to an award pursuant to § 8(d)1 of the Act. § 8(d)1 provides that if the employee becomes partially incapacitated from pursuing his usual and customary line of employment as a result

of his injuries, he is entitled to benefits of 66-2/3% of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or is able to earn in some suitable employment after the accident. To be successful in a claim under §8(d)1, Petitioner must prove a partial incapacity that prevents him from pursuing his usual and customary line of employment and an impairment of earnings. Gallianetti v. Industrial Commission, 315 Ill. App. 3d 721 (2000).

Based upon the medical records and medical expert testimony, the testimony of Petitioner, Messrs. Kelly and Rinehart and Ms. Stafseth, the Arbitrator finds that Petitioner's injuries prevent him from returning to work as a union painter. Thus, Petitioner has proved that he is partially incapacitated from pursuing his usual and customary line of employment.

Petitioner was able to obtain employment with ERA Valdevia on July 8, 2012 as a yard attendant and later obtained a job at Staff Source as an order picker at a parts warehouse, on his own. He currently makes $10.00 per hour. Union scale for a painter is $40.00 per hour. The Arbitrator finds the testimony and opinions of Kari Stafseth on the appropriateness of this employment for Petitioner to be credible and persuasive The report of Daniel Minnich is found to be not persuasive because it does not appear to consider that Petitioner does not have a GED or a high school diploma and many of the transferable occupations are supervisory and Petitioner had no supervisory experience. Clearly, Petitioner would need extensive vocational assistance to be placed in a job making more money than he currently is and these services were not made available to him. Ms. Stafseth's opinion that Petitioner is currently performing gainful employment in a position that is commensurate with his level of skills and education most comports with the evidence adduced. Petitioner was proud of his skills and accomplishments as a painter and the Arbitrator believes that he would have returned to work in this skilled position if he was capable of doing so. Thus, the Arbitrator finds that Petitioner has proved a permanent impairment of earnings.

Ms. Stafseth's first report is dated September 7, 2012 and this is the date that the Arbitrator finds that Petitioner's permanent impairment of earnings begins. There is no expert opinion to support such an award prior to this date. Petitioner's medical and vocational conditions are stabilized as of the date of Ms. Stafseth's opinion. Petitioner's current wage is $10.00 per hour ($400.00 per week). A union painter makes $40.00 per hour ($1,600.00 per week). Thus, the diminution in earnings is $1,200.00 per week and the 8(d)1 rate is $800.00 per week.

Accordingly, the Arbitrator finds that Petitioner is entitled to have and receive from Respondent the amount of $800.00 per week, beginning September 7, 2012, for the duration of his disability.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES OR FEES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Given the inconsistent histories given by Petitioner, the medical opinion of Dr. Mirkovic and the vocational opinion of Daniel Minnich, the Arbitrator does not find that Respondent acted in bad faith in its disputes in this claim and does not find an unreasonable or vexatious delay in payment of benefits to have occurred. Accordingly, Petitioner's claim for Penalties and Attorney Fees is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Debra Rohman,
Petitioner,

vs. NO: 10 WC 34609

State of Illinois,
Dept. of Financial & Professional Regulation,
Respondent.

16IWCC0129

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical expenses, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 21, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

16IWCC0129

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

DATED: FEB 2 3 2016

Joshua D. Luskin

o-01/20/16
jdl/wj
68

Ruth W. White

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

ROHMAN, DEBRA
Employee/Petitioner

Case# **10WC034609**

STATE OF ILLINOIS
Employer/Respondent

16IWCC0129

On 1/21/2015, 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 0.07% 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:

0333 SHAY & ASSOC LAW FIRM LLC
TIMOTHY S SHAY
1030 S DURKIN DR
SPRINGFIELD, IL 62704

4993 ASSISTANT ATTORNEY GENERAL
AMY S OXLEY
500 S SECOND ST
SPRINGFIELD, IL 62706

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
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SPRINGFIELD, IL 62794-9255

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 6M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

JAN 21 2015

Ronald A. Piccia, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

☐ 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
19(b)

Debra Rohman
Employee/Petitioner

Case # 10 WC 34609

v.

Consolidated cases: n/a

State of Illinois
Employer/Respondent

16IWCC0129

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 William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on November 19, 2014. 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

16IWCC0129

FINDINGS

On the date of accident (manifestation), August 5, 2010, 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.

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

In the year preceding the injury, Petitioner earned $44,733.00; the average weekly wage was $860.25.

On the date of accident, Petitioner was 57 years of age, single with 0 dependent child(ren).

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

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00.

Respondent is entitled to a credit of amounts paid under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 23, limited to those bills for treatment of Petitioner's right hand, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for prospective medical treatment including right carpal tunnel release surgery as recommended by Dr. Mark Greatting and all reasonable and necessary treatment pertaining to same.

Petitioner's claim for TTD benefits is denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

William R. Gallagher, Arbitrator
ICArbDec19(b)

January 16, 2015
Date

JAN 21 2015

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained a repetitive trauma injury arising out of and in the course of her employment for Respondent. The Application alleged a date of accident (manifestation) of August 5, 2010, and that Petitioner sustained repetitive trauma to the "Hands and Nerves" that caused bilateral carpal tunnel syndrome and an aggravation of a cervical injury (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills and temporary total disability benefits as well as prospective medical treatment. Respondent disputed liability on the basis of accident and causal relationship.

Petitioner testified that she began working for the Department of Financial and Professional Regulation on March 1, 2007. Petitioner's job title was Office Coordinator and her job required her to sit as a desk in a cubicle for six to eight hours a day. Petitioner's job required her to deal with issues concerning licensing and regulation of various professions. When seated at her workstation, Petitioner would type, use a computer mouse, talk on the telephone and hand write. On direct examination, Petitioner reviewed a "Demands of the Job" form which stated that she was required to use her hands for fine manipulation six to eight hours per day (Respondent's Exhibit 3). Petitioner agreed that this was accurate.

Petitioner testified that her first workstation was an oak desk that had both the computer monitor and keyboard located on the top of the desk. There was not a keyboard drawer/extension. She also used an older chair that was not ergonomic. She worked at this workstation from March, 2007, to Fall, 2008.

Petitioner worked at her second workstation from Fall, 2008, to February 1, 2012. Petitioner tendered into evidence photos of this workstation (Petitioner's Exhibit 5). Petitioner testified that the keyboard pad and mouse pad shown in Exhibit were not present when she first started to work at the station and were not obtained until sometime close to January, 2012. The keyboard was on the top of the desk and not on a pullout drawer. Petitioner testified that when she typed, she would pull the keyboard to the edge of the desk and would pull the mouse pad closer to her when she would use the computer. When Petitioner would write, she would push the keyboard forward. The chair seen in the photo is an ergonomic chair; however, Petitioner did not receive this chair until mid December, 2011.

Petitioner began working at her third and current workstation on February 1, 2012. Petitioner tendered into evidence a photo of this workstation (Petitioner's Exhibit 25). The photo does show that the keyboard is located on a pullout drawer and the computer mouse is a "vertical" mouse. Petitioner testified that the extension for the keyboard was not installed until August, 2012.

Petitioner testified that her working at the workstations caused repetitive trauma to her neck and hands. In regard to the neck, Petitioner stated that she would be in one position looking at the computer screen all day and that she did not get up to move around or perform other tasks. In regard to her hands, she stated that excessive use of the mouse and the keyboard placement caused the problems in her hands. Petitioner is right hand dominant. While at work, Petitioner stated that she experienced swelling of her right hand which she attributed to its excessive use.

Petitioner testified that she sustained some prior injuries to her neck in 2003 and 2005 when she was in two motor vehicle accidents. Following both accidents, Petitioner was treated by Dr. David Fletcher, an occupational medicine specialist. Petitioner testified that she sustained "whiplash" type neck injuries following both accidents and did receive some physical therapy after one of them. She also had pain in her jaw and Dr. Fletcher referred Petitioner to a TMJ specialist. No neck surgery was either recommended or performed at that time. Petitioner testified that she recovered from these two prior car accidents, but she still was experiencing some achiness in her neck prior to August 5, 2010.

Dr. Fletcher ordered an MRI of Petitioner's cervical spine which was performed on December 31, 2009. This revealed disc bulges at C2-C3, C3-C4 and C6-C7 as well as disc osteophyte complex on the right side at C4-C5 and C5-C6. Dr. Fletcher saw Petitioner for neck pain on January 18, February 5, March 19, April 16, June 18, and July 16, 2010. With the singular exception of the record of January 8, 2010, Dr. Fletcher's records noted that Petitioner had chronic pain following several MVAs and that the cervical MRI showed objective pathology to explain her pain (Petitioner's Exhibit 9).

Dr. Fletcher referred Petitioner to Dr. Edward Trudeau, who performed EMG/nerve conduction studies on August 5, 2010 (the manifestation date alleged in the Application). The studies were positive for a right C6 radiculopathy and a mild to moderately severe right carpal tunnel syndrome. Left carpal tunnel syndrome was not diagnosed at that time (Petitioner's Exhibit 7).

Dr. Fletcher saw Petitioner on August 25, 2010, and diagnosed Petitioner with carpal tunnel syndrome and cervical radiculopathy. Dr. Fletcher again saw Petitioner on November 2, 2010, and, because of the neck and right upper extremity symptoms, diagnosed Petitioner with Double Crush Syndrome. He opined that Petitioner was a candidate for both right carpal tunnel surgery and a cervical fusion at C5-C6. He attributed both the neck and hand conditions to "cumulative trauma." (Petitioner's Exhibit 6).

Dr. Fletcher referred Petitioner to Dr. Lawrence Li, an orthopedic surgeon, who saw Petitioner on November 12, 2010. Dr. Li confirmed the diagnosis of right carpal tunnel syndrome and he recommended Petitioner have carpal tunnel release surgery. Petitioner was again seen by Dr. Li on August 25, 2011, and he again discussed treatment options with her; however, Petitioner wanted to defer obtaining any treatment for her right hand symptoms because she was waiting to obtain treatment for her neck (Petitioner's Exhibit 8).

Dr. Fletcher referred Petitioner to Dr. Kern Singh, an orthopedic surgeon, primarily for her neck symptoms. Dr. Singh saw Petitioner on December 13, 2010. In the intake form completed by Petitioner, she indicated that the hand problem was work-related but that the neck problem was pre-existing. In connection with his examination, Dr. Singh reviewed the December, 2009, MRI and August, 2010, EMG/nerve conduction studies. Dr. Singh opined that Petitioner had a C5-C6 disc protrusion and recommended that Petitioner have an MRI without contrast to determine if Petitioner's hand problems were from the cervical spine. He noted that Petitioner's pain increased while she was at work; however, he did not opine as to causality (Petitioner's Exhibit 9).

Dr. Fletcher continued to treat Petitioner for both her cervical and right hand conditions. When he saw Petitioner on November 30, 2010, he again opined that Petitioner should have a cervical fusion at C5-C6 and a right carpal tunnel release (Petitioner's Exhibit 6). Dr. Fletcher referred Petitioner to the Center for Living at St. John's Hospital for acupuncture treatment which she received from March 31, 2011, through June 24, 2012 (Petitioner's Exhibit 11). He also referred Petitioner to Dr. Louis DiStasio, a chiropractor, who treated her for neck symptoms from July 27, 2010, through January 18, 2011 (Petitioner's Exhibit 15). Dr. Fletcher also referred Petitioner to Dr. Mark Hale, a chiropractor, who treated Petitioner for neck symptoms from August 5, 2011, through January 9, 2012 (Petitioner's Exhibit 14).

At the direction of Respondent, Petitioner was examined by Dr. Joseph Williams, an orthopedic surgeon, on October 3, 2011. In connection with his examination of Petitioner, Dr. Williams reviewed medical records provided to him by Respondent which included the MRI scan performed in December, 2009. Petitioner informed Dr. Williams of the prior neck problem she had subsequent to the motor vehicle accidents. Dr. Williams noted that Petitioner had right hand symptoms that were atypical for carpal tunnel syndrome; however, he opined that her symptoms may have been attributed to degenerative changes in the cervical spine and not to her repetitive activities at work. Further, he opined that Petitioner should have further conservative treatment prior to any surgical procedures being recommended (Respondent's Exhibit 4).

At the direction of the Respondent, Petitioner was examined by Dr. James Williams, an orthopedic surgeon, on October 5, 2011. In connection with his examination of Petitioner, Dr. Williams reviewed medical records provided to him by Respondent as well as information regarding Petitioner's job duties. Dr. Williams opined that Petitioner had right carpal tunnel syndrome which was mild to moderately severe and right C6 radiculopathy. He opined that these conditions were not related to Petitioner's work, but rather to her previously diagnosed hypothyroidism, her post menopausal status, her increased BMI of 29, her elevated blood sugar and her two prior MVAs. He opined Petitioner should have both carpal tunnel release surgery and a C5-C6 fusion performed (Respondent's Exhibit 6).

Dr. Fletcher ordered another MRI of the cervical spine which was performed on June 28, 2011. The scan revealed disc osteophytes at C4-C5 and C5-C6 (Petitioner's Exhibit 17). In his medical record of that date, Dr. Fletcher opined that Petitioner had right cervical radiculopathy secondary to a right side C5-C6 disc herniation and severe right carpal tunnel syndrome and that both conditions were work-related (Petitioner's Exhibit 6).

Dr. Fletcher subsequently referred Petitioner back to Dr. Trudeau for EMG/nerve conduction studies which were performed on August 28, 2012. This study revealed right C6 radiculopathy increased when compared to the prior test of August 5, 2010; moderately severe right wrist carpal tunnel syndrome, also increased when compared to the prior test of August 5, 2010; and left C6 nerve root irritation relatively mild, but new since the prior study of August 5, 2010. There was no finding indicative of left carpal tunnel syndrome (Petitioner's Exhibit 18).

At trial, Petitioner acknowledged that it was recommended that she have a cervical fusion performed; however, she decided not to have the surgical procedure performed because she knew of other individuals who had fusion surgeries performed on them and she was not impressed with

the results that they obtained. On her own, Petitioner did some research and located a physician in Los Angeles, California, Dr. Michel Levesque, a neurosurgeon. At her request, Dr. Fletcher provided her with a referral to Dr. Levesque.

Dr. Levesque examined Petitioner on October 29, 2012, and reviewed all three MRI scans. He opined that Petitioner had cervical radiculopathy C4-C5 and C5-C6 that failed to respond to conservative measures. Dr. Levesque performed surgery on October 31, 2012, the procedure consisting of microdiscectomies at C5-C6 and C6-C7 (Petitioner's Exhibit 12). Following the surgery, Petitioner was off work for one week, October 31, 2012, through November 6, 2012.

Subsequent to the neck surgery, Petitioner returned to Dr. Fletcher who referred her to Dr. Claude Fortin, a neurosurgeon, who saw Petitioner on December 10, 2012. In regard to the neck, Dr. Fortin ordered Petitioner to continue the physical therapy that had been ordered by Dr. Levesque. In regard to the right carpal tunnel syndrome, Dr. Fortin ordered another EMG/nerve conduction study which was performed on October 18, 2013. This study was positive for mild to moderate bilateral carpal tunnel syndrome (Petitioner's Exhibit 16). This was the first time that carpal tunnel syndrome of the left hand had been diagnosed.

Dr. Fortin referred Petitioner to Dr. Mark Greatting, an orthopedic surgeon in that same office, who saw Petitioner on December 19, 2013. Dr. Greatting confirmed the diagnosis of bilateral carpal tunnel syndrome and recommended splinting, injections and possible surgery. At that time, Petitioner decided not to proceed with any further treatment and to monitor her symptoms (Petitioner's Exhibit 16).

Dr. Joseph Williams was deposed on January 31, 2012, and his deposition testimony was received into evidence at trial. Dr. Williams' testimony on direct examination was consistent with his medical report and he reaffirmed his opinions that Petitioner's conditions may have been solely related to her cervical pathology and that she did not necessarily have right carpal tunnel syndrome. He also testified that Petitioner's cervical condition was pre-existing and was not aggravated by her work activities (Respondent's Exhibit 5; pp 11-13).

On cross-examination, Dr. Joseph Williams agreed that the EMG/nerve conduction studies performed by Dr. Trudeau were consistent with a carpal tunnel syndrome and C6 radiculopathy and that he had no reason to dispute Dr. Trudeau's findings. He also agreed that the slowing of the median nerve at the wrist could be caused by Petitioner's repetitive tasks at work as indicated both by the history she provided and the information provided to him by Respondent. Dr. Williams also agreed that if someone sat at a desk in a "static" position for six to eight hours per day that this could cause an aggravation or exacerbation of a pre-existing degenerative disc disease (Respondent's Exhibit 5; pp 25-26; 30-32).

Dr. Fletcher was deposed on February 1, 2012, and his deposition testimony was received into evidence at trial. Dr. Fletcher reaffirmed his opinion that Petitioner had Double Crush Syndrome based on the C6 radiculopathy and right carpal tunnel syndrome. In regard to causality, Dr. Fletcher testified that he reviewed the photo of Petitioner's second workstation (Petitioner's Exhibit 5) and that the keyboard and mouse were in non-ergonomic locations and that the monitor needed to be closer. He further opined that an individual who was required to set as such

a workstation for six to eight hours per day would have a static posture of her neck and would develop right upper extremity symptoms. He opined that Petitioner's use of the mouse with her right hand was why Petitioner had carpal tunnel syndrome in her right, but not in her left wrist. Dr. Fletcher opined that the non-ergonomic arrangement of Petitioner's workstation and her job duties caused the right carpal tunnel syndrome and aggravated the cervical spine condition (Petitioner's Exhibit 3; pp 8-12; 19-20; 26-28).

On cross-examination, Dr. Fletcher agreed that for Petitioner to develop a carpal tunnel syndrome as a result of repetitive trauma she would need to be exposed to such repetitive trauma for more than two-thirds of the workday. He agreed that switching tasks every 15 minutes or so could reduce this effect (Petitioner's Exhibit 3; pp 41-43).

Dr. James Williams was deposed on April 5, 2012, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Williams' testimony was consistent with his medical report and he reaffirmed his opinions that Petitioner had right carpal tunnel syndrome and right C6 radiculopathy, but that neither condition was related to Petitioner's work activities. He attributed Petitioner's right carpal tunnel syndrome to other risk factors including hypothyroidism, her postmenopausal state, her BMI and the fact that Petitioner may have been diabetic. He opined that the C6 radiculopathy was related to Petitioner's pre-existing degenerative disc disease (Respondent's Exhibit 7; pp 20-27).

On cross-examination, Dr. James Williams agreed that keyboard usage, if repetitive, could cause or contribute to carpal tunnel syndrome if Petitioner was typing continuously six or more hours per day. He also agreed that the position of the keyboard and the absence of a gel pad could have been a contributing factor to the development of carpal tunnel syndrome (Respondent's Exhibit 7; pp 31-33).

At trial, Petitioner testified that the neck surgery relieved many of her symptoms but that she still has some complaints. In regard to the upper extremities, Petitioner still has complaints of tingling in both forearms and the thumbs/fingers of both hands. Petitioner does want to proceed with the bilateral carpal tunnel surgery as recommended by Dr. Greatting.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner sustained a repetitive trauma injury arising out of and in the course of her employment for Respondent to her right hand that manifested itself on August 5, 2010.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony regarding her job duties and the non-ergonomic arrangement of her work station was unrebutted. When keyboarding, Petitioner was required to place her hands/arms in an awkward position because the keyboard was elevated and on the same plane as the computer

screen. Further, the computer mouse was likewise elevated and on the same plane as the computer screen.

Petitioner is right hand dominant and, over time, developed symptoms in her right hand. With the singular exception of Dr. Joseph Williams (one of Respondent's Section 12 examiner's), all of the physicians that have examined or treated Petitioner for her upper extremity symptoms have opined that she does have right carpal tunnel syndrome.

In regard to the etiology of Petitioner's right carpal tunnel syndrome, the Arbitrator finds the opinion of Dr. Fletcher to be more persuasive than that of Respondent's Section 12 examiners, Dr. Joseph Williams and Dr. James Williams. Further, Dr. James Williams agreed that the position of the keyboard could have been a contributing factor to the development of carpal tunnel syndrome.

In regard to the left carpal tunnel syndrome, this condition was not diagnosed until October 18, 2013. When deposed, Dr. Fletcher testified that Petitioner had carpal tunnel syndrome of the right wrist, but not of the left wrist. There is no evidence that Petitioner's left carpal tunnel syndrome condition manifested itself on August 5, 2010.

In regard to Petitioner's cervical spine condition, there is no question that Petitioner had symptoms that preexisted the alleged date of manifestation of August 5, 2010. An MRI was performed on December 31, 2009, and Petitioner received treatment for neck symptoms from January, 2010, through July, 2010. Dr. Fletcher noted in his medical record that the MRI revealed objective pathology to explain Petitioner's complaints. Further, the Arbitrator acknowledges Petitioner had other tasks she performed and it was unlikely that Petitioner kept her neck in a "static" position for six to eight hours per day.

In regard to the etiology of Petitioner's neck condition, the Arbitrator finds the opinion of Respondent's Section 12 examiner, Dr. James Williams, to be more persuasive than that of Dr. Fletcher.

In regard to disputed issue (J) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that all of the medical treatment provided to Petitioner in regard to the right hand was reasonable and necessary and that Respondent is liable for payment of medical bills related to treatment of the right hand condition incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 23, limited to those bills for treatment of Petitioner's right hand, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In regard to disputed issue (K) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner is entitled to prospective medical treatment including right carpal tunnel release surgery as recommended by Dr. Mark Greatting and all reasonable and necessary treatment pertaining to same.

In regard to disputed issue (L) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner is not entitled to any temporary total disability benefits.

In support of this conclusion the Arbitrator notes the following:

Petitioner's lost time was related to Petitioner's neck condition which the Arbitrator has determined is not work-related.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF MCHENRY)

☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☒ Rate Adjustment Fund (§8(g))
☐ Reverse	☒ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JESUS TRINIDAD,

Petitioner,

16IWCC0132

vs.

NOs: 10 WC 38873
12 WC 18080

CHILI'S & DAN RUTHERFORD AS STATE TREASURER
& EX-OFFICIO CUSTODIAN OF SECOND INJURY FUND,

Respondent.

DECISION AND OPINION ON REVIEW

These matters come before the Commission pursuant to timely filed Petition for Review filed by Respondent, Second Injury Fund. Respondent, Second Injury Fund, appeals the July 16, 2014 "Corrected Decision" of Arbitrator Andros entered in 12 WC 18080 finding that that Petitioner sustained accidental injuries arising out of and in the course of his employment with Chili's, that Petitioner was temporarily totally disabled for a period of 7 weeks, from August 19, 2010 through October 6, 2010, at the rate of $460.00 per week, that Petitioner is entitled to $4,015.00 in medical expenses, that Respondent is entitled to a credit of $1,493.31 for temporary total disability benefits paid, that Petitioner permanently lost 100% loss of use of the right eye under Sec 8(e), 162 weeks at $414.00, with credit to Respondent for payment of $67,068.00 previously paid satisfying the statutory permanent partial disability award, and finding that based upon Petitioner's previously sustaining 100% loss of use of the left eye, Petitioner is eligible for statutory permanent total disability benefits of $466.13 for life, commencing September 22, 2013, as provided under Section 8(e)18. Arbitrator Andros ordered Respondent Chili's to pay

$414.00 per week for 162 weeks commencing August 15, 2010, and that the Second Injury Fund pay $52.13 per week for 162 weeks, to equal the total permanent total disability rate of $466.13, as provided in Section 8(f). Arbitrator Andros further ordered that commencing September 22, 2013, the Second Injury Fund pay Petitioner $466.13 a week for life.

History of Applications for Adjustment of Claim:

On October 7, 2010, Attorney Mario Perez filed an Application for Adjustment of Claim, 10 WC 38873, on behalf of Petitioner alleging a date of accident of August 15, 2010, naming Chili's as Respondent, and alleging a "co-worker kicked a box and it flew up in the air and hit his right eye."

On May 24, 2012, Attorney Richard Hannigan filed an Application for Adjustment of Claim, 12 WC 18080, alleging a date of accident of August 15, 2010, naming Chili's as Respondent. The Application alleges that Petitioner "hit in right eye" and sustained injury to "both eyes."

On November 7, 2012, Arbitrator Lee granted Attorney Richard Hannigan's Motion to Substitute as Petitioner's attorney in 10 WC 38873, based upon the passing of Attorney Mario Perez.

On October 3, 2013, an Amended Application was filed in 12 WC 18080, naming the Second Injury Fund/Illinois State Treasurer as an additional Respondent.

On December 5, 2013, the Illinois Attorney General's Office filed an Appearance of Representative on behalf of Second Injury Fund/Illinois State Treasurer in 12 WC 18080.

On January 4, 2014, a hearing was held on Petitioner's Motion for Hearing and Respondent Attorney General's Motion for Continuance. Petitioner's attorney represented that he was prepared to proceed to hearing, and intended to prove up a statutory permanent total based upon 100% loss of use of an injured right eye, and pre-existing 100% loss of use of the left eye. Petitioner's attorney further indicated he agreed to the Attorney General's request for a continuance to prepare a defense. Arbitrator Andros granted Respondent Attorney General's Motion for Continuance, and the matter was continued to April 2, 2014 for hearing. (PX15).

On April 2, 2014, Arbitrator Andros conducted a hearing in 10 WC 38873 and 12 WC 18080. At that time, a discussion was held on the record whether to consolidate the two claims, or to dismiss the 10 WC 38873 claim, which was the claim former Attorney Perez had filed, and then have one decision issue only thereafter under case 12 WC 18080. Arbitrator Andros recommended that Petitioner dismiss 10 WC 38873, and proceed under case 12 WC 18080. Petitioner's attorney then made an oral Motion to Dismiss 10 WC 38873, and thereafter

Arbitrator Andros dismissed the Application for Adjustment of Claim filed in 10 WC 38873. (ARB 4/2/14, T81-86).

On May 15, 2014, 05/15/14 Arbitrator Andros issued a Decision in 10 WC 38873, despite having dismissed the matter at the time of the April 2, 2014 hearing. The Arbitrator further issued a Decision in 12 WC 18080.

In the 10 WC 38873 Decision issued on May 15, 2014, naming Respondent Chili's, Arbitrator Andros found that Petitioner sustained accidental injuries arising out of and in the course of his employment with Chili's, that Petitioner was temporarily totally disabled for a period of 7 weeks, from August 19, 2010 through October 6, 2010, at the rate of $460.00 per week, that Petitioner is entitled to $4,015.00 in medical expenses, that Respondent is entitled to a credit of $1,493.31 for temporary total disability benefits paid, and that Petitioner permanently lost 100% loss of use of the right eye under Sec 8(e), 162 weeks at $414.00, with credit to Respondent for payment of $67,068.00 previously paid satisfying the statutory permanent partial disability award.

In the 12 WC 18080 Decision issued on May 15, 2014, naming both Chili's and Second Injury Fund, Arbitrator Andros found that Petitioner sustained accidental injuries arising out of and in the course of his employment with Chili's, that Petitioner was temporarily totally disabled for a period of 7 weeks, from August 19, 2010 through October 6, 2010, at the rate of $460.00 per week, that Petitioner is entitled to $4,015.00 in medical expenses, that Respondent is entitled to a credit of $1,493.31 for temporary total disability benefits paid, that Petitioner permanently lost 100% loss of use of the right eye under Sec 8(e), 162 weeks at $414.00, with credit to Respondent for payment of $67,068.00 previously paid satisfying the statutory permanent partial disability award, and finding that based upon Petitioner's previously sustaining 100% loss of use of the left eye, Petitioner is eligible for statutory permanent total disability benefits of $466.13 for life, commencing September 22, 2013, as provided under Section 8(e)18. Arbitrator Andros ordered Respondent Chili's to pay $414.00 per week for 162 weeks commencing August 15, 2010, and that the Second Injury Fund pay $52.13 per week for 162 weeks, to equal the total permanent total disability rate of $466.13, as provided in Section 8(f). Arbitrator Andros further ordered that commencing September 22, 2013, the Second Injury Fund pay Petitioner $466.13 a week for life.

On June 9, 2014, Petitioner's Attorney filed a Motion to Recall the Arbitrator's May 15, 2014 Decision issued under "10 WC 38873" for Clerical Error under Section 19(f). Petitioner's Attorney argued that the Decision May 15, 2014 Decision in 10 WC 38873 incorrectly listed the case number as "10 WC 38873," instead of "12 WC 18080," and that the case 10 WC 38873 was filed by Petitioner's former attorney and was dismissed orally at the beginning of the trial in 12 WC 18080.

On June 25, 2014, the Attorney General's Office filed a Petition For Review with respect to the May 15, 2014 Decision in 12 WC 18080.

On July 16, 2014, Arbitrator Andros Recalled the May 15, 2014 Decision issued in case 10 WC 38873, and issued a July 16, 2014 "Corrected Decision," which was then then renumbered as "12 WC 18080," and named Respondent Chili's. In the July 16, 2014 "Corrected Decision" the Arbitrator found that Petitioner sustained accidental injuries arising out of and in the course of his employment with Chili's, that Petitioner was temporarily totally disabled for a period of 7 weeks, from August 19, 2010 through October 6, 2010, at the rate of $460.00 per week, that Petitioner is entitled to $4,015.00 in medical expenses, that Respondent is entitled to a credit of $1,493.31 for temporary total disability benefits paid, that Petitioner permanently lost 100% loss of use of the right eye under Sec 8(e), 162 weeks at $414.00, with credit to Respondent for payment of $67,068.00 previously paid satisfying the statutory permanent partial disability award.

On October 7, 2014, Petitioner's Attorney filed a Petition for Section 16 and Section 19(k) Penalties & Fees with respect to 12 WC 18080, against Respondent, Second Injury Fund, alleging they failed to pay the accrued and weekly statutory permanent total disability under Section 8(f). On November 10, 2014, Petitioner's Attorney withdrew the Petition for Penalties and Fees, per the Order of Commissioner Lamborn.

On December 2, 2014, Petitioner filed a Petition to Recall the July 16, 2014 "Corrected Decision" issued in 12 WC 18080, under Section 19(f). On December 2, 2014, a hearing was held on Petitioner's Petition to Recall the July 16, 2014 Decision in 12 WC 18080, before Arbitrator Andros. At that time the Arbitrator granted Petitioner's Motion to Recall the July 16, 2014 Decision issued in 12 WC 18080, and reopened proofs. (T8A-12A). On January 22, 2015, Arbitrator Andros recalled the July 16, 2014 "Corrected Decision" in 12 WC 18080 for correction clerical error under Section 19(f), and issued a January 22, 2015 "Amended Decision," naming Respondent Chili's and the Second Injury Fund, and finding that Petitioner sustained accidental injuries arising out of and in the course of his employment with Chili's, that Petitioner was temporarily totally disabled for a period of 7 weeks, from August 19, 2010 through October 6, 2010, at the rate of $460.00 per week, that Petitioner is entitled to $4,015.00 in medical expenses, that Respondent is entitled to a credit of $1,493.31 for temporary total disability benefits paid, that Petitioner permanently lost 100% loss of use of the right eye under Sec 8(e), 162 weeks at $414.00, with credit to Respondent for payment of $67,068.00 previously paid satisfying the statutory permanent partial disability award, and finding that based upon Petitioner's previously sustaining 100% loss of use of the left eye, Petitioner is eligible for statutory permanent total disability benefits of $466.13 for life, commencing September 22, 2013, as provided under Section 8(e)18. Arbitrator Andros ordered Respondent Chili's to pay $414.00 per week for 162 weeks commencing August 15, 2010, and that the Second Injury Fund pay $52.13 per week for 162 weeks, to equal the total permanent total disability rate of $466.13, as provided in Section 8(f). Arbitrator Andros further ordered that commencing September 22,

2013, the Second Injury Fund pay Petitioner $466.13 a week for life. Therein the Arbitrator further stated that "This award and order supersedes all other awards including the original award and any corrected awards issued by this arbitrator."

Findings of Facts and Conclusions of Law:

1. Petitioner testified that on August 15, 2010, a co-worker was kicking a box, that the box hit him in his right eye. Petitioner testified he provided notice of the accident to Curtis. There are no disputes between Petitioner and Respondent's Chili's with respect to the alleged accident arising out of and in the course of his employment, or with respect to Petitioner providing timely notice. (T39)(ARB EX1).

2. Petitioner testified that prior to August 15, 2010, he had been working for Respondent, approximately 30 hours a week as a food prep employee, and for a second employer, Outback Steakhouse, on a full time basis for five years. Petitioner further testified that Respondent's owner, Curtis, knew about his concurrent employment with Outback Steakhouse at the time of his August 15, 2010 work-related injury, and that Curtis adjusted his schedule around his work at Outback. (T34-38). Petitioner testified that contained within PX12 are his concurrent employment pay stubs he received from Outback Steakhouse. (T37). There is no dispute between Petitioner and Respondent Chili's with respect to Petitioner's concurrent employment at Outback Steakhouse, or with respect to the inclusion of those concurrent wages in calculating Petitioner's average weekly wage, as the parties stipulated to an average weekly wage of $690.00. (ARB EX1, T50).

3. Petitioner testified that he was educated in Mexico up to the 6th grade, that he wore glasses in school, that he brought glasses with him when he came to the United States in 2002, and that his vision in his left eye both before and after his August 15, 2010 work-related injury was the same. Petitioner further testified that obtained new eye glasses from his mother when she was in Mexico, that she would send them to him, that he obtained his glasses and contacts without seeing any eye doctor, and that between 2002 and 2010 he regularly wore glasses and contacts but never saw an eye doctor. (T38-39, 76-79).

4. Petitioner testified that on August 19, 2010 he went to Lens Crafter. (T39). At that time Petitioner provided and history of being struck in the right eye, was diagnosed with retinal detachment of the right eye, and was referred to Dr. Shapiro for immediate follow-up. (PX2). Petitioner was examined by Dr. Shapiro, at Retina Consultants later that same day. Dr. Shapiro noted that Petitioner's corrected visual acuity in his left eye was 20/40-2 and pinhole was 20/30-3, and that Petitioner's uncorrected vision in his right eye was of counting fingers at 6 inches, with eccentric fixation. Dr. Shapiro diagnosed a total/subtotal retinal detachment with multiple relatively large retinal breaks of the right

eye, as well as mild lattice degeneration of the left eye. Dr. Shapiro opined Petitioner's retinal detachment was most likely related to his work injury, and that it required surgery. (PX2). Petitioner underwent retinal reattachment surgery on August 20, 2010 at Lutheran General. (PX1).

5. Petitioner continued to follow-up with Dr. Shapiro post-operatively, and was released to return to full duty work for Respondent Chili's on October 7, 2010. Petitioner returned to Dr. Shapiro on December 3, 2010 with complaints of floaters and blurry vision in his right eye, as well as 4/10 pain in both of his eyes. Dr. Shapiro opined that Petitioner's right eye likely required new glasses, that his left eye might need laser-preventative treatment, and that he follow-up in three months or as needed. (PX1).

6. On December 5, 2010, Petitioner was fitted for contact lenses at Lens Crafters. (PX2). Petitioner returned to Dr. Shapiro on May 14, 2012, and reported floaters in both eyes, in right eye greater than left. P also reported pain in both eyes, rated as 7/10, as well as blurring vision in his right eye. On that date Dr. Shapiro performed a laser retinopexy in his left eye for the multiple areas of lattice degeneration. On July 30, 2012 Petitioner followed-up with Dr. Shapiro, at which time he complained of longstanding poor vision in both eyes, with intermittent flashes of light in his right eye, and longstanding intermittent floaters in both eyes. Dr. Shapiro noted the left eye looked satisfactory post laser procedure, and advised Petitioner to follow-up in three months. (PX1).

7. On March 7, 2013 Petitioner underwent a Section 12 Examination with Dr. Gieser at the Wheaton Eye Clinic, at the request of Respondent Chili's. Dr. Gieser documented vision of counting fingers in the right eye and 20/400 in the left eye without correction, as well as atrophy in the right macular region and myopic macular degeneration. Dr. Gieser also noted high myopia in both eyes, and a significant cataract in the right eye related to Petitioner's vitrectomy surgery from retinal reattachment. Dr. Gieser opined that the cause of the decreased vision in Petitioner's eye was the cataract and the myopic macular degeneration. Dr. Gieser also noted that Petitioner's left eye was a very nearsighted eye with no sign of other significant pathology. Dr. Gieser opined a cataract operation would need to be performed in the right eye before the actual vison could be accurately determined, and that the right eye would never see normally regardless because of the myopic macular degeneration. Dr. Gieser also opined that Petitioner's left eye should allow him to function normally, except for night driving. (R Chili's EX2).

8. On August 26, 2013, Petitioner was examined by Dr. LaFranco, at Retina Services of Illinois, at request of his attorney. Dr. LaFranco noted a satisfactory reattachment of the right retina, definite myopic macular degeneration changes, and a significant cataract developing in the right eye. Dr. LaFranco also noted peripheral laser coagulation marks in the left eye with myopic changes in the posterior pole. Dr. LaFranco opined that Petitioner's traumatic right retinal detachment was the cause of the marked decrease in

his right eye vision to counting fingers (20/800), and that it was doubtful removing the cataract would improve his central visual acuity because of the macula detachment at the time of the retinal detachment and the myopic degeneration already present in the right eye. (PX3).

9. On March 12, 2014, Petitioner underwent a Section 12 Examination with Dr. Taub, at the request of the Illinois Assistant Attorney General. On examination, Dr. Taub documented: right eye vision to be limited to only light perception with light projection both with and without correction; left eye vision to be 20/400 without correction and 20/70 with correction. Dr. Taub noted that Petitioner's vision records pre-dating his work injury were not obtainable, and that Petitioner's left eye visual acuity had been stable since the date of the work injury. Dr. Taub diagnosed myopic degenerative changes in both eyes, a healed retinal detachment of the right eye, and prophylactic laser therapy to the left eye. Dr. Taub further opined that Petitioner's right eye is causally related to the August 15, 2010 work accident, that his left eye was not causally related to the accident, and that Petitioner was at maximum medical improvement for his right eye with no need for additional treatment. (R Asst. AG EX1).

10. On March 14, 2014 Dr. LaFranco was deposed. Dr. LaFranco testified that an individual with greater than 20/200 loss of vision is considered legally blind in the State of Illinois. Dr. LaFranco testified that based upon Petitioner's visual acuity of counting fingers, whether corrected or uncorrected vision, Petitioner was legally blind in his right eye as a result of his work-related injury, that the cause of his decreased vision in his right eye was the retinal detachment and subsequent repair. Dr. LaFranco further testified that based upon his review of the treating records from August 19, 2010, four days after Petitioner's right eye injury, Petitioner's left eye was noted to have degenerative myopic macula, meaning profound nearsightedness, and uncorrected vision of 20/400. Dr. LaFranco testified that based upon this August 19, 2010 finding with respect to his left eye vision, it was more likely than not that Petitioner's uncorrected vision would have been greater than 20/400 prior to his August 15, 2010 right eye injury. (PX13, T9-11).

11. Petitioner testified that prior to his August 15, 2010 work injury he could see a little better in his right eye, and that he could see beyond three feet, but that he could not read with his right eye without his glasses. (T43-44). On cross-examination, Petitioner testified he returned to work for Respondent Chili's and Outback Steakhouse for approximately two years, and then began began working only for Outback Steakshouse, full-time, approximately 35 hours a week performing same job as before his accident as a prep cook. (T67-69).

12. On cross-examination Petitioner testified that he continues to drive, that he still has floaters in both of his eyes, that he still has pain in his eyes, and that his eyesight in his left eye has not worsened since his accident. (T69-73).

13. Petitioner and Respondent Chili's stipulated at hearing that Petitioner received $1,493.31 in TTD benefits for the period of August 19, 2010, the date Petitioner was first taken off work, and October 6, 2010, at a weekly rate of $213.33, which did not take into account Petitioner's concurrent employment with Outback Steakhouse. Petitioner and Respondent Chili's further orally stipulated at hearing that Respondent Chili's had already satisfied its statutory obligation to pay permanent partial disability benefits representing 100% loss of use of Petitioner's right eye, totaling $67,068.00, based upon the applicable permanent partial disability rate of $414.00 per week. (ARB EX1, T30-33, 50-51).

14. Petitioner introduced medical bills into evidence, $2,530.00 from Park Ridge Anesthesiology and $1,485.00 from Retina Consultants. (PX4) Respondent Chili's orally stipulated at hearing those bills would be paid. Petitioner stipulated orally at hearing that Respondent Chili's should be entitled to a credit for any outstanding medical bills awarded that have already been paid by Respondent Chili's. (T47-48).

At the time of the April 2, 2014 Arbitration hearing, Petitioner's attorney made a Motion to Dismiss Petitioner's Application for Adjustment of Claim in 10 WC 38873. On that date, Arbitrator Andros granted Petitioner's Motion to Dismiss the Application for Adjustment of Claim in 10 WC 38873. Despite the dismissal of Petitioner's Application for Adjustment of claim in 10 WC 38873, the Arbitrator erroneously issued a Decision in 10 WC 38873 on May 15, 2014. The Commission finds that the Arbitration Decision issued in 10 WC 38873 is *void ab initio,* as it at no time had any legal validity. Accordingly, the Commission vacates the May 15, 2014 Arbitration Decision entered in 10 WC 38873 on May 15, 2014.

On July 16, 2014, the Arbitrator recalled the May 15, 2014 Decision in 10 WC 38873, and issued a "Corrected" Decision renumbering it as 12 WC 18080. The Commission finds that the Arbitrator's July 16, 2014 "Corrected Decision" issued as 12 WC 18080 is also *void ab initio*, as it at no time had any legal validity, given that the original May 15, 2014 Decision in 10 WC 38873 was erroneously entered by the Arbitrator on a claim that had already been dismissed. Accordingly, the July 16, 2014 "Corrected Decision" issued under 12 WC 18080 is hereby vacated.

On January 22, 2015, more than five months after the "Corrected" Decision was entered, the Arbitrator issued a letter recalling the July 16, 2014 Decision under Section 19(f), and issued an "Amended Decision." The Commission finds that the July 16, 2014 "Amended Decision" is *void ab initio* as the matter, 10 WC 38873, was dismissed at the time of the April 4, 2014 Arbitration hearing. The Commission further finds that the Arbitrator lacked jurisdiction to recall the July 16, 2014 "Corrected" Decision and to issue an "Amended Decision" under Section 19(f). Section 19(f) provides that the "Arbitrator or Commission may on his or its own

motion, or on the motion of either party, correct any clerical error or errors in computation within 15 days after the date of receipt of any award by such Arbitrator or any decision on review of the Commission and shall have the power to recall the original award on arbitration or decision on review, and issue in lieu thereof such corrected award or decision." The Commission finds that the Arbitrator was without authority to recall the July 16, 2014 Decision under Section 19(f) of the Act, as the time for recalling the July 16, 2014 "Corrected Decision" had clearly ran by January 22, 2015, more than five months after the "Amended Decision" was issued. Accordingly, the Commission vacates the Arbitrator's January 22, 2015 "Amended Decision,"

Based upon a review of the record, the Commission concludes the only viable Decision entered in this matter is the May 15, 2014 Decision entered in 12 WC 18080.

With regard to the issue of temporary total disability benefits, the Commission finds that Petitioner was temporarily totally disabled for a period of 7 weeks, from August 19, 2010 through October 6, 2010, at the rate of $460.00 per week, totaling $3,220.00, under Section 8(b) of the Act, and that Respondent Chili's shall have a credit against the temporary total disability benefits in the amount of $1,493.31.

With regard to the issue of medical expenses, the Commission finds that Petitioner is entitled to an award of $4,015.00 for necessary medical expenses under Section 8(a) of the Act.

Under Section 8(e)18 of the Act, a "specific loss of both hands, both arms, or both leg, or both eyes, or of any two thereof, or the permanent and complete loss of the use thereof, constitutes total and permanent disability to be compensation according to the compensation fixed by paragraph (f) of this Section." The Section further provides: "Any employee who previously suffered the loss or permanent and complete loss of the use of any such members, and in a subsequent independent accident loses another or suffers the permanent and complete loss of the use of any one of such members the employer for whom the injured employee is working at the time of the last independent accident is liable to pay compensation only for the loss or permanent and complete loss of use of the member occasioned by the last independent accident."

Section 8(f) of the Act provides: "If an employee who had previously incurred loss or the permanent and complete loss of use of one member, through the loss or the permanent and complete loss of the use of one hand, one arm, one foot, one leg, or one eye, incurs permanent and complete disability through the loss or the permanent and complete loss of the use of another member, he shall receive, in addition to the compensation payable by the employer and after such payments have ceased, an amount from the Second Injury Fund provided for in paragraph (f) of Section 7, which, together with the compensation payable from the employer in whose employ he was when the last accidental injury was incurred, will equal the amount payable for permanent and complete disability as provided in this paragraph of this Section."

In Gilbert v. Shughart Painting Contractors v. Industrial Commission, 136 Ill.App.3d 163, 169(1985), the Court addressed a narrow question concerning the loss of use of an eye, where an industrial injury caused the uncorrected vision to be almost totally extinguished but was almost totally restored by the use of artificial lenses. The Court held stated the sum of all the case law is that "there is no mechanical standard and that the Commission may base an award for loss of vision on either corrected or uncorrected vision or a hybrid of both according to the particular circumstances of the case."

The record clearly indicates Petitioner wore glasses prior to leaving Mexico in 2002, and that it is not known what his corrected or uncorrected vision was when those glasses were prescribed. Petitioner testified that prior to his August 15, 2010 work-related injury he saw better with his right eye than his left eye. Presently his uncorrected vision in his right eye is limited to finger count at three feet. Based upon a review of the record as a whole, the Commission concludes that Petitioner has established that prior to his August 15, 2010 work-related injury, he suffered from the complete and permanent loss of use of the left eye. Furthermore, as a result of the August 15, 2010 work-related injury Petitioner sustained the complete and permanent loss of use of the right eye. Dr. LaFranco testified an individual with great than 20/200 loss of vision is considered legally blind in the State of Illinois, and that Petitioner has greater than 20/200 uncorrected vision in his right eye, as a result of his August 15, 2010 work-related injury, and 20/200 uncorrected vision in his left eye that pre-dated his work-related injury. Therefore, Petitioner has established that he has sustained permanent total disability as contemplated by Section 8(e)18 of the Act. Thus, the Second Injury Fund, and Dan Rutherford as State Treasurer and Ex-Officio Custodian of the Second Injury Fund have been made a party to this claim. On December 5, 2013, the Illinois Attorney General's Office filed an Appearance of Representative on behalf of Second Injury Fund/Illinois State Treasurer in 12 WC 18080.

Based upon the Commission's finding that Petitioner had previously sustained 100% loss of use of the left eye, and that as a result of his August 15, 2010 work-related accident Petitioner sustained 100% loss of use of the right eye, Petitioner is eligible for statutory permanent total disability benefits of $416.13 per week for life commencing September 22, 2013, as provided in §8(e)18 of the Act. Accordingly, Respondent Chilli's shall pay Petitioner $414.00 per week for 162 weeks, commencing August 15, 2010, for the loss of the second body part and, during this time, the Second Injury Fund shall pay Petitioner the sum of $ 8,445.06, representing $52.13 per week for 162 weeks, to equal the total permanent total disability rate of $466.13 per week, as provided in §8(f) of the Act. Commencing September 22, 2013, the Second Injury Fund shall pay to Petitioner $ 466.13, weekly, for the life of the Petitioner.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator in 10 WC 38873, filed on May 15, 2014, is hereby vacated for the reasons stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that the "Corrected Decision" of the Arbitrator in 12 WC 18080, filed on July 16, 2014, is hereby vacated for the reasons stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that the "Amended Decision" of the Arbitrator in 12 WC 18080, filed on January 22, 2015, is hereby vacated for the reasons stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $4,015.00 for medical expenses under §8(a) and per §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $460.00 per week for a period of 7 weeks, from August 19, 2010 through October 6, 2010, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $414.00 per week for a period of 162 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 100% loss of use of the right eye.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent Chili's is entitled to a credit of $67,068.00 for the statutory permanent partial disability benefits already paid under §8(e)13 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Second Injury Fund shall pay Petitioner $52.13 per week for 162 weeks, as provided in §8(f) of the Act, to equal the total permanent total disability rate of $466.13, and that commencing September 22, 2013, the Second Injury Fund shall pay Petitioner $466.13 for life.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for an award of penalties and attorneys' fees under § 16, § 19(k), and § 19(l) of the Act is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that commencing on the second July 15th after the entry of this award, the Petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in Section 8(g) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

16IWCC0132

Bond for the removal of this cause to the Circuit Court by Respondent Chili's is hereby fixed at the sum of $5,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 2 4 2016
KWL/kmt
O-01/12/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☒ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Charlie Bratcher,

Petitioner,

16IWCC0143

vs.

NO: 11 WC 4435

State of Illinois/DQIIP,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, notice and being advised of the facts and law, changes the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

As indicated above, this matter was arbitrated under §19(b) of the Act. The Arbitrator found that Petitioner failed to meet his burden of proving a compensable accident. The Commission affirms that finding. However, in the "ORDER" section of the decision, the Arbitrator included the language that "in no instance shall this award be a bar to subsequent hearing and determination of any additional amount of medical benefits or compensation for a temporary or permanent disability, if any." Because the claim was denied in its entirety, the matter will not be remanded for determination of any additional benefits and therefore the decision does bar subsequent awards. Therefore, the Commission strikes the above quoted language from the "ORDER" section of the Decision of the Arbitrator.

16IWCC0143

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 15, 2015 is hereby affirmed and adopted with the changes noted above.

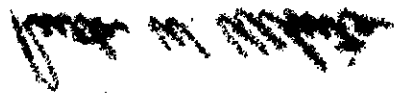
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

DATED: MAR 1 - 2016
o2/9/16
RWW/rm
46

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin



ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

16IWCC0143

BRATCHER, CHARLIE Case# **11WC004435**
Employee/Petitioner

ST OF IL/DQIIP
Employer/Respondent

On 2/9/2015, 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 0.06% 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:

0969 THOMAS C RICH PC
MICHELLE RICH
#6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

0558 ASSISTANT ATTORNEY GENERAL
KYLEE J JORDAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 6M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

FEB 9 - 2015

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

16IWCC0143

STATE OF ILLINOIS)
)SS.
COUNTY OF **Madison**)

- ☐ 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
19(b)

Charlie Bratcher
Employee/Petitioner

Case # **11** WC **4435**

v.

State of Illinois/DuQuoin Impact Incarceration Program
Employer/Respondent

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 **Michael K. Nowak**, Arbitrator of the Commission, in the city of **Collinsville**, on **November 20, 2014**. 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Admission of Exhibits**

16IWCC0143

FINDINGS

On the date of accident, **January 19, 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 not*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was not*** given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**57,839.60**; the average weekly wage was $**1,112.30**.

On the date of accident, Petitioner was **43** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

Because Petitioner failed to prove he sustained an accident on January 19, 2011 that arose out of and in the course of his employment or that his current condition of ill-being is causally related to said accident Petitioner's claim for compensation is denied and no benefits are awarded.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

Signature of Arbitrator

1/27/15
Date

ICArbDec19(b)

FEB 9 - 2015

16IWCC0143

FINDINGS OF FACT

Petitioner alleges that he sustained injuries to both hands and arms/elbows as a result of repetitive duties while working for Du Quoin Impact Incarceration Program (DQIIP). Petitioner has alleged the date of accident as January 19, 2011. Petitioner was 43 years old at the time of his alleged accident. He has been employed as a correctional officer with the Illinois Department of Corrections since 1993. He worked at Joliet Correctional Center from 1993–1996, Menard Correctional Center from 1996–2000, Big Muddy Correctional Center from 2000–2003, and Du Quoin Impact Incarceration Program (DQIIP) from 2003 through the date of hearing

At the hearing Petitioner testified that his job duties while at Joliet were similar to his duties at Menard. He testified that while working at Menard he would open 50 doors at a time 10-20 times per day, which would be 500-1,000 doors per day. However, on cross-examination Petitioner admitted that 500 would be a high estimate if the facility was on lockdown and they were moving a lot of inmates. Petitioner was unable to give an estimate for how many cell doors he would have opened when the facility was not on lockdown. Petitioner testified that at Big Muddy inmate movement was done via mass movement and that inmates were not fed through a chuckhole but went on chow lines. Petitioner also admitted that there was no bar rapping at Big Muddy. He transferred to Du Quoin Impact Incarceration Program (DQIIP) in 2003. He testified on cross-examination that at DQIIP, otherwise known as the boot camp, there were no Folger Adams keys used, no bar rapping, and minimal cuffing/uncuffing of inmates. Petitioner indicated the job duties at this facility were much easier than at to other facilities where he had worked in the past. On cross-examination he was asked if the history he reported to Dr. Brown of turning keys 20 times an hour at the boot camp was accurate. He responded that he did not think he ever said that and he did not turn keys 20 times an hour at the boot camp.

Petitioner testified that he experienced numbness, tingling, and symptoms of pain in his hands almost every day while working at Joliet and Menard. On cross-examination Petitioner was asked why he told Dr. Brown and Dr. Phillips his symptoms began in 2009, Petitioner stated he only reported to them when his symptoms were of immediate concern to him. Petitioner testified that he picked January 19, 2011 as his manifestation date because that was the date he was notified that he had a problem with his hands.

Petitioner testified that he advised Major Hammonds of his injury and obtained a workers' comp packet from him. He also told Superintendent Campanella when he completed his 434. After he completed his packet he forwarded it through institutional mail to Charlene Whitley. Petitioner testified that the superintendent or the shift commander did their own paperwork and submitted it separately.

Petitioner testified that he works out and lifts weights. He was able to bench pressing around 200 lbs., and do butterflies with 140-150 lbs. He testified that he is being treated for high blood pressure. He also takes hydrochlorothiazide every day as a diuretic for fluid retention, and he has done so since 2000. Petitioner testified that at some point he had x-rays done of his arms and was told that arthritis may become an issue later in his life.

Petitioner called Lt. Jason Thompson in his case in chief. Lt. Thompson testified that he has worked for the Department of Corrections since 1996. He was recently promoted to the position of shift supervisor, commonly known as major. He worked at DQIIP from December 2011–

March 2013, and that he supervised the Petitioner while there. Lt. Thompson was asked on cross-examination if he disagreed with any of the Petitioner's testimony or felt that it was inaccurate. Lt. Thompson testified that he felt that it was inaccurate or an exaggeration when Petitioner testified that he opened 50 cell doors 10–20 times a day at Menard. He testified that if Petitioner opened that many doors he would be opening doors nonstop for four hours per day and, even in lockdown conditions, he has never witnessed anything like that. He also disagreed with Petitioner's testimony that he would move 300 mattresses in one day to x-ray them. He indicated "[i]t's just not going to happen." Lt. Thompson also disagreed with Petitioner's testimony of how his report of injury was submitted. He testified that proper procedure would involve giving the report to your immediate supervisor, at which point the supervisor would give him the workers' comp packet. When the comp packet is given to the employee the employee would fill out their portion, and then the supervisor would fill out his portion, after he receives the information from the employee. He pointed out it would be really rare for a superintendent to be given a 434 and then later down the road have a major give an employee the work comp packet. He testified that "[n]ot only should it have been done by the same person, it should have been done right then and there as soon as it was given to the supervisor."

On January 19, 2011 Petitioner presented to Dr. David Brown. (PX3) Prior to seeing the doctor Petitioner completed a new patient questionnaire. (PX3, pg. 4) Petitioner stated on the form that he was being seen for a work related injury, had filed a claim for the injury, and that he had been referred by his attorney. He also reported having high blood pressure for which he took medication. He indicated he had symptoms in his right hand, right elbow, and left hand. (PX3, pg. 6) He first noticed his symptoms of tingling in 2010.

Dr. Brown noted that Petitioner was 44 years old and worked at the Du Quoin Boot Camp and had worked there for 7 years. (PX3 pg. 1) He indicated that Petitioner's job entailed turning keys, which Petitioner stated he did up to twenty times an hour, and cuffing/uncuffing inmates, and writing reports. Petitioner estimated that 70% of his job entailed writing reports, 30% keying, unlocking doors, gates, and lock boxes. On physical examination Dr. Brown noted that Petitioner had a negative Tinel's over the ulnar nerve bilaterally, negative direct compression/elbow flexion test bilaterally, negative Tinel's over the carpal tunnel bilaterally, and a negative Phalen's test bilaterally. Dr. Brown noted that the cause of Petitioner's symptoms was not entirely clear and that his examination was relatively benign. Dr. Brown ordered a nerve conduction study for both of Petitioner's upper extremities.

Petitioner also presented to Dr. Daniel Phillips on January 19, 2011. (PX4, pg. 1) Petitioner reported to Dr. Phillips that he had gradually progressive sharp/throbbing/aching bilateral hand and right elbow pain since 2009. Petitioner also reported intermittent numbness involving the index, middle, and ring fingers. Dr. Phillips found that the upper extremity nerves studied fell in the range of normal and the study was not impressive for carpal or cubital tunnel at that time. (PX4, pg. 2)

On January 19, 2011, following the nerve conduction study, Dr. Brown drafted an addendum to his note. (PX3, pg. 2) Dr. Brown advised that Petitioner's nerve conduction study fell within the normal range, and that at that point he recommended observation. Dr. Brown advised that if Petitioner's symptoms failed to improve over the next six months to one year he would recommend a reevaluation.

On March 1, 2011 Petitioner presented to Lisa Ward, LPN. (PX5) A nerve conduction study was ordered with Dr. Glennon and Petitioner was referred to Dr. Young.

On March 10, 2011 Petitioner presented to Dr. Terrence Glennon for a nerve conduction study. (PX6) Dr. Glennon reported that the electrodiagnostic study revealed evidence of moderate right median neuropathy at the wrist (carpal tunnel syndrome) affecting sensory and motor components. (PX6)

On April 12, 2011 Petitioner presented to Dr. Steven Young and completed a patient questionnaire. (PX7, pg. 11) Petitioner reported that his chief complaint was pain in his right wrist. Petitioner reported that his symptoms began 1 ½ years prior, and that he had no previous similar problems or complaints. (PX7, pg. 11) Petitioner reported that writing and night time made his symptoms worse. Dr. Young performed a physical exam on that date. (PX7, pg. 5) On exam Dr. Young noted that Petitioner has good movement of his wrist in flexion, extension, supination, pronation, ulnar and radial deviation. Petitioner had a positive Tinel's, and he reported numbness and tingling in his long and ring finger. (PX7, pg. 5) Dr. Young recommended a carpal tunnel release of the right wrist and Petitioner advised he wished to proceed with surgery. (PX7, pgs. 5-7)

Dr. Young testified that he did not recall reviewing any medical records other than his own. (PX8, pg. 23) Until the day of his deposition, he was unaware that Petitioner had treated with Dr. Brown and underwent a nerve conduction study with Dr. Phillips. (PX8, pg. 23) Neither was he aware that Dr. Phillips had found that Petitioner had a normal examination that was not impressive for carpal and cubital tunnel. (PX8, pg. 24) He felt that would have been important information to know. (PX8, pgs. 24-25) He reviewed a job description that Petitioner wrote. (PX8, pg. 13, PX9) However, he had not been provided the job description until the day of the deposition. (PX8, pg. 25) The job description did not provide the frequency of the job duties listed in it. (PX8, pg. 26, PX9) Dr. Young admitted to having very little knowledge of the facility at which Petitioner worked. (PX8, pg. 26) Dr. Young could not remember if Petitioner ever discussed his job duties with him, and he was not aware of what his job duties were at DQIIP other than what he was provided the day of the deposition. (PX8, pg. 27) Dr. Young did not know what shift Petitioner worked, what post he was assigned to, or how often Petitioner utilized keys at DQIIP. (PX8, pg. 27) Dr. Young testified that he did not know what type of keys were used at DQIIP, he did not know how the inmates were housed at the facility, and he did not know if the inmates were cuffed during movement. (PX8, pg. 31) Likewise, Dr. Young did not know the frequency of the job duties Petitioner performed at Joliet, Menard, or Big Muddy. (PX8, pg. 32) Dr. Young admitted it would be beneficial to have that information when making an opinion regarding causation. (PX8, pg. 32) Finally, Dr. Young agreed that the cause of Petitioner's right carpal tunnel syndrome could be idiopathic. (PX8, pg. 35)

Petitioner was examined by Dr. Anthony Sudekum on September 9, 2013 pursuant to §12. (RX4) Dr. Sudekum testified that he reviewed medical records from Drs. Brown, Phillips, Moore-Connely, Glennon, Young, and Southern Illinois Family Medical Clinic. (RX4, pgs. 1-9) Dr. Sudekum also reviewed the Supervisor's Report of Injury, the Demands of the Job, the Incident Report, and the Illinois Form 45. (RX4, pgs. 3-7) Dr. Sudekum testified that he obtained a verbal job description from the Petitioner. (RX5, pg. 12) He conducted a physical examination of Petitioner as well. His diagnosis of the Petitioner was that of neuropathic symptoms affecting both upper extremities, possible left carpal tunnel syndrome, possible very

mild right carpal tunnel syndrome even though the nerve conduction studies were in the normal ranges. (RX5, pg. 17) Dr. Sudekum testified that Petitioner did not have any findings of cubital tunnel syndrome in his right or left elbow. (RX5, pgs. 17-18) He indicated that Petitioner did complain of left medial elbow pain, especially when weightlifting, but that Petitioner did not feel that it was work related. (RX5, pg. 18)

Dr. Sudekum indicated that based upon the information he reviewed and that which he obtained from Petitioner, he did not believe Petitioner's job duties at DQIIP caused or aggravated Petitioner's carpal tunnel syndrome. (RX5, pgs. 24-25) While Dr. Sudekum indicated that he has previously opined that some job duties performed at Menard can cause or aggravate carpal tunnel syndrome, he did not believe that the Petitioner's work there caused or contributed to the development of the Petitioner's condition. (RX5, pg. 26) He noted that Petitioner worked at Menard from 1996-2000, and from the history Petitioner gave to Dr. Sudekum and others, Petitioner did not have any complaints or symptoms associated with carpal tunnel syndrome at that time. (RX5, pgs. 26-27) Likewise, Dr. Sudekum testified that he carefully evaluated the job duties performed by correctional officers at Big Muddy and he did not feel that those job duties could either cause or aggravate carpal tunnel syndrome. (RX5, pgs. 29-30)

CONCLUSIONS OF LAW

Issue (O): Whether Petitioner's Exhibits 12, 13 and 14 are admissible?

Petitioner seeks to admit Petitioner's Exhibit Nos. 12, 14, and 17. Petitioner's Exhibits 12 and 17 are narrative reports from Dr. Anthony Sudekum discussing general job duties of correctional officers at two separate Department of Correction facilities. Clearly PX 12 and PX 17 are hearsay documents. If Petitioner wished to use these materials to attempt to impeach the testimony of Dr. Sudekum he should have done so at the time of his deposition. Petitioner had the opportunity to cross-examine Dr. Sudekum with respect to each of these reports during the doctors deposition in the case at bar. He chose not to do so. PX 12 and PX 17 are rejected.

Petitioner's Exhibit 14, is the deposition of Dr. Sudekum and was taken in the matter of *James Bauersachs v. SOI/Menard CC*, 10 WC 027503. Respondent objected to the admission of this document based upon hearsay pursuant to the rules of evidence, specifically rule 804. Pursuant to rule 804 depositions taken in another proceeding are hearsay unless proven by the party introducing them that the witness is unavailable. *See Stephen Bradshaw v. State of Illinois/Menard Correctional Center*, 14 IWCC 0394 and *Dustin Bowles v. Pinckneyville Correctional Center*, 14 IWCC 0842. Again, Petitioner had the opportunity to impeach Dr. Sudekum with this exhibit during the doctor's deposition in the case at bar. PX 14 is inadmissible under the Rules of Evidence and is rejected.

Issue (C): Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?

Although Dr. Young was of the opinion that Petitioner's job duties caused or contributed to Petitioner's condition of ill being, the job description given to Dr. Young was not an accurate representation of Petitioner's jobs or duties. In addition shortly before seeing Dr. Young, Petitioner was evaluated by Drs. Brown and Phillips, both of whom were given a history of

Petitioner's symptoms developing in 2009 or 2010 while he was employed at DQIIP. By Petitioner's own admission, the duties at that facility were much easier than the other places he had worked. Petitioner's testimony was inconsistent with the medical records, including documents completed by Petitioner himself. An examination of the records and deposition of Dr. Young clearly show his opinion regarding causation is based upon the assumption that Petitioner turned keys, locked/unlocked doors, and cuffed and uncuffed inmates throughout the day at DQIIP. The Arbitrator does not find this to be the case. Dr. Sudekum obtained an accurate job assignment history and accurate description of Petitioner's job duties before rendering his opinion. The Arbitrator finds the opinions of Dr. Sudekum more persuasive.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has failed to meet his burden of proving that he sustained accidental injuries which arose out of and in the course of his employment with Respondent. He further failed to meet his burden of proving his current condition is causally related to his employment with Respondent. The claim for benefits is denied.

Issue (D): What was the date of the accident?
Issue (E): Was timely notice of the accident given to Respondent?
Issue (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?
Issue (K): Is Petitioner entitled to any prospective medical care?

Based upon the foregoing, the claim is denied. All other issues moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify: Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PATRICK CONNELLY,

Petitioner,

16IWCC0145

vs.

NO: 11 WC 5065

COOK COUNTY FACILITIES MANAGEMENT,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of the nature and extent of Petitioner's permanent partial disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Findings of Fact and Conclusions of Law

1. Petitioner testified he was employed as an electrician for Respondent for more than eight years. He had been an electrician since about February of 1992. His job for Respondent involved climbing ladders, bending, and cutting pipe, kneeling, stooping, squatting, and a lot of lifting.

2. On October 22, 2009, he was on a lift with another employee. He was getting off the lift when "the manufactured wall of the spring bar broke free." He fell straight to his back onto the lift. He slammed his back, head, and shoulders. He reported the accident and sought medical treatment from his general practitioner, Dr. Zaman, that day. He complained of pain in his neck back, hip, and arms. On review, the parties stipulated that Petitioner sustained injuries to his cervical spine, lumbar spine, and shoulders bilaterally as a result of this work accident.

3. A cervical MRI taken on January 20, 2010 showed a moderately large right lateral and posterior disc protrusion with cervical cord displacement without compression but encroachment on the neural foramen and nerve root to the right arm at C3-4.

4. A lumbar MRI taken on July 14, 2010 showed mild spondylosis with disc bulging, a small left paracentral disc protrusion at L4-5, and a tiny central disc protrusion at L5-S1.

5. An MRI of the right shoulder taken on October 1, 2010 showed small joint effusion suggesting a very small localized tear of the anterior insertion of the supraspinatus tendon. Fluid in the subacromial deltoid space would suggest a full thickness tear but was not identified. The radiologist suspected it was associated with bursitis and there was only a small articular surface tear.

6. An MRI of his left shoulder taken on April 23. 2013 showed rotator cuff tendonitis and a 1.7 cm paralabral cyst with inferior labral tear.

7. Petitioner eventually had four surgeries. Dr. Chang performed C3-4 anterior discectomy fusion with instrumentation on July 6, 2011 and L4-5 & L5-S1 laminectomy partial facetectomy, foraminotomy, and decompression on March 21, 20/12. Dr. Tioco performed right shoulder surgery on June 25, 2012 and Dr. Dedhia performed left shoulder surgery on November 6, 2013. He went back to work on full duty as of February 18, 2014.

8. Petitioner also testified he can still perform his job duties but he does it slower and it causes him pain. He currently takes Cyclobenzaprine, a muscle relaxer, and Hydrocodone. He takes the Hydrocodone two to three times a day. He has two daughters who are 18 months apart. They were two and three years old at the time of the accident. The injuries interfered with his ability to pick them up. They are now six and eight. He can play softball with the elder daughter because he can pitch underhand. He also plays soccer with his younger daughter but cannot run as fast. He tries to help with household chores but bending over causes pain in his back. He bought a riding lawn mower because it is easier to mow the lawn sitting.

9. Throughout his treatment, Petitioner had some complaints of neck, low back and shoulder pain, though the right shoulder was clearly more problematic than the left. Petitioner returned to full duty work as an electrician on February 18, 2014 and has worked in that capacity since.

The Arbitrator awarded Petitioner a permanent partial disability award of 85% of the person-as-a-whole. She allocated the award thusly: 30% loss of the person-as-a-whole for the cervical injury; 25% loss of the person-as-a-whole for the lumbar injury; and 15% loss of the person-as-a-whole for each shoulder injury. Petitioner supports the Arbitrator's award by citing cases in which the Commission awarded similar awards for each individual injury.

16IWCC0145

The Commission finds the award in this case to be somewhat excessive, after assessing Petitioner's total functionality. While Petitioner had four separate surgeries to four different parts of the body, he was able to return to work full duty as an electrician which clearly requires extensive lifting and overhead work, causing significant cervical/shoulder stress, and extensive work activities involving bending, kneeling and squatting, causing significant lumbar stress. The ability for Petitioner to continue working with those activities suggests less impairment than would be expected in a person with the loss of 85% of the person-as-a-whole. In addition, Petitioner testified to relatively minor current complaints. He can still perform all of his job duties, though at a slower pace, and can participate in softball and soccer with his daughters, even though at a less intense level than prior to the accident.

The Commission finds that a permanent partial disability award of the loss of 50% of the person-as-a-whole is appropriate in this claim. We allocate the award thusly: 20% loss of the use of the person-as-a-whole for the cervical injury; 15% loss of the person-as-a-whole for the lumbar injury; 10% loss of the person-as-a-whole for the right shoulder injury; and 5% loss of the person-as-a-whole for the left shoulder injury.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $664.72 per week for a period of 250 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of 50% of the person-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $12,615.21 for medical expenses under §8(a) of the Act pursuant to the applicable medical fee schedule, as allocated in the Decision of the Arbitrator.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The party commencing the proceeding for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: MAR 2 - 2016

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-1/20/16
46

[illegible]

[illegible]

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0145

CONNELLY, PATRICK
Employee/Petitioner

Case# 11WC005065

COOK COUNTY DEPARTMENT OF FACILITIES MANAGEMENT
Employer/Respondent

On 12/4/2014, 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 0.07% 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:

2221 VRDOLYAK LAW GROUP LLC
MICHAEL P CASEY
741 N DEARBORN ST 3RD FL
CHICAGO, IL 60654

0132 COOK COUNTY STATES ATTORNEY
JEREMY SCHWARTZ ASA
500 RICHARD J DALEY CTR
CHICAGO, IL 60602

16IWCC0145

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Patrick Connelly
Employee/Petitioner

v.

Cook County Department of Facilities Management
Employer/Respondent

Case # **11** WC **005065**

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. 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 **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Chicago**, on **10-9-2014**. By stipulation, the parties agree:

On the date of accident, **10-22-2009**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

On this date, Petitioner sustained 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 $**84,031.74**, and the average weekly wage was $**1615.99**.

At the time of injury, Petitioner was **39** years of age, ***married*** with **2** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

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

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER SEE ATTACHED RIDER

Respondent shall pay Petitioner the sum of **$664.72**/week for a further period of **425** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused losses to Petitioner as follows:

- 30% loss man as a whole resulting from the injury to his neck;
- 25% loss man as a whole resulting from the injury he sustained to his low back;
- 15% loss man as a whole resulting from the injury to his right shoulder;
- 15% loss man as a whole resulting from the injury to his left shoulder.

Respondent shall pay Petitioner compensation that has accrued from **10-22-2009** through **10-9-2014**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent is ordered to pay medical bills subject to the fee schedule with due credit for any payment made as follows:

- Midwest Spine Care $146.00;
- Dr. Asad Zaman $330.00;
- Accelerated Rehab Center $7765.21;
- Community Hospital $3234.00;
- Reimbursement to Petitioner for out-of-pocket medication in the amount of $1140.00..

RULES REGARDING APPEALS Unless a Petition for Review is filed within 30 days after receipt of this decision, and a review is perfected 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.

Signature of Arbitrator

12/4/2014
Date

DEC 4 - 2014

16IWCC0145

STATE OF ILLINOIS)
) ss.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PATRICK CONNELLY	)	
	)	
Petitioner,	)	
	)	
	)	No. 11 **WC 5065**
	)	
vs.	)	
	)	
	)	
COOK COUNTY DEPT. of FACILITIES MANAGEMENT	)	
	)	
Respondent.	)	

FINDINGS OF FACT

The only issue in dispute is the nature and extent of the Petitioner's injury.

On October 22, 2009, Petitioner suffered a fall at work, sustaining injuries to his neck, lower back and right and left shoulders.

On July 6, 2011, Dr. Mark Chang performed surgery on Petitioner consisting of a C3-4 anterior discectomy, fusion with allograft, interbody spacer, and instrumentation. Petitioner was diagnosed with a C3-4 disc herniation postoperatively. (PX 6, p 58-60).

On March 21, 2012, Dr. Mark Chang performed surgery on Petitioner consisting of an L4-L5, L5-S1, laminectomy, partial facetectomy, foraminotomy, and decompression . Petitioner's postoperative diagnosis was L4-L5, L5-S1 foraminal stenosis. (PX 6, p 61-62).

On June 25, 2012, Dr. Jeffrey M. Tioco performed surgery on Petitioner consisting of a right shoulder arthroscopy with SLAP repair and an arthroscopic right subacromial decompression. Petitioner's postoperative diagnosis was a right rotator cuff tendinitis and right SLAP lesion (Superior Labral Anterior Posterior). (PX 10, p 11-12).

On November 6, 2013, Dr. Sunil Dedhia performed surgery on Petitioner consisting of a left shoulder arthroscopic labral repair and subacromial decompression and debridement. Petitioner's postoperative diagnosis was a left shoulder anterior labral tear and impingement syndrome. (PX 14, p. 9-10). On February 18, 2014, Petitioner returned to work full duty at his job with Respondent as an electrician.

At the arbitration hearing Petitioner testified that his job requires significant overhead work at elevated heights and that holding his arms over his head for any extended period of time causes pain and weakness in both his right arm, left arm and neck. He testified that he continues to have pain in his back and neck while attempting to perform his job duties. Petitioner testified that his job requires significant squatting, kneeling and bending on a daily basis. Petitioner notices weakness in his arms when he has to lift and carry objects. He takes prescription medication on a daily basis for the pain in his neck, low back and right and left arms. He notices weakness in his arms when he has to reach out to lift something. If he is going to lift and hold something he has to hold it close to him because of the weakness in his right and left arms. Standing or sitting in one position for any length of time causes low back pain.

The parties stipulated that Respondent would pay unpaid medical as follows:

- Midwest Spine Care $146;
- Dr. Asad Zaman $330;
- Accelerated Rehab Center $7765.21;
- Community Hospital $3234;
- Reimbursement to Petitioner for out-of-pocket medication in the amount of $1140.

Respondent is ordered to pay the foregoing medical bills subject to the fee schedule with due credit for any amounts paid.

Petitioner has undergone a total of four (4) surgeries as result of the October 22, 2009 work injury.

The Arbitrator finds that as a result of the work accident and injuries, Petitioner sustained the following losses:

- 30% loss man as a whole resulting from the injury to his neck;
- 25% loss man as a whole resulting from the injury he sustained to his low back;
- 15% loss man as a whole resulting from the injury to his right shoulder;
- 15% loss man as a whole resulting from the injury to his left shoulder.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Urbano Villasano,

Petitioner,

vs.

NO. 11WC030948

16IWCC0173

Armour Eckrich Meats, LLC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary disability, causal connection, medical expenses, prospective medical care, penalties, attorney fees, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 21, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

No bond is required for the removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 11 2016
SJM/sj
o-2/25/2016
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

VILLASANO, URBANO
Employee/Petitioner

Case# 11WC030948

09WC024430

16IWCC0173

ARMOUR ECKRICK MEATS LLC
Employer/Respondent

On 1/21/2015, 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 0.07% 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:

5317 JOHN J CASTANEDA PC
47 DuPAGE COURT
ELGIN, IL 60120

2461 NYHAN BAMBRICK KINZIE & LOWRY
HEATHER BOYER
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

16IWCC0173

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

- ☐ 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
19(b)/8(a)

Urbano Villasano,
Employee/Petitioner

v.

Armour Eckrich Meats, LLC.
Employer/Respondent

Case # **11** WC **30948**

Consolidated cases: **09 WC 24430**

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 **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **Geneva**, on **7/14/14** and **10/16/14.** 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☒ TPD ☐ Maintenance ☒ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **6/15/11**, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**39,111.28**; the average weekly wage was $**752.14**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **1** dependent child.

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

Respondent shall be given a credit of $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**42.79** for other benefits, for a total credit of $**42.79**.

Respondent is entitled to a credit of $**0.00** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that Petitioner sustained accidental injuries arising out of and in the course of his employment on June 15, 2011, but that Petitioner failed to prove by a preponderance of the credible evidence that his current conditions of ill-being relative to his lumbar and/or cervical spine are causally related to said accident. Accordingly, Petitioner's claim for compensation is hereby denied.

No benefits are awarded.

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.

Signature of Arbitrator

1/15/15
Date

ICArbDec19(b)

JAN 21 2015

16IWCC0173

STATEMENT OF FACTS:

Petitioner testified through Spanish interpreters at the arbitration hearings held on July 14, 2014 and October 16, 2014. At the time of trial, Respondent conceded that Petitioner sustained a lumbar strain injury as a result of the incident on February 21, 2009 (09 WC 24430) but disputed Petitioner's claim that said incident resulted in an injury to the cervical spine. (Arb.Ex.#1). In addition, Petitioner alleges a date of accident of June 15, 2011, the subject of claim 11 WC 30948. (Arb.Ex.#2). The parties also noted that a third claim (11 WC 21010), involving the bi-lateral upper extremities, is still pending and not presently in dispute.

Petitioner testified that he began working for Respondent on September 2, 2003. Petitioner worked various positions for Respondent that required him to operate a forklift, place packages of meat into a box, and move packages with a hand jack. Petitioner had no physical limitations when he began his employment with the Respondent nor was he treating with any physician for back or neck pain. Petitioner denied he took any medication for pain or discomfort before he started working. Petitioner also denied prior symptoms of back or neck pain.

On Saturday February 21, 2009 (09 WC 24430), Petitioner was working in the "aging" department where he had been assigned for three or four years. His job activities included washing ovens and bending over to pick up sausages. Petitioner testified that on that date he bent over to pick up a sausage when he felt pain in the lower part of his back. On cross examination, Petitioner agreed that he only picked up five (5) pieces of meat that day and that he did so separately. He indicated that his shift on the day in question was from 5:00 a.m. until 1:30 p.m., and that he thought the incident occurred at 10:30 a.m. He noted that before his shift ended he told his supervisor about his low back. Petitioner left work, went home and informed his son, who was 22 years old at the time, that his back was hurting. Petitioner requested that his son retrieve medication for him. The next day, Sunday, Petitioner stayed home. He indicated that he was taking Tylenol three times a day.

The following Monday, February 23, 2009, Petitioner returned to work to his regular job. Petitioner had constant pain in his back. Petitioner continued working with a forklift to move pallets. That day after work Petitioner presented at the Dreyer Medical Clinic. The medical records of Dreyer Medical Clinic reflect that on Saturday (2 days prior) Petitioner was doing a lot of lifting when his pain started in the "lumbar/sacral" area of his back. (PX10). Petitioner advised the clinic that his pain was aggravated with bending and twisting. (PX10). It was noted that he had had prior recurrent limited episodes of low back pain. (PX10). On cross examination, Petitioner claimed that he had not experienced the complained of pain before. Petitioner was diagnosed with a lumbar strain and placed on light duty of no bending at the waist, no lifting greater than 15 lbs., and no overhead lifting. (PX10). Petitioner subsequently returned to work within his restrictions.

On February 24, 2009, Petitioner visited his family physician, Dr. Cristina Brotea. (PX1). Petitioner advised Dr. Brotea that he had an injury at work, that he had pain in his lower back, and that he tried to return to work. (PX1). Petitioner denied any radiation to the lower extremities or numbness or tingling. (PX1). Dr. Brotea diagnosed a back strain and recommended that Petitioner not work. (PX1).

On February 25, 2009, Petitioner was sent to Tyler Medical Services by Respondent's corporate health and safety manager, E.J. Klages. (PX2). At Tyler Medical Services, Petitioner described his injury to Dr. Robert Long, D.O. stating that "he was at work performing his usual job responsibilities of cleaning an oven, operating a forklift, and also carrying buckets of meat that weighed between 15 to 20 lbs. repetitively to the oven" and that "[w]hen he began performing this responsibility he developed soreness involving his low back that progressed to pain... States he was asymptomatic up until that time." (PX2). Petitioner denied any previous back history or injury to Dr. Long. (PX2). Dr. Long diagnosed a lumbar strain and spasm. (PX2). Dr. Long

recommended therapy for six (6) sessions and prescribed light duty restrictions of no lifting, pushing, pulling more than 10 lbs., stoop/bend as tolerated, alternate sitting/standing, no operation of forklift, limited climbing of stairs and no reaching or lifting above the shoulder. (PX2).

Petitioner attended physical therapy from March 3, 2009 through April 13, 2009. (PX2). He continued to work during this period, cleaning the ovens, picking up meat off the floor and cleaning the department. Petitioner's symptoms persisted after his completion of physical therapy. On April 13, 2009, Tyler Medical ordered an MRI of the lumbar spine without contrast. (PX2). On April 24, 2009, Petitioner underwent the MRI which was interpreted as evidencing "disc degeneration at L5-S1 with small to moderate disc protrusion, which is somewhat broad base and asymmetric to the right. Disc is noted ventral to both nerve roots at this level." (PX3).

At the follow up visit with Dr. Pappas at Tyler Medical, Petitioner complained of persistent low back pain with radiation into the gluteal region. (PX2). Dr. Pappas noted on examination that Petitioner had a "spasm of the lumbar paravertebral musculature with tenderness of the spinous process region." (PX2). Dr. Pappas diagnosed persistent low back pain secondary to L5-S1 protrusion and recommended that Petitioner attend a pain clinic. (PX2). As a result, Petitioner was referred to Dr. James Kelly. (PX2).

On May 7, 2009, Petitioner consulted with Dr. Kelly for a pain clinic evaluation. Dr. Kelly noted that Petitioner "strained his lower back while engaged in repetitive activity" on February 21, 2009. (PX2). Dr. Kelly also noted that Petitioner "... denies any specific incident such as a fall or any particular incident of heavy lifting or any accident, etc. that he can point to. He states that by the end of the day and from that point forward he has been experiencing severe pain, which he describes a virtually always presents, although of somewhat variable intensity." (PX2). Petitioner denied any radiation of pain in the lower extremities and any numbness, tingling or weakness. (PX2). Dr. Kelly also recorded that "[a]t times the pain seems to radiate upwards along the spine towards the base of the neck." (PX2). Upon examination it was noted that Petitioner had one positive Waddell's sign. (PX2). Dr. Kelly opined that the Petitioner had pain of possible radicular etiology. (PX2). Dr. Kelly recommended an epidural steroid injection. (PX2). Petitioner underwent the injection on June 2, 2009 at the DuPage Pain Center. (PX4). Petitioner returned to Dr. Kelly on June 11, 2009. At that time, Petitioner indicated that he still had pain in his lower back and that he had not even experienced temporary relief from the injection. (PX2). Dr. Kelly thereupon recommended facet injections. (PX2).

On August 28, 2009, Petitioner visited Dr. Jesse Butler at the request of Respondent for purposes of a §12 examination. (RX9). Dr. Butler reviewed the MRI and opined that it revealed a "degenerative protrusion of the disc at L5-S1 without any acute findings." (RX9). Dr. Butler's impression was lumbar strain with a central lumbar disc herniation. (RX9). Dr. Butler noted that there did not appear to be a history of prior injury or pre-existing condition and that "[t]he mechanism of injury is difficult to state as a reasonable cause for the patient's current symptomatology. The degenerative disc findings clearly predate this incident, and it is very difficult to state that the simple act of lifting these sausages as is described is enough to cause an aggravation of his underlying degenerative condition. While on the quick report I checked the box that there does appear to be a causal connection between his injury and the history provided, having had the opportunity to further review the medical records available with this case, my opinion is that there is not likely to be a causal relationship between his complaints of pain and the workplace exposure. The patient, in my opinion, is not currently disabled relative to the incident of February 21, 2009." (RX9). Dr. Butler felt that Petitioner did not require any additional treatment, had reached maximum medical improvement ("MMI") and should be able to return to regular-duty capacity. (RX9).

On September 24, 2009, Petitioner visited Dr. Mark Lorenz at Hinsdale Orthopaedic Associates pursuant to a referral by his family physician, Dr. Brotea. (PX1; PX5). At that time, Petitioner advised Dr. Lorenz that he was lifting up packages of meat and throwing them and in the process developed neck pain, arm pain, back pain and leg pain. (PX5). This would appear to be the first reference to any neck pain in the medical record. Petitioner testified that he could not remember when he started having problems with his cervical spine. Dr. Lorenz reviewed the MRI and noted mild spondylosis at L4-L5, moderate spondylosis at L5-S1 with a central disk herniation. (PX5). Dr. Lorenz diagnosed cervical pain and an L5-S1 central disk herniation. (PX5). Dr. Lorenz recommended an MRI of the cervical spine, an FCE, and allowed Petitioner to work sedentary duty with no lifting. (PX5). In addition, Dr. Lorenz referred Petitioner to Dr. Steven G. Bardfield, also at Hinsdale Orthopaedics, "... in followup to see if there is any further rehabilitation that would be beneficial." (PX5). Finally, Dr. Lorenz noted that "... the patient's subjective findings are consistent with cervical pain, low back pain, arm pain and leg pain and an L5-S1 disk herniation emanating out of an injury where he was lifting on February 21, 2009." (PX5).

Petitioner underwent an MRI of his cervical spine on October 2, 2009. The MRI report noted a mild C5-C6 central left paramedian focal disk protrusion and bony spondylotic changes with spurring at C3. (PX5). Petitioner also underwent a functional capacity evaluation ("FCE") on October 8, 2009. The FCE was reported as a valid test consistent with Petitioner performing at the light duty level. (PX6). Petitioner described his activities of a forklift driver as medium duty.

On October 30, 2009, Petitioner visited Dr. Bardfield. Dr. Bardfield diagnosed Petitioner as having a cervical/lumbar strain injury with L5-S1 central disc protrusion and mild disc bulges in the cervical spine. (PX5). Dr. Bardfield referred Petitioner for physical therapy, work conditioning and light duty. (PX5).

Petitioner attended physical therapy at ATI from November 9, 2009 through December 20, 2009. (PX6). However, Petitioner's complaints of back and neck pain persisted. On December 28, 2009 Dr. Bardfield recommended another FCE. On January 7, 2010, Petitioner underwent a second FCE at ATI which was noted to be invalid. (PX6). The therapist at ATI noted that since the evaluation was invalid, Petitioner might be capable of more than the medium capacity noted. (PX6). On January 18, 2010, Petitioner returned to see Dr. Bardfield who noted that Petitioner had reached maximum medical improvement and released petitioner from care with a restriction of no lifting over 20 lbs. (PX5).

On May 10, 2010, Respondent's §12 examiner, Dr. Butler, issued an addendum based upon a review of records. (RX10). Dr. Butler noted that "[t]he medical records accurately describe his reports of low back pain as a result of lifting at work. The date of injury is February 21, 2009." (RX10). However, Dr. Butler goes on to note that subsequent to his own examination in August 2009, Petitioner visited Dr. Lorenz with complaints that were "... markedly different from that demonstrated to me at the time of the independent medical exam." (RX10). Along these lines, Dr. Butler indicated that Petitioner reported neck, arm, thoracic, low back and bilateral knee pain at that time and that this was "... the first mention of any cervical pain syndrome throughout his care and treatment." (RX10). Dr. Butler also noted that "[n]owhere in [Petitioner's] work history was there an injury to his cervical spine document" and that "[e]ven after [his previous §12 examination] there is no documentation to my knowledge of any specific injury to his neck." (RX10). As a result, Dr. Butler indicated that his opinion had not changed since his previous report, and that "[t]he additional medical records, if anything[,] further support that there is some degree of symptom magnification present in this patient. The lack of response to physical therapy and injections indicate that the patient is not a surgical candidate and the progressive deterioration even with appropriate physical therapy, work conditioning and medical management clearly indicates to me that this patient has secondary gain issues at hand." (RX10). Dr. Butler concluded that Petitioner "should easily be able to perform the job of a fork lift driver" and that "... his permanent restrictions are somewhere between the full

duty level and the restrictions that are currently indicated." (RX10). More to the point, Dr. Butler stated that it was "... not unreasonable to expect [Petitioner] to be able to perform at the medium physical demand level, which would be consistent with his occupational title and therefore, he could return back to work in a regular duty capacity." (RX10).

Petitioner returned to Dr. Bardfield on July 19, 2010, approximately six (6) months since his last appointment on January 18, 2010. At that time, Dr. Bardfield recorded that Petitioner "... has a flareup in symptoms involving the neck and low back. He did have to do more work activities and at a heavier rate than his 20-pound limit because other employees were out of town. This flared up his symptoms in the low back greater than the neck..." (PX5). Dr. Bardfield's impression was "[f]lareup of neck and low-back pain with primarily myofascial symptoms and history of L5-S1 disc protrusion." (PX5). Dr. Bardfield recommended another course of physical therapy, medication and provided restrictions of no lifting over 20 pounds. (PX5).

Petitioner attended physical therapy again at ATI from July 22, 2010 through October 1, 2010. On October 1, 2010, Dr. Bardfield prescribed a third FCE that Petitioner underwent on October 14, 2010. (PX5). The therapist noted that the FCE was a valid representation of Petitioner's capabilities and placed him at the medium level work capacity. (PX5). On October 29, 2010, Dr. Bardfield reviewed the FCE with Petitioner and released him back to work with a 30 pound lifting restriction and the ability to drive a forklift. (PX5).

Petitioner did not see another physician again until five (5) months later when he returned to Dr. Lorenz on March 21, 2011. On that date, Dr. Lorenz noted Petitioner continued to complain of pain. (PX5). Dr. Lorenz diagnosed Petitioner as suffering from aggravations of cervical and lumbar herniations. (PX5). Dr. Lorenz recommended an epidural injection for his cervical spine but otherwise discharged him from further follow up. (PX5). On May 17, 2011, Petitioner visited Dr. Morgan at the Chicago Pain & Ortho Institute via referral from Dr. Lorenz. (PX7). On May 24, 2011, Dr. Morgan administered an epidural injection to Petitioner's cervical spine. (PX7). On May 31, 2011, Dr. Morgan noted that Petitioner had "zero percent improvement" referred him back to Dr. Lorenz and Dr. Barfield. (PX7).

Petitioner testified that on June 15, 2011 (11 WC 30948), he was taking meat from a cart and putting it on a line when another employee struck him in the stomach with a cart he was pushing. Petitioner noted that the cart struck him underneath his stomach towards the right side and he was pushed backwards into a woman working next to him. Petitioner indicated that they hit each other "back to back" and that he did not go all the way to the floor. He stated that the incident occurred between 9:30 p.m. and 10:00 p.m. and that his shift ended at 11:00 p.m. Petitioner testified that he reported the incident to his supervisor and finished working that day. He noted that at the end of his shift he could not tolerate the pain in his back and neck.

Petitioner returned to see Dr. Lorenz on June 29, 2011 at which time he informed the latter that he had had a new injury. (PX5). Dr. Lorenz examined Petitioner and noted that he was still complaining of neck and upper extremity pain. (PX5). Dr. Lorenz mentioned a discography, which Petitioner declined. (PX5). Dr. Lorenz thereupon referred Petitioner back to Dr. Bardfield and took Petitioner off work. (PX5).

On July 8, 2011, Petitioner returned to Dr. Bardfield at which time it was noted that Mr. Villasano "had a new injury, which has flared up his lower back pain..." (PX5). Dr. Bardfield's impression was a lumbar strain and contusion with flare-up symptoms secondary to a work-related injury. (PX5). Dr. Bardfield also ordered physical therapy and order Petitioner off work. (PX5). Petitioner attended physical therapy at ATI from July 1, 2011 through September 2, 2011. (PX6).

On August 31, 2011, Petitioner visited Dr. Butler for another §12 examination. (RX11). Following his examination and review of the records, Dr. Butler opined that Petitioner's complaints of lower back pain were not causally related to his accident of February 21, 2009. (RX11). Instead, Dr. Butler related Petitioner's complaints to pre-existing disc degeneration at L5-S1. (RX11). Dr. Butler also noted that cervical complaints were not documented after the injury of February 21, 2009 until seven (7) months later. (RX11). Thus, Dr. Butler opined that the cervical complaints are not related to the accident of February 21, 2009. (RX11). Dr. Butler did opine that treatment for the lumbar spine had been reasonable and necessary up through the functional capacity evaluation of October 2009. (RX11).

On September 2, 2011, Dr. Bardfield noted that Petitioner did not improve with additional therapy and continued to have the same complaints of neck and low back pain. (PX5). Dr. Bardfield's impression was cervical and lumbar strain injury with contusions and history of L5-S1 disc herniation and C5-C6 bulge. (PX5). Dr. Bardfield recommended another FCE once Petitioner completed treatment for his wrist condition. (PX5). Dr. Bardfield also maintained Petitioner's off work restriction. (PX5).

At the request of Respondent, Petitioner visited Dr. Edward Goldberg on February 22, 2012 for purposes of a §12 examination. The report of Dr. Goldberg was not offered into evidence by either party.

On March 26, 2012, Petitioner underwent surgery for another condition [presumably the wrist] not related to the neck or lower back condition at issue in the present claims.

Petitioner did not return to Dr. Bardfield until July 18, 2012. By this date, Petitioner had returned to light duty work with Respondent doing the same work he currently performs – namely, putting labels on boxes; erasing the bar code on packages; and moving meat that may get stuck as it proceeds on the conveyor line. Petitioner could also alternate between sitting and standing. On the date of this examination, Dr. Bardfield noted Petitioner had increased pain in the neck, low back, arms and legs. (PX5). Dr. Bardfield diagnosed cervical and lumbar radiculopathy with underlying myofascial pain and recommended repeat a MRI of both the cervical and lumbar spine. (PX5).

On July 16, 2012, Petitioner underwent an MRI of the lumbar spine and cervical spine. (PX5). The lumbar spine MRI revealed a "stable appearance of L5-S1 broad-based central disc protrusion . . . abutting bilateral S1 nerve roots in the lateral recesses.". (PX5). The cervical MRI revealed a C4-C5 shallow posterior central disc protrusion, a C5-C6 broad-based posterior left paracentral protrusion indenting the anterior left thecal sac, a C6-C7 minimal disc bulge and a T2-T3 small posterior disc protrusion that slightly indents the anterior thecal sac. (PX5). On August 1, 2012, Dr. Bardfield recommended a lumbar epidural injection that Petitioner underwent on September 6, 2012 at Salt Creek Surgery Center. (PX9).

Petitioner recalled telling Dr. Bardfield that the injection did not help his pain. Dr. Bardfield noted this lack of improvement at the time of his November 1, 2012 examination. (PX5). Dr. Bardfield thereupon recommended that Petitioner return to Dr. Lorenz. (PX5).

At the request of Respondent, Petitioner visited Dr. Jay Levin on January 7, 2013 for purposes of yet another §12 examination. (RX12). Following his examination and review of the voluminous records, Dr. Levin noted that he did see anything "... to support that this examinee sustained an injury to his lumbar spine on February 21, 2009" and that "... this examinee did not sustain an injury to the cervical spine from the February 21, 2009 occurrence." (RX13). Dr. Levin also indicated that he agreed with Dr. Butler's assessment that Petitioner's "... degenerative disk changes predated the incident and it would be very difficult to state that a simple act of lifting sausages that was described ... was enough to cause an aggravation of underlying degenerative condition."

(RX13). Finally, Dr. Levin opined that since Petitioner did not sustain any injury to his cervical spine as a result of the February 21, 2009 occurrence, given that he was totally asymptomatic for months thereafter, "... [Petitioner] did not require any care or treatment to the cervical spine from that event." (RX13).

Petitioner underwent surgery for his other condition, said condition not currently in dispute, and did not return to Dr. Lorenz until January 13, 2014. (PX5). At that time Dr. Lorenz recommended repeat MRIs of the cervical and lumbar spine. (PX5). Petitioner underwent the MRIs on February 21, 2014. The MRI of the lumbar spine indicated a "broad-based disc bulge and superimposed 5 mm central disc protrusion at the L5-S1 level slightly effaces the ventral aspect of the thecal sac but does not cause significant stenosis." (PX5). The cervical MRI indicated "scattered levels of degenerative disc disease and cervical spondylosis present throughout the cervical spine..." (PX5). On February 27, 2014, Dr. Lorenz recommended a myelogram and CT scan. (PX5). Dr. Lorenz noted the cervical spine images were "very hard to interpret due to a very grainy picture." (PX5).

On April 7, 2014, Dr. Lorenz examined Petitioner and reviewed the MRIs. Dr. Lorenz noted that the CT scan showed very minor degenerative changes. (PX5). Dr. Lorenz noted that Petitioner had a chronic neck and back strain not amenable to surgical intervention and referred Mr. Villasano to pain management specialist Dr. Jain. (PX5). Petitioner did not go to Dr. Jain but instead saw another physician, Dr. Theodore Fischer, on his own for a second opinion. Petitioner has not seen any other physicians since that time.

Petitioner testified that he has not suffered any other accidents or injuries to his neck or his back. Petitioner also noted that currently his neck hurts when he turns it and that his lower back hurts when he sits, stands, walks or sleeps. Petitioner takes Norco and Naprosyn for his pain complaints.

Petitioner agreed that he received his regular pay from the date of his initial injury of February 21, 2009 through February 7, 2011 at which time he was placed in a slicing line operator position. He indicted that when he switched positions his rate of pay changed and that Respondent paid the difference for two months. Petitioner acknowledged that while he is assigned to the slicing line department he is not working on the slicing line but instead is doing other jobs – namely, watching product to ensure there is no jam-up, assisting in completing inspection sheets, and wiping off codes and applying labels to single packages.

Petitioner testified that he is currently working the same light duty position as in 2012 earning $16.70 per hour. He indicated that Respondent has accommodated his restrictions but claimed that they still wanted him to do a job that required him to do activities contrary to his restrictions. However, Petitioner admitted that his supervisor, Ray Gonzalez, instructed him to have someone else pick up meat that fell on the floor. He indicated that he has not worked overtime since 2012.

Respondent's corporate safety and health manager, E.J. Klages, confirmed that Petitioner is currently working in the slicing line operator position on restrictions doing other tasks within the department. Those restrictions are related to his bilateral upper extremity claim that is not being litigated at this trial. Ms. Klages confirmed that the slicing line operator position to which Petitioner is presently assigned meets the restrictions imposed by Dr. Bardfield in October of 2010.

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner testified that on June 15, 2011 he was taking meat from a cart and putting it on a line when another employee struck him in the stomach with a cart he was pushing. Petitioner noted that the cart struck him

underneath his stomach towards the right side and he was pushed backwards into a woman working next to him. Petitioner indicated that they hit each other "back to back" and that he did not go all the way to the floor. He stated that the incident occurred between 9:30 p.m. and 10:00 p.m. and that his shift ended at 11:00 p.m. Petitioner testified that he reported the incident to his supervisor and finished working that day. He noted that at the end of his shift he could not tolerate the pain in his back and neck.

An "Illinois Form 45: Employer's First Report of Injury" dated August 29, 2011 was admitted into evidence at RX4. This report notes a date of accident of June 15, 2011 and described the accident as occurring when "another employee bumped an empty box truck which bumped the [employ]ee in the stomach[,] sustained a contusion to lower back." (RX4). The report was prepared by E.J. Klages. (RX4). Ms. Klages reiterated this account at trial, testifying that it was her understanding that another employee was moving a pallet using a hand jack when the pallet bumped into a box truck which in turn bumped into Petitioner's stomach.

Petitioner testified that he contacted Dr. Lorenz's office via telephone the day after the incident but was unable to get an appointment until June 29, 2011. Petitioner had last seen Dr. Lorenz three (3) months earlier on March 21, 2011. (PX5). Petitioner testified on direct examination that he told Dr. Lorenz on June 29, 2011 what had happened to him at work. However, on cross examination, Petitioner indicated that he could not recall whether he mentioned the accident to him. Dr. Lorenz's progress note on that date makes no mention of any incident having occurred at work several weeks earlier. (PX5). Instead, Dr. Lorenz's note simply states that Petitioner was being seen for reevaluation and that he was "... still complaining of neck pain which is 9/10" along with "... pain into the shoulders and also pain down both forearms." (PX5). Dr. Lorenz's diagnosis was C5-6 disc herniation with axial neck pain and L5-S1 herniation. (PX5).

Petitioner next saw Dr. Bardfield on July 8, 2011. In an office note on that date, Dr. Bardfield recorded that Petitioner "... has had a new injury at work which has flared up his low back pain. This occurred on June 15th. He has had aching pain in the low back. No leg symptoms." (PX5). Dr. Bardfield's impression was "1. Lumbar strain and contusion with flare-up of symptoms secondary to a work-related injury, 2. History of L5-S1 disk herniation, 3. Cervical myofascial pain with underlying C5-6 disk bulge." (PX5). Dr. Bardfield recommended a course of physical therapy "directed at the dorsal spine area" and instructed Petitioner to remain off work for four (4) weeks. (PX5). Dr. Bardfield also joined Dr. Lorenz in recommending a repeat FCE following physical therapy. (PX5).

Based on the above, and the record taken as a whole, the Arbitrator finds that on June 15, 2011 Petitioner was struck in the stomach by a cart being pushed by another employee. As a consequence, Petitioner sustained accidental injuries arising out of and in the course of his employment on June 15, 2011. However, the real question, once again, is whether Petitioner's current conditions of ill-being relative to his lumbar and/or cervical spine are causally related to said accident.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

At the request of Respondent, Petitioner visited Dr. Jesse Butler for a second time on August 31, 2011 for purposes of a §12 examination. Dr. Butler opined that Petitioner's current complaints of pain at the low back and cervical spine were not causally related to either his first accident at work on February 21, 2009 or the new alleged accident at work on June 15, 2011. (RX11). He stated that the second alleged work accident on June 15, 2011 was poorly documented and was not noted until Dr. Bardfield's visit of July 8, 2011, despite the fact that Petitioner was seen by Dr. Lorenz on June 29, 2011. (RX11). Further, he opined any issues regarding

Petitioner's low back was related to pre-existing disc degeneration at L5-S1 and were present prior to the first alleged accident on February 21, 2009. (RX11).

As far as the Arbitrator can tell, the only medical opinion offered by any of the treating physicians on the issue of causation can be found in the initial progress note by Dr. Lorenz dated September 24, 2009 wherein he stated that "[i]t is of medical and surgical certainty the patient's subjective findings are consistent with cervical pain, low back pain, arm pain and leg pain and an L5-S1 disk herniation emanating out of an injury where he was lifting on February 21, 2009." (PX5). The record does not appear to contain any opinion by any of the treating physicians on the question of causation with respect to the June 15, 2011 incident.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner failed to prove by a preponderance of the credible evidence that his current conditions of ill-being relative to his lumbar and/or cervical spine are causally related to the accident on June 15, 2011. More to the point, the Arbitrator is not persuaded that an injury wherein an individual is struck in the stomach would somehow result in Petitioner's current complaints relative to his lower back and neck. In addition, the Arbitrator finds the opinions of Drs. Butler and Levine to be persuasive on the issue of causation, particularly in light of the fact that none of Petitioner's treating physicians appear to have even weighed in on the subject, other than Dr. Lorenz, whose opinion is found in his initial progress note and predates the accident in question here. Accordingly, Petitioner's claim for compensation is hereby denied.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Given the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds that Petitioner failed to prove his entitlement to medical expenses pursuant to §8(a) of the Act. Accordingly, Petitioner's claim for same with respect to claim 11 WC 30948 is hereby denied.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Given the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds that Petitioner failed to prove his entitlement to any additional care or treatment. Accordingly, Petitioner's claim for prospective medical treatment with respect to claim 11 WC 30948 is hereby denied.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY AND TEMPORARY PARTIAL DISABILITY, THE ARBITRATOR FINDS AS FOLLOWS:

Given the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds that Petitioner failed to prove his entitlement to temporary total disability and/or temporary partial disability benefits. Accordingly, Petitioner's claim for same with respect to claim 11 WC 30948 is hereby denied.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that issues of law and fact existed between the parties and that Respondent's defense of this claim was neither unreasonable nor vexatious so as to warrant the imposition of penalties. Accordingly, Petitioner's claim for additional compensation pursuant to §19(k) and §19(l) as well as attorneys' fees pursuant to §16 of the Act is hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Donald Brown,
Petitioner,

vs.

NO: 11WC 34257

Tri County Coal, LLC,
Respondent,

16IWCC0184

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of occupational disease, statute of limitations, evidentiary issues, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 22, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 14 2016
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DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BROWN, DONALD
Employee/Petitioner

Case# **11WC034257**

16IWCC0184

TRI COUNTY COAL LLC
Employer/Respondent

On 8/22/2015, 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 0.24% 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:

0755 CULLEY & WISSORE
KIRK CAPONI
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

1662 CRAIG & CRAIG LLC
KENNETH F WERTS
PO BOX 1545
MT VERNON, IL 62864

16IWCC0184

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

☐ 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

DONALD BROWN
Employee/Petitioner

Case # 11 WC 034257

v.

Consolidated cases: _____

TRI COUNTY COAL, LLC
Employer/Respondent

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 Molly Dearing**, Arbitrator of the Commission, in the city of **Springfield**, on **June 24, 2015**. 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 **Disease, Sections 1(d)-(f) of the Occupational Diseases Act**

16IWCC0184

FINDINGS

On **January 4, 2010**, 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 not*** sustain disease 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner's earnings were **$44,488.63** and his average weekly wage was **$988.64**.

On the date of accident, Petitioner was **62** years of age, ***married*** with **0** dependent children.

Petitioner claims no medical.

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

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

ORDER

Because Petitioner failed to prove by a preponderance of the evidence that he sustained an occupational disease arising out of and in the course of the exposures of his employment, and that his current condition of ill-being is causally related to the exposure, all benefits are denied.

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.

Arbitrator Molly Dearing

August 22, 2015
Date

AUG 2 2 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DONALD BROWN
Employee/Petitioner

v. Case #11 WC 034257

TRI COUNTY COAL, LLC
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On his date of accident, Petitioner was sixty-two years of age. He was employed by Respondent as a coal miner at its Crown III mine. Prior to becoming employed by Respondent, Petitioner graduated from Gillespie High School and obtained a certificate in heating and air conditioning from Belleville Area College. Thereafter, he worked at Olin Brass manufacturing ammunition for nine and a half years before beginning his coal mine career with Consol Coal Company at its Hillsboro mine. Petitioner worked at the Hillsboro mine for eight and a half years, and he testified that he performed "all of the underground jobs" at that mine, including operating a continuous miner, roof bolting, hanging tubing, and working as a utility man.

Petitioner went to work for Respondent in 1981. He was classified as a laborer at that time loading supplies for the roof bolter and rock dusting by hand. Petitioner described the laborer position as a dusty job, as he was exposed to rock dust being blown out of a machine on a daily basis. Respondent's mine closed in 1982 and reopened in 1985. Petitioner was classified as a continuous miner operator in 1985 or 1986, in which he was directly exposed to coal dust as coal is being cut. Respondent's mine operated until approximately 1987, when it closed. In 1991, Respondent's mine resumed operations, and Petitioner was classified as a continuous mine operator at that time. He testified that a continuous miner operator is considered one of the dustier jobs in the coal mine, alongside the roof bolter. Petitioner stated that the roof bolter is situated on the return side of the continuous miner operator and is exposed to coal dust as it is ejected through the return. He stated that a continuous miner is constantly exposed to a tremendous amount of dust while operating the machine. Petitioner worked as a continuous miner operator for sixteen or seventeen years, and he testified he also roof bolted for approximately one and a half years. As a roof bolter, he stated that he was exposed to the strong odor of broken glue pins and some rock dust. Thereafter, Petitioner operated a shuttle car, where the coal is taken from the continuous miner to the belts and then is unloaded off the belts and taken out of the mine. He testified that in that position, "you are eating that dust that comes from the miner...and that's why you wear a respirator." He stated that a respirator does not prevent inhalation of all the particles of coal dust, but stated "that's the idea of the respirator." Petitioner worked continuously for Respondent at its Crown III mine six days a week, nine to ten hours per day from 1991 until he retired.

Petitioner retired from Respondent's Crown III mine on January 4, 2010. On that date, he signed a "quit slip", which he testified severed all of his rights to employment with Respondent, and he received a pension thereafter. On January 4, 2010, he was classified as a shuttle car operator and

he testified that he breathed coal dust on his last day of coal mine employment. Petitioner testified that he retired on January 4, 2010 because he "figured 62 years old was a good time to retire. I was eating a lot of that dust on that particular job and my body was getting wore out." Petitioner did not look for any work thereafter. Petitioner testified that he worked in the coal mine industry for more than twenty nine and three-quarters years, all of which were worked underground, and during that time, he was exposed to and breathed silica dust, roof bolting glue fumes, and diesel fumes.

Petitioner testified that he noticed breathing difficulties during the last few years in the mine while he was operating the shuttle car. He began experiencing shortness of breath at that time and he was unable to perform much of the other work that he had been capable of performing in the past. Petitioner testified that his breathing problems worsened from when he first noticed them until he left the mine. He testified that since leaving the mine, he becomes winded with ascending stairs. Petitioner testified that he can currently climb approximately fifteen stairs before having to stop to rest, and he can walk one mile on level ground at a normal pace before becoming short of breath. He testified that he experiences difficulty breathing on days with high humidity, and on hot days while working outside, he oftentimes has to stop his activity to catch his breath before resuming his activities. Petitioner does not take any breathing medications and denied ever smoking. Petitioner denied any hobbies, other than taking care of his nine year old granddaughter and cutting the grass. In 2011, Petitioner was a member of the Fitness Center in Staunton, Illinois, where he lifted five-pound hand weights and performed approximately ten repetitions. He also walked on a treadmill for twenty minutes or the equivalent of one mile. Petitioner testified that he is no longer a member of the Fitness Center. Petitioner testified that he had a heart murmur, which was surgically addressed on July 15, 2014. He takes medicine for his blood pressure and heart condition.

Dr. Glennon Paul examined Petitioner on December 19, 2011 at the request of Petitioner's counsel. Dr. Paul is the medical director of St. John's Respiratory Therapy and Clinical Assistant Professor of Medicine at SIU Medical School. Dr. Paul is a senior physician at the Central Illinois Allergy & Respiratory Clinic, and specializes in allergy and pulmonary diseases, as well as the care of patients with respiratory diseases, critical care, allergic diseases and some internal medicine problems. Dr. Paul is not a B-reader and he is not board certified in pulmonary disease. Dr. Paul testified that he reads approximately 5,000 chest x-rays per year and he interprets approximately the same number of pulmonary function tests. In his practice, he has had occasion to treat coal miners for coal mine induced lung disease and he has also frequently examined coal miners at the request of coal companies. PX 1.

During his examination of Petitioner on December 19, 2011, Petitioner reported shortness of breath after walking a couple of miles, and he denied severe wheezing or coughing except when he gets a cold. Upon physical examination, Dr. Paul found that Petitioner had decreased breath sounds with expiratory rhonchi. Petitioner's pulmonary function studies revealed minimal obstructive airway disease with a positive methacholine stimulation test, which reversed back towards normal after the administration of a bronchodilator. Dr. Paul interpreted Petitioner's chest x-ray as showing maculopapular fibrous lesions throughout both lung fields. Dr. Paul's impression was simple coal workers' pneumoconiosis complicated by asthma. PX 1.

Dr. Paul testified by way of evidence deposition on March 2, 2015. He concluded that Petitioner suffers from coal workers' pneumoconiosis, asthma, chronic bronchitis, chronic obstructive pulmonary disease, and emphysema. Dr. Paul testified that "[y]ou can't really tell if it's chronic bronchitis or asthma or a combination of both. We'll call it chronic bronchitis, I don't

care." Dr. Paul testified that Petitioner's physical examination and pulmonary function studies that revealed decreased breath sounds with expiratory rhonci and an obstruction "could be" consistent with emphysema and chronic obstructive pulmonary disease. Dr. Paul testified that Petitioner "probably doesn't" have emphysema, but also testified that if Petitioner's treatment records revealed chest x-rays that indicate emphysema and other radiographic studies that indicate emphysematous changes, and in light of the obstruction and physical examination abnormalities, Petitioner could or might have emphysema. PX 1.

Dr. Paul opined that Petitioner's diagnoses of coal workers' pneumoconiosis, asthma, chronic bronchitis, chronic obstructive pulmonary disease, and emphysema were causally related to his work as a coal miner, and he testified that in light of his conditions, Petitioner cannot have any further exposure to the environment of a coal mine without endangering his health. Dr. Paul testified that Petitioner has clinically significant pulmonary impairment in the form of pulmonary symptoms, complaints and physical examination results. He testified that Petitioner also has radiographically apparent pulmonary impairment and physiologically significant pulmonary impairment as demonstrated on his pulmonary function testing. Dr. Paul opined that Petitioner's impairments were caused by exposure to the coal mine environment. Dr. Paul testified that Petitioner is medically precluded from working as a coal miner, and that Petitioner could only perform light duty work. PX 1.

Dr. Paul explained that coal workers' pneumoconiosis is a tissue reaction from the deposition of coal mine dust in the lungs called scarring or fibrosis. Dr. Paul testified that the portion of the lung that is scarred cannot perform the normal function of healthy lung tissue and there is no cure for coal workers' pneumoconiosis. By definition, if one has coal workers' pneumoconiosis he would have some impairment in the function of the lung at the site of the scarring whether it can be measured by spirometry or not. Dr. Paul testified that it is possible to have injury or disease to the lung despite having normal pulmonary function test results, and an individual with radiographically significant coal workers' pneumoconiosis may have normal pulmonary function testing, normal blood gasses, and a normal physical examination. Dr. Paul testified that simple coal workers' pneumoconiosis is a condition that typically is asymptomatic. Coal workers' pneumoconiosis is considered a progressive disease that can be life threatening and can progress even after the miner ceases his exposure in the coal mine, though Dr. Paul testified that it is less likely that it will not progress after the exposure ends. PX 1.

Dr. Paul acknowledged that Petitioner was not taking any breathing medication at the time he evaluated him, and Petitioner did not provide a history to Dr. Paul of ever having taken breathing medication. Petitioner did not relate to Dr. Paul that he left coal mining due to a health concern or on the advice of a physician, nor did he report any difficulties in performing his last job duties at the coal mine. Dr. Paul did not know the date of the film that he reviewed nor did he assess the film a profusion rating. PX 1.

Dr. Henry K. Smith, board certified radiologist and NIOSH B-reader, interpreted Petitioner's chest x-ray dated April 10, 1974 as positive for pneumoconiosis, profusion 1/0 with P/P opacities in all lung zones. Dr. Smith interpreted Petitioner's chest x-ray dated March 11, 1996 as positive for pneumoconiosis, profusion 1/1 with P/P opacities in all lung zones. He made identical interpretations of chest x-rays dated October 12, 2000, August 17, 2005, and August 9, 2012. Dr. Smith interpreted Petitioner's chest x-ray of July 1, 2011 as positive for pneumoconiosis, profusion 1/0 with P/S opacities in all lung zones. Dr. Smith found the chest x-ray of July 1, 2011 to be

quality two due to being overexposed and dark. The chest x-ray of April 10, 1974 was quality two due to being underexposed or light. Dr. Smith also found the chest x-ray of May 8, 2007 to be underexposed or light. PX 2.

Dr. Michael Alexander, board certified radiologist and NIOSH B-reader, interpreted Petitioner's chest x-ray of May 8, 2007 as positive for coal workers' pneumoconiosis, profusion 1/1 with P/P opacities in all lung zones. Dr. Alexander interpreted Petitioner's chest x-ray of July 1, 2011 as positive for pneumoconiosis, profusion 1/0 with P/S opacities in all lung zones. Dr. Alexander found the July 1, 2011 chest x-ray to be quality three because it was too dark and low contrast. Dr. Alexander interpreted chest x-ray dated August 9, 2012 as positive for pneumoconiosis, profusion 1/1 with P/P opacities in all lung zones. Dr. Alexander also noted apical emphysema and pleural thickening. PX 3.

At the request of counsel for Respondent, Dr. Cristopher A. Meyer reviewed Petitioner's chest x-rays and he testified by way of evidence deposition on May 17, 2013. Dr. Meyer has been board certified in radiology since 1992 and he has been a B-reader since 1999. Dr. Meyer testified that the B-reader looks at the films and the lungs to decide whether there are any small nodular opacities or any linear opacities, and based on size and appearance of those small opacities, they are given a letter score. Dr. Meyer explained that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described by small, round opacities and is typically an upper zone predominant process. The last component of the interpretation is the extent of the lung involvement, or the profusion. Dr. Meyer testified that the profusion defines the density of the small opacities in the lung. RX 1.

Dr. Meyer graded the chest x-rays as quality three with the exception of the July 1, 2011 chest x-ray, which he graded as quality two. He testified that the films suffered from such things as scapula overlay, underexposure and poor contrast. Dr. Meyer testified that several of the x-rays were copy exams. One also had mottle. Dr. Meyer testified that although the films were quality three, they were still acceptable for diagnostic quality. Dr. Meyer testified that he was able to give a fair reading of the films, otherwise, he would have scored them as unreadable. During his examination of Petitioner's x-ray dated April 10, 1974, Dr. Meyer found no radiographic findings of coal workers' pneumoconiosis. Dr. Meyer reviewed Petitioner's x-ray of March 11, 1996, and he interpreted same as negative for coal workers' pneumoconiosis. Dr. Meyer interpreted Petitioner's chest x-ray of October 12, 2000 as negative for coal workers' pneumoconiosis. Dr. Meyer interpreted Petitioner's chest x-ray of August 17, 2005 as a normal chest x-ray with no findings of coal workers' pneumoconiosis. Dr. Meyer interpreted Petitioner's chest x-ray of May 8, 2007 as negative for coal workers' pneumoconiosis, though he found tortuous ecstatic thoracic aorta. Dr. Meyer interpreted Petitioner's chest x-ray of July 1, 2011 and found no radiographic findings of coal workers' pneumoconiosis, though he noted a calcified granuloma anteriorly in the right upper lobe and asymmetric apical pleural thickening. RX 1.

Dr. Meyer reviewed NIOSH A-reader and B-reader interpretations of Petitioner's x-ray of April 10, 1974 and he agreed with their negative findings. He reviewed NIOSH interpretations for the examination of Petitioner's x-ray of March 11, 1996 by B-readers RTS and PRW, and he agreed with their interpretations as negative for pneumoconiosis. Mr. Meyer reviewed the interpretations of NIOSH B-readers SDL and ELC of Petitioner's x-ray of October 12, 2000. He concurred with the examination of SDL that found no evidence of pneumoconiosis, but he disagreed with the report of ELC, who found fine linear opacities in all zones of 1/0. Dr. Meyer noted that nodular,

rather than linear, opacities would be characteristic of minimal coal workers' pneumoconiosis. Dr. Meyer reviewed three NIOSH B-reader interpretations of Petitioner's x-ray of August 17, 2005 and he agreed with the majority of B-readers who found the x-ray negative for coal workers' pneumoconiosis. Dr. Meyer disagreed with the interpretations of Dr. Sood, who described rare basilar linear opacities of profusion 1/0, and he noted that early findings of coal workers' pneumoconiosis are characteristically upper zone fine nodular opacities, rather than the isolated basilar fine linear opacities identified by Dr. Sood. Dr. Meyer also reviewed two NIOSH B-reading interpretations for the examination of May 8, 2007, and he agreed with both B-readers interpretations of no parenchymal findings of pneumoconiosis. Dr. Meyer noted that the second B-reader's secondary findings of pleural findings are consistent with extra-pleural fat, which he stated is not a manifestation of coal dust exposure. Dr. Meyer reviewed the narrative summary and ILO B reading form of Dr. Henry Smith dated July 24, 2011, and he disagreed with Dr. Smith's findings of P/S opacities. RX 1.

Dr. Meyer testified that the films he reviewed encompassed thirty-seven years, which he found valuable in formulating his opinions because he stated that a series of films allows a physician or radiologist to look for subtle findings that may develop slowly over time. It also allows the radiologist to compare the earliest and most recent examination to look for interval change. He testified that the ability to look at serial films over a long period of time makes it more sensitive in detecting slowly developing abnormalities. Dr. Meyer testified that he looks at films in chronological order, always starting with the oldest one first. RX 1.

Dr. Meyer testified that manifestations of coal workers' pneumoconiosis are a body's ability to clear the coal dust depositions in the lungs. Dr. Meyer stated that at the site of the tissue reaction to the coal dust, there would be some change in the function of the lung regardless of whether it could be measured. He explained that the macule of coal workers' pneumoconiosis is a permanent abnormality and can progress even once the worker leaves the site of exposure. Dr. Meyer stated that the only treatment for coal workers' pneumoconiosis is to remove the worker from the exposure. He testified that if an individual has coal workers' pneumoconiosis, then he likely that he had some level of the disease when he left the coal mine. Dr. Meyer testified that coal workers' pneumoconiosis may develop at any time during a miner's career, and may even manifest itself radiographically a month or so after the miner leaves the coal mine environment. RX 1.

Dr. Jeffrey W. Selby examined Petitioner on August 9, 2012 at the request of Respondent's counsel. Dr. Selby has been board certified in internal medicine and pulmonary disease since 1980 and 1984, respectively. Dr. Selby has been a B-reader since 1985. Dr. Selby performs general pulmonary work, and he treats patients with lung disease on a daily basis. Dr. Selby has occasion to see individuals who have the disease process coal workers' pneumoconiosis, and he performs evaluations on behalf of claimants and employers.

Dr. Selby took a medical history from Petitioner. His chief complaint was "none" and Petitioner had no complaints. Petitioner reported to Dr. Selby that he could walk approximately two miles, and that after doing so, he would tire but would not be short of breath. Petitioner reported having a cough since May 2012. Petitioner denied a productive cough, wheezing, and shortness of breath. Petitioner has never smoked. A chest examination showed clear breath sounds with good airflow. Petitioner also underwent exercise testing. He completed stage III of Bruce Protocol or nine minutes of total exercise time. Petitioner stopped because he was tired, and due to pain in his hips and legs. Dr. Selby testified that this confirmed no heart or lung abnormality that

interfered with heavy manual labor or exertion. Dr. Selby testified that he considers exercise testing to be the gold standard to determine the presence of a cardiopulmonary impairment. Dr. Selby testified that although Petitioner's testing was submaximal, it was of diagnostic quality. Dr. Selby testified that based upon the exercise testing, Petitioner was capable of heavy manual labor from a pulmonary standpoint. RX 2.

Dr. Selby interpreted Petitioner's chest x-ray taken on August 9, 2012. Dr. Selby testified that the film was negative for coal workers' pneumoconiosis. Dr. Selby caused pulmonary function testing to be performed on Petitioner, and his interpretation was a normal spirometry, normal lung volumes, and normal diffusion capacity with no presence of an obstruction or restriction. Dr. Selby also reviewed chest x-rays dated May 8, 2007 and July 1, 2011. He graded the films as quality three but found them of sufficient diagnostic quality to interpret for the presence of pneumoconiosis. Dr. Selby found no abnormalities consistent with pneumoconiosis on these films. Dr. Selby testified that when simple pneumoconiosis is present and exposure ceases, it is less likely that the disease will progress. Dr. Selby performed a methacholine test, which revealed a 28% drop from baseline following the fifth dose of Provocholine, which Dr. Selby noted to be a positive methacholine test. Dr. Selby diagnosed Petitioner as having an occult asthma, or asthma that was hidden until Petitioner underwent testing. Dr. Selby testified that there were no indications of asthma in Petitioner's treating records, and based upon the objective testing he performed, Petitioner exhibited no evidence of any permanent functional impairment as the result of his occult asthma. RX 2.

Dr. Selby opined that based upon Petitioner's occupational and medical history, and his physical examination and various laboratory data, Petitioner does not suffer from any respiratory or pulmonary abnormalities as a result of coal mine dust inhalation or his coal mine employment. Dr. Selby denied that Petitioner has coal workers' pneumoconiosis, and he opined that Petitioner has the respiratory and pulmonary capacity to perform any and all of his previous coal mine duties. While he diagnosed him with asthma, Dr. Selby opined that Petitioner's asthma was asymptomatic and was not resultant from coal mine dust inhalation. Dr. Selby testified that in the film he reviewed, which was taken on August 9, 2012, there was no evidence of emphysema. Dr. Selby testified that the medical records he reviewed revealed no pathologic evidence of pneumoconiosis. He testified that Petitioner was never diagnosed with chronic obstructive pulmonary disease, chronic bronchitis or asthma in his treatment records. RX 2.

Dr. Selby testified that coal workers' pneumoconiosis is a tissue reaction to coal mine dust called scarring or fibrosis. He stated that by definition, if a person has pneumoconiosis, he would have impairment in the function of his lung at the very site of his scarring, whether that impairment could be measured by spirometry or not. Dr. Selby testified that it is possible for a person to have radiographically significant coal workers' pneumoconiosis and have normal findings on physical examination of the chest, a normal pulmonary function test and a normal arterial blood gas test. Dr. Selby testified that it would be unlikely, yet possible, for coal workers' pneumoconiosis that appears radiographically to manifest itself in the last year of exposure. RX 2.

Dr. James Castle, board certified pulmonologist and B-reader, interpreted Petitioner's chest x-ray of August 9, 2012 as negative for pneumoconiosis. He noted some apical thickening on the right. RX 3.

Records from NIOSH of Petitioner's chest x-rays obtained as part of the Coal Workers' Health Surveillance Program were admitted into evidence. The chest x-ray taken on April 10, 1974

was interpreted by A-reader GAC and a B-reader HBS as negative for pneumoconiosis. The chest x-ray of March 11, 1996 was interpreted as negative for pneumoconiosis by two B-readers, PRW and RIB. The chest x-ray of October 12, 2000 was interpreted by B-reader Scott D. Long as negative for pneumoconiosis. B-reader ELC interpreted the chest x-ray as positive for pneumoconiosis, category 1/0 with S/T opacities in all lung zones. The chest x-ray taken on August 17, 2005 was interpreted by B-reader ELC as negative for pneumoconiosis, profusion 0/1 with T/T opacities in the bilateral, middle and lower lung zones. Another B-reader did not find any abnormalities consistent with pneumoconiosis on the August 17, 2005 chest x-ray. Dr. Akshay Sood, B-reader, interpreted the August 17, 2005 chest x-ray as positive for pneumoconiosis, profusion 1/0 with S/S opacities in the bilateral lower lung zones. A chest x-ray taken on May 8, 2007 was interpreted by two B-readers as having no findings consistent with pneumoconiosis. RX 4.

Medical records of Petitioner's primary care physician, Dr. Emerito Ureta, were admitted into evidence. Dr. Ureta's records begin in 1978. On February 25, 1997, Petitioner presented to Dr. Ureta with complaints of a hacky, productive cough with congestion. On May 11, 2000, Petitioner reported a hoarse voice, cough and sore throat present for one day. On January 18, 2002, Petitioner presented for a routine examination, and on that date, his lungs were clear. Petitioner presented to Dr. Ureta on October 10, 2002 with complaints of a sinus infection. On November 4, 2002, Petitioner complained of a head cold. On November 9, 2002, Petitioner presented to Dr. Ureta and complained of a sore throat, a dry, hacky cough, and head congestion that had been present intermittently for one month. On physical examination, his lungs were clear. On September 3, 2004, Petitioner presented to Dr. Ureta and reported head congestion and a dry, hacky cough. Petitioner's lungs were clear on examination. Petitioner again complained of a cold and cough on February 17 and February 18, 2005. On May 12, 2005, Petitioner presented to Dr. Ureta with complaints of a cough, congestion and headache with onset one-month prior. His lungs were noted by Dr. Ureta to be clear. Petitioner presented to Dr. Ureta on April 29, 2006 and complained of a cold with cough and sore throat present for one and a half weeks. Petitioner's lungs were noted to be clear on that date. Petitioner's lungs were also noted to be clear upon examination on September 25, 2006 and December 19, 2006. On February 3, 2007, Petitioner presented to Dr. Ureta with complaints of cough and runny nose with an onset one-week prior. His cough was dry, and his lungs were clear on examination. Petitioner presented to Dr. Ureta on November 17, 2007 and reported chest pain radiating to the right side. He denied shortness of breath. A chest x-ray performed on November 17, 2007 revealed old granulomatous disease in the upper lung on the right. Petitioner presented to Dr. Ureta on May 7, 2009, September 8, 2009, June 17, 2010, and February 1, 2011, and his lungs were clear upon examination on those dates. Petitioner underwent a chest x-ray on February 11, 2011 for abdominal pain, which showed slight hyper-expansion of the lung, indicating possible chronic obstructive pulmonary disease, and some upper lung lucency suggestive of emphysema. On March 11, 2011, Petitioner presented to Dr. Ureta with complaints of a cough and phlegm for two days. His lungs were clear. Petitioner presented to Dr. Ureta on June 20, 2011 and reported left-sided chest pain with no shortness of breath. A physical examination revealed Petitioner's lungs to be clear. On November 13, 2012, Petitioner underwent a chest x-ray due to complaints of shortness of breath. The x-ray revealed no evidence of active disease and no interval change (very mild emphysema). Petitioner's lungs were clear on physical examination on April 11, 2014, July 31, 2014, and February 25, 2014, as well as on January 13, 2015, when Petitioner presented for a routine examination. PX 4, RX 6. Petitioner testified that he did not discuss his breathing difficulties with Dr. Ureta.

Medical records of the Department of Veterans Affairs Medical Center in St. Louis, Missouri were admitted into evidence. On April 26, 2011, Petitioner presented to the Medical Center for a physical and to transfer his care. Petitioner denied dyspnea and a physical examination of the chest revealed his lungs to be clear to auscultation. Petitioner returned to the Medical center on October 7, 2011. He again denied dyspnea and a physical examination of the chest revealed the lungs to be clear to auscultation. On May 2, 2012, Petitioner presented to the Medical Center and denied shortness of breath. A physical examination of the lungs revealed a chest clear to auscultation bilaterally and a pulse oximetry of 97%. RX 5.

Medical records of Prairie Cardiovascular Consultants were admitted into evidence. Petitioner presented to Dr. Robert Woodruff on June 19, 2008 for complaints of chest pain. Petitioner reported developing difficulties with chest pain approximately two weeks prior. He denied dyspnea on exertion or overt symptoms of congestive heart failure. On physical examination, Petitioner's lungs were clear to auscultation. Dr. Woodruff noted that the chest pain syndrome was atypical in nature and seemed more consistent with a musculoskeletal etiology. RX 7. Petitioner returned to Dr. Woodruff on July 14, 2011 with continued difficulties of chest pain. He denied shortness of breath and a review of systems revealed no chronic cough. A physical examination of the chest revealed the lungs to be clear to auscultation. Petitioner presented to Dr. Woodruff on April 17, 2014 with complaints of shortness of breath associated with a cardiac murmur upon referral by Dr. Ureta. Petitioner reported a "new-onset" of shortness of breath that that is exertional in nature and began approximately six months prior. He also described a chronic chest pain syndrome that generally lasted for only seconds. Petitioner denied a chronic cough and a physical examination of his chest was clear to auscultation. Dr. Woodruff assessed Petitioner with atypical chest pain, hyperlipidemia, a murmur, and depression/anxiety. He noted that the exact etiology of Petitioner's new onset shortness of breath was unclear, but he suspected that it was likely related to mitral regurgitation in light of his presenting history and examination findings. Dr. Woodruff ordered Petitioner to undergo further evaluation. A transesophageal echocardiogram performed on May 5, 2014 revealed moderate to severe eccentric mitral regurgitation. Petitioner presented to Dr. William Stevens on June 2, 2014 for consideration of mitral valve repair versus replacement. Petitioner denied cough, wheeze or pulmonary infection, and his lungs were clear on examination. Petitioner underwent a mitral valve repair on July 15, 2014 and he returned to Dr. Woodruff post-operatively on August 21, 2014, at which time Petitioner denied shortness of breath, anginal chest pain and a chronic cough, and his chest was clear to auscultation. RX 7.

CONCLUSIONS OF LAW

In regard to disputed issues of disease and causal connection, pursuant to Section 1(d) of the Workers' Occupational Diseases Act, "the term 'Occupational Disease' means a disease arising out of and in the course of the employment or which has become aggravated and rendered disabling as a result of the exposure of the employment. Such aggravation shall arise out of a risk peculiar to or increased by the employment and not common to the general public." To recover compensation under the Act, a claimant must prove that he suffers from an occupational disease and that a causal connection exists between the disease and his employment. *Bernardoni v. Indus. Comm'n*, 362 Ill. App. 3d 582, 596 (2005). An occupational exposure need not be the sole or principal causative factor, as long as it was a causative factor in the development of the condition of ill-being. *Id.*

In this case, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he suffers from coal workers' pneumoconiosis. In so concluding, the Arbitrator relies

upon the majority of opinions of the NIOSH B-Readers, who interpreted Petitioner's x-rays of April 10, 1974, March 11, 1996, October 12, 2000, August 7, 2005, and May 8, 2007 as negative for coal workers' pneumoconiosis. The Arbitrator specifically notes the findings of the two NIOSH B-Readers who reviewed Petitioner's x-ray of May 8, 2007, three years prior to Petitioner's date of accident, and did not find any evidence of coal workers' pneumoconiosis. RX 4. The Arbitrator relies on the majority of opinions of the NIOSH physicians, as NIOSH is the governmental agency responsible for administering the health surveillance program for the benefit of coal miners, NIOSH is not a party to this action, and the x-rays were taken and reviewed for reasons independent of litigation. The Arbitrator notes that the positive interpretation of NIOSH B-Reader ELC dated October 12, 2000 is contradicted by the negative interpretation performed by ELC of Petitioner's x-ray taken five years later on August 7, 2005. The single remaining NIOSH x-ray interpretation positive for coal workers' pneumoconiosis was that of Dr. Sood regarding Petitioner's x-ray dated August 7, 2005. However, Dr. Sood's interpretation is outweighed by the two subsequent NIOSH interpretations of an x-ray dated May 8, 2007, which were interpreted as negative. RX 4. In light of the aforementioned, the Arbitrator places significant weight on the interpretations and conclusions of the majority of NIOSH B-readers who found no evidence of coal workers' pneumoconiosis. RX 4.

The Arbitrator recognizes that the most recent NIOSH interpretations were that of Petitioner's x-ray dated May 8, 2007, and both Dr. Meyer and Dr. Selby testified that coal workers' pneumoconiosis may manifest itself radiographically in the last year of coal mine employment or in a short time thereafter. RX 1, 2. Nonetheless, the Arbitrator finds the x-ray film interpretations of Drs. Meyer, Castle, and Shelby to be more persuasive than the interpretations of Drs. Smith and Alexander. Dr. Meyer interpreted a sequence of Petitioner's chest x-rays spanning a period of thirty-seven years, and the interpreted the most recent x-ray in that sequence dated July 1, 2011 as negative for coal workers' pneumoconiosis, (RX 1), as did Dr. Selby. RX 2. Dr. Selby and Dr. Castle both interpreted Petitioner's chest x-ray of August 9, 2012 as negative for coal workers' pneumoconiosis. RX 2, 3. The Arbitrator does not find the interpretations of Dr. Smith persuasive because his interpretations of Petitioner's March 11, 1996, October 12, 2000, and August 7, 2005 x-rays are inconsistent with the majority of opinions of the B-readings performed by NIOSH, whereas Dr. Meyer's negative reading of Petitioner's May 8, 2007 chest x-ray is consistent with the findings of the independent NIOSH B-readers. RX 1, 4. The Arbitrator is further disinclined to rely upon the interpretations of Dr. Smith, given that his interpretations demonstrate that Petitioner's condition regressed from a profusion 1/1 on the earlier x-rays of March 11, 1996, October 12, 2000, and August 17, 2005 to a profusion of 1/0 on the July 1, 2011 chest x-ray, which is inconsistent with the permanent nature of the opacities of coal workers' pneumoconiosis. RX 1. The Arbitrator is similarly dissuaded by the interpretations of Dr. Alexander as his interpretations indicate that Petitioner's coal workers' pneumoconiosis improved over the course of four years from a profusion of 1/1 on the x-ray of May 8, 2007 to a profusion of 1/0 on the x-ray of July 1, 2011 (PX 3), which again, is inconsistent with the permanent nature of the disease. RX 2. Further, the Arbitrator is disinclined to rely on the opinions of Dr. Paul, who opined that Petitioner has coal workers' pneumoconiosis, because he could not testify to the date of the x-ray he reviewed, he did not assign it a profusion rate, and he only reviewed a single x-ray (PX 1), whereas Dr. Meyer reviewed a sequence of x-rays (RX 1), which the Arbitrator finds lends weight to Dr. Meyer's opinion. Based upon the foregoing and the totality of the record, the Arbitrator finds the interpretations of B-readers Drs. Meyer, Selby, and Castle more reliable than those of Drs. Smith, Alexander, and Paul, and the Arbitrator accordingly places greater weight on the opinions of Drs. Meyer, Selby and Castle.

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he suffers from chronic bronchitis, chronic obstructive pulmonary disease, or emphysema causally related to the exposures of his coal mine employment. In so concluding, the Arbitrator finds the opinions of Dr. Selby to be more informed and well-founded in the record than the opinions of Dr. Paul. Dr. Selby reviewed Petitioner's treating records, whereas Dr. Paul did not. The Arbitrator notes that Dr. Selby's opinion that Petitioner does not suffer from bronchitis, chronic obstructive pulmonary disease, or emphysema is consistent with the lack of any such diagnoses by his treating physicians, as is the absence of findings upon physical examination and objective testing suggestive of such conditions. PX 4, RX 2, 6, 7. The Arbitrator further notes that Dr. Paul only diagnosed Petitioner with coal workers' pneumoconiosis and asthma during his examination of December 19, 2011. He did not proffer a diagnosis of bronchitis, chronic obstructive pulmonary disease, or emphysema until his deposition over three years later, and he specifically testified that he did not believe Petitioner suffered from emphysema. PX 1. Moreover, the physical examination and pulmonary studies performed by Dr. Selby on August 9, 2012 that revealed a normal spirometry, normal lung volumes and normal diffusion capacity, and negated the presence of an obstruction, restriction or abnormality, is consistent with Petitioner's repeated denials of shortness of breath in 2010 and 2011, more than a year after Petitioner separated from his coal mine employment, to Dr. Woodruff and his review of symptoms that revealed no chronic cough. The Arbitrator finds it significant that while Dr. Woodruff opined that the exact etiology of Petitioner's "new onset" of shortness of breath in 2014 was unclear, he suspected that such symptoms were related to Petitioner's mitral regurgitation. The Arbitrator finds that Dr. Woodruff's records demonstrate that the shortness of breath and chronic cough reported by Petitioner to Dr. Woodruff was solely causally related to his mitral regurgitation condition that was alleviated by surgical intervention on July 15, 2014, given that Petitioner returned to Dr. Woodruff post-operatively on August 21, 2014 and denied a shortness of breath, anginal chest pain, and a chronic cough. RX 7.

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he suffers from asthma causally related to the exposures of his coal mine employment. While the diagnosis of asthma is supported by the positive methacholine test administered by Dr. Paul on December 19, 2011 (PX 1) as well as that performed by Dr. Selby on August 9, 2012 (RX 2), there is no evidence in the record to demonstrate that Petitioner's asthma was aggravated or exacerbated by his employment. The Arbitrator notes that Petitioner's treating records from Dr. Ureta, which date back to 1978, are devoid of any treatment for or diagnosis of asthma in the years prior to his work accident or thereafter. PX 4, 6. Although Petitioner testified that he did not discuss his breathing difficulties with Dr. Ureta, he was capable of doing so, given that he reported shortness of breath to Dr. Ureta in November 2012 for which Dr. Ureta ordered him to undergo a chest x-ray (RX 6), and Dr. Ureta referred Petitioner to Dr. Woodruff for complaints of shortness of breath and a cardiac murmur in 2014. RX 6, 7. The lack of treatment or diagnosis of asthma in Petitioner's treating records is probative, as is the absence of findings upon physical examination or objective testing, and corroborates Dr. Selby's opinions that Petitioner's asthma was not exacerbated by his coal mine employment and that he does not suffer any permanent functional impairment as a result of same. RX 2.

Based upon the foregoing and the totality of the record, the Arbitrator concludes that Petitioner failed to prove that he suffers coal workers' pneumoconiosis, chronic bronchitis, chronic obstructive pulmonary disease, emphysema and asthma that arose out of or in the course of the exposures of his coal mine employment, and that his current condition of ill-being is causally related to that employment. All benefits are denied. The remaining issues are rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Javier Perez,

Petitioner,

vs.

NO: 11 WC 36403
11 WC 36475
11 WC 36565
11 WC 43292

State of Illinois-DHS,

16IWCC0155

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner, herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, medical, prospective medical, causal connection, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 26, 2015 is hereby affirmed and adopted.

No bond is required for State of Illinois cases.

DATED: MAR 4 - 2016

MB/mam
o:1/7/16
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PEREZ, JAVIER
Employee/Petitioner

Case# **11WC036403**

11WC043292
11WC036565
11WC036475

STATE OF ILLINOIS-DHS
Employer/Respondent

16IWCC0155

On 5/26/2015, 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 0.08% 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:

2934 BOSHARDY LAW OFFICE PC
JOHN BOSHARDY
1610 S 6TH ST
SPRINGFIELD, IL 62703

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

5002 ASSISTANT ATTORNEY GENERAL
JOSEPH NLEWITT
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SPRINGFIELD, IL 62706

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

1745 CMS - RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

MAY 26 2015

RONALD A.RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

16IWCC0155

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

Javier Perez
Employee/Petitioner

v.

State of Illinois - DHS
Employer/Respondent

Case # 11 WC 36403

Consolidated cases: 11 WC 43292
11 WC 36565 and 11 WC 36475

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 William R. Gallagher, Arbitrator of the Commission, in the city of Quincy, on April 1, 2015. 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 13, 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 not sustain an accident that arose out of and in the course of employment.

Petitioner's current condition of ill-being is not causally related to the accident.

In the year preceding the injury, Petitioner earned $65,000.00; the average weekly wage was $1,250.00.

On the date of accident, Petitioner was 48 years of age, married with 0 dependent child(ren).

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 $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00.

Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

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.

William R. Gallagher, Arbitrator

May 20, 2015
Date

MAY 26 2015

Findings of Fact

Petitioner filed four Applications for Adjustment of Claim which alleged he sustained repetitive trauma injuries arising out of and in the course of his employment for Respondent. In cases 11 WC 36565 and 11 WC 36475, Petitioner alleged dates of accident (manifestations) of April 8 and April 21, 2011, respectively, and that Petitioner sustained repetitive trauma to the right upper extremity. In cases 11 WC 43292 and 11 WC 36403, Petitioner alleged dates of accident (manifestations) of August 1 and September 13, 2011, respectively, and that Petitioner sustained repetitive trauma to the left upper extremity (Petitioner's Exhibit 1). In all four cases, Respondent disputed liability on the basis of accident, notice and causal relationship.

Petitioner began working for Respondent at the Joliet Treatment and Detention Facility in August, 2002. He was subsequently transferred to the Rushville Treatment and Detention Facility in August, 2006.

Petitioner testified that during the time he worked at the Joliet facility, he used Folger-Adams keys on cell doors, chuckholes and gates. Petitioner estimated that during a typical shift he would perform more than 100 Folger-Adams key turns. Petitioner stated that, because his hands would get tired during a shift, he would alternate using the Folger-Adams keys between his right and left hands. Joliet was an old facility and did not have any doors operated by a computer.

In addition to the preceding, when Petitioner was working at the Joliet facility, he also performed other duties that involved the repetitive use of his hands. This included doing "takedowns" which was physically restraining combative residents, cuffing/uncuffing residents and typing of reports.

Petitioner testified that his job duties at the Rushville facility were essentially the same as what they were at the Joliet facility. Petitioner continued to use Folger-Adams keys at Rushville but not to the same extent that he did at Joliet. Rushville is a newer facility then Joliet, so most of the doors were opened/closed via computer. Petitioner stated that he still used Folger-Adams keys to open/close chuckholes.

Petitioner also stated that he used "medium" sized keys which were larger than house keys but smaller than Folger-Adams keys to gain access to various pods in the Rushville facility. These pods could be opened by computer, but they could also be opened with a key. Petitioner stated that he would many times use a key to open a door instead of waiting for the control room to open the door via computer.

Kevin Winters, Assistant Security Director, at Rushville, testified at the trial of this case. Winters reviewed the Demands of the Job form dated October 13, 2011, which he completed and signed (Petitioner's Exhibit 3). Winters agreed that the form stated that Petitioner used his hands for gross manipulation or activities that required grasping, twisting and handling four to six hours per day.

Winters also testified that 80% of the doors in Rushville were computer controlled and only 20% required the use of Folger-Adams keys. He did agree that the use of Folger-Adams keys was not limited to doors and could also be used on hatches, chuckholes, etc.

Dale Kunkel, the Assistant Facility Director, also testified at the trial. Kunkel confirmed that Petitioner used Folger-Adams keys and that he generally carried 40 keys with him. He agreed Petitioner would use Folger-Adams keys on both doors and chuckholes. Kunkel also acknowledge that Petitioner informed him of having sustained a left hand injury and the report of October 6, 2011, regarding same (Petitioner's Exhibit 2).

Greg Scott, the Program Director at Rushville, also testified at the trial. Scott confirmed that he had notice that Petitioner sustained a right hand injury and identified the injury report dated April 27, 2011 (Petitioner's Exhibit 4).

Petitioner testified that he began to experience symptoms of sharp pain in his right hand/wrist and that it was getting tired upon active use sometime in February, 2011. Petitioner was initially seen by Dr. Jennifer Schroeder, on February 4, 2011. At that time, Petitioner had complaints of tingling in the right hand, primarily in the thumb and first two fingers of approximately one month. Dr. Schroeder opined Petitioner had right carpal tunnel syndrome and prescribed a splint. She also ordered an EMG/nerve conduction study (Petitioner's Exhibit 5).

On April 8, 2011, Petitioner was seen by Dr. David Gelber, who performed an EMG/nerve conduction study which confirmed that Petitioner had moderately severe right carpal tunnel syndrome (Petitioner's Exhibit 6). Petitioner subsequently reported his injuries as swelling/pain in the right wrist from repetitious locking/unlocking of gates/doors on April 21, 2011 (Petitioner's Exhibit 4).

At the direction of Respondent, Petitioner was examined by Dr. James Williams, an orthopedic surgeon, on July 6, 2011. In connection with his examination of Petitioner, Dr. Williams reviewed medical records provided to him by Respondent. Dr. Williams opined that Petitioner may have had right and left carpal tunnel syndrome; however, he also opined that the carpal tunnel syndrome was not related to Petitioner's turning keys at his work because Petitioner's job duties did not involve vibration or significant repetition (Respondent's Exhibit 1).

On August 29, 2011, Petitioner was again seen by Dr. Schroeder, primarily for left hand symptoms. At that time, Petitioner attributed his hand symptoms to repetitive typing and turning locks at work. Dr. Schroeder again ordered an EMG/nerve conduction study (Petitioner's Exhibit 5).

On September 13, 2011, Petitioner was again seen by Dr. Gelber, who performed an EMG/nerve conduction study on the left hand which confirmed that Petitioner had moderately severe left carpal tunnel syndrome (Petitioner's Exhibit 6). On October 7, 2011, Petitioner informed Respondent that he had left carpal tunnel syndrome as a result of repetitive motion of locking/unlocking doors (Petitioner's Exhibit 4).

Petitioner subsequently sought treatment from Dr. Christopher Wottowa, an orthopedic surgeon, on March 12, 2012. At that time, Petitioner informed Dr. Wottowa that he did a significant amount of keying at work and that he had been having progressive symptoms of numbness/tingling in both hands. Dr. Wottowa opined that Petitioner had bilateral carpal tunnel syndrome, the right being worse than the left and he recommended Petitioner undergo carpal

tunnel release surgeries, initially recommending that they proceed with doing the right hand first (Petitioner's Exhibit 6).

Dr. Wottowa performed right and left carpal tunnel release surgeries on May 22 and June 12, 2012, respectively. When Dr. Wottowa saw Petitioner on June 25, 2012, he stated that Petitioner would be released to return to work in one weeks time (Petitioner's Exhibit 6).

Dr. Williams was deposed on November 1, 2012, and his deposition testimony was received into evidence at trial. Dr. Williams' testimony was consistent with his medical report and he reaffirmed the opinions contained therein. While he agreed that Petitioner had bilateral carpal tunnel syndrome, he opined that Petitioner's work activities neither aggravated nor contributed to the condition. Dr. Williams stated that the force required in turning keys was insufficient to aggravate or contribute to the condition. Further, Dr. Williams noted that Petitioner had other risk factors that predisposed him to the condition, specifically, that Petitioner was an insulin dependent diabetic and that he had increased BMI (Respondent's Exhibit 2; pp 14-17).

On cross-examination, Dr. Williams agreed that he did not know precisely how much key turning Petitioner did on a day-to-day basis and that repetitive use of the hand is a known causative factor of carpal tunnel syndrome. He also agreed that causality of carpal tunnel syndrome is based upon a combination of an individual's personal predispositions or risk factors, genetic factors and environmental exposures at work (Respondent's Exhibit 2; pp 23-26).

Dr. Wottowa was deposed on April 7, 2014, and his deposition testimony was received into evidence at trial. Dr. Wottowa's testimony in regard to his diagnosis and treatment of Petitioner's bilateral carpal tunnel syndrome condition was consistent with his medical records (Petitioner's Exhibit 9; pp 7-11).

Dr. Wottowa acknowledged that Petitioner was predisposed to development of carpal tunnel syndrome because Petitioner had type II diabetes and his BMI put him in the obese range. When questioned about Petitioner's work activities, Dr. Wottowa opined that Petitioner's forceful extension and flexion of the wrist in opening doors and closing locks would be an aggravating factor (Petitioner's Exhibit 9; pp 11-15).

On cross-examination, Dr. Wottowa agreed that he did not have specific information about how many times Petitioner would turn a key in an hour, that he did not know what a Folger-Adams key was, and that he had no knowledge as to how much force was required to turn such a key (Petitioner's Exhibit 9; pp 21-25).

At trial, Petitioner testified that he still experiences some pain, numbness and stiffness in both hands, more so in the right than left. Petitioner acknowledged that he did return to work to his regular job for Respondent.

At trial, Petitioner's counsel made a hearsay objection to Respondent's Exhibit 1, the narrative report of Respondent's Section 12 examiner, Dr. Williams. At that time, the Arbitrator sustained the objection and rejected the exhibit. However, it was subsequently determined that Petitioner's

counsel had waived his hearsay objection and withdrew same. Accordingly, Respondent's Exhibit 1 is part of the record in this case.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner did not sustain a repetitive trauma injury to his left upper extremity arising out of and in the course of his employment for Respondent that manifested itself on September 13, 2011, and that his present condition of ill-being is not related to his work activities.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified that he used both Folger-Adams keys and what he described as "medium" size keys in a repetitive nature while working at the Rushville facility. However, it was noted that unlike the Joliet facility, the Rushville facility had computer controlled doors that did not require the use of Folger-Adams keys.

The testimony of both Kevin Winters and Dale Kunkel confirmed Petitioner's repetitive use of both hands/wrists while performing his job duties.

Both Petitioner's treating physician, Dr. Wottowa, and Respondent's Section 12 examiner, Dr. Williams, agreed that Petitioner had bilateral carpal tunnel syndrome.

Dr. Williams opined that Petitioner's work activities did not aggravate or contribute to the carpal tunnel syndrome condition because the amount of force in turning keys was insufficient to aggravate or contribute to that condition and that Petitioner had other risk factors, specifically, diabetes and an increased BMI.

While Dr. Wottowa opined that Petitioner's forceful extension and flexion of the wrist in turning keys would be an aggravating factor, Dr. Wottowa had minimal information regarding what repetitive activities Petitioner engaged in while at work. Specifically, Dr. Wottowa did not have any knowledge about the number of times Petitioner used a Folger-Adams key or the amount of force required to turn it.

The Arbitrator acknowledges Dr. Wottowa to be a well qualified expert; however, Dr. Wottowa lacked sufficient details of Petitioner's work duties to give a definitive opinion as to whether there was a causal relationship between Petitioner's work activities and the carpal tunnel syndrome condition.

The Arbitrator finds the opinion of Respondent's Section 12 examiner, Dr. Williams, to be more persuasive than that of Petitioner's treating physician, Dr. Wottowa.

In regard to disputed issues (E), (J), (K) and (L) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issues (C) and (F).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Javier Perez,

Petitioner,

vs.

NO: 11 WC 36475
11 WC 36565
11 WC 43292
11 WC 36403

State of Illinois-DHS,

16IWCC0158

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner, herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, medical, prospective medical, causal connection, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 26, 2015 is hereby affirmed and adopted.

No bond is required for State of Illinois cases.

DATED: MAR 4 - 2016

MB/mam
o:1/7/16
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PEREZ, JAVIER
Employee/Petitioner

Case# **11WC036475**

11WC036565
11WC043292
11WC036403

STATE OF ILLINOIS-DHS
Employer/Respondent

16IWCC0158

On 5/26/2015, 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 0.08% 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:

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PO BOX 19208
SPRINGFIELD, IL 62794-9208

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

MAY 26 2015

RONALD A.RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

16IWCC0158

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

Javier Perez
Employee/Petitioner

v.

State of Illinois - DHS
Employer/Respondent

Case # 11 WC 36475

Consolidated cases: 11 WC 36565
11 WC 43292 and 11 WC 36403

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 William R. Gallagher, Arbitrator of the Commission, in the city of Quincy, on April 1, 2015. 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 April 21, 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 not sustain an accident that arose out of and in the course of employment.

Petitioner's current condition of ill-being is not causally related to the accident.

In the year preceding the injury, Petitioner earned $65,000.00; the average weekly wage was $1,250.00.

On the date of accident, Petitioner was 48 years of age, married with 0 dependent child(ren).

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 $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00.

Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

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.

William R. Gallagher, Arbitrator

May 20, 2015
Date

MAY 26 2015

Findings of Fact

Petitioner filed four Applications for Adjustment of Claim which alleged he sustained repetitive trauma injuries arising out of and in the course of his employment for Respondent. In cases 11 WC 36565 and 11 WC 36475, Petitioner alleged dates of accident (manifestations) of April 8 and April 21, 2011, respectively, and that Petitioner sustained repetitive trauma to the right upper extremity. In cases 11 WC 43292 and 11 WC 36403, Petitioner alleged dates of accident (manifestations) of August 1 and September 13, 2011, respectively, and that Petitioner sustained repetitive trauma to the left upper extremity (Petitioner's Exhibit 1). In all four cases, Respondent disputed liability on the basis of accident, notice and causal relationship.

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On August 29, 2011, Petitioner was again seen by Dr. Schroeder, primarily for left hand symptoms. At that time, Petitioner attributed his hand symptoms to repetitive typing and turning locks at work. Dr. Schroeder again ordered an EMG/nerve conduction study (Petitioner's Exhibit 5).

On September 13, 2011, Petitioner was again seen by Dr. Gelber, who performed an EMG/nerve conduction study on the left hand which confirmed that Petitioner had moderately severe left carpal tunnel syndrome (Petitioner's Exhibit 6). On October 7, 2011, Petitioner informed Respondent that he had left carpal tunnel syndrome as a result of repetitive motion of locking/unlocking doors (Petitioner's Exhibit 4).

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On cross-examination, Dr. Williams agreed that he did not know precisely how much key turning Petitioner did on a day-to-day basis and that repetitive use of the hand is a known causative factor of carpal tunnel syndrome. He also agreed that causality of carpal tunnel syndrome is based upon a combination of an individual's personal predispositions or risk factors, genetic factors and environmental exposures at work (Respondent's Exhibit 2; pp 23-26).

Dr. Wottowa was deposed on April 7, 2014, and his deposition testimony was received into evidence at trial. Dr. Wottowa's testimony in regard to his diagnosis and treatment of Petitioner's bilateral carpal tunnel syndrome condition was consistent with his medical records (Petitioner's Exhibit 9; pp 7-11).

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On cross-examination, Dr. Wottowa agreed that he did not have specific information about how many times Petitioner would turn a key in an hour, that he did not know what a Folger-Adams key was, and that he had no knowledge as to how much force was required to turn such a key (Petitioner's Exhibit 9; pp 21-25).

At trial, Petitioner testified that he still experiences some pain, numbness and stiffness in both hands, more so in the right than left. Petitioner acknowledged that he did return to work to his regular job for Respondent.

At trial, Petitioner's counsel made a hearsay objection to Respondent's Exhibit 1, the narrative report of Respondent's Section 12 examiner, Dr. Williams. At that time, the Arbitrator sustained the objection and rejected the exhibit. However, it was subsequently determined that Petitioner's

counsel had waived his hearsay objection and withdrew same. Accordingly, Respondent's Exhibit 1 is part of the record in this case.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner did not sustain a repetitive trauma injury to his right upper extremity arising out of and in the course of his employment for Respondent that manifested itself on April 21, 2011, and that his present condition of ill-being is not related to his work activities.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified that he used both Folger-Adams keys and what he described as "medium" size keys in a repetitive nature while working at the Rushville facility. However, it was noted that unlike the Joliet facility, the Rushville facility had computer controlled doors that did not require the use of Folger-Adams keys.

The testimony of both Kevin Winters and Dale Kunkel confirmed Petitioner's repetitive use of both hands/wrists while performing his job duties.

Both Petitioner's treating physician, Dr. Wottowa, and Respondent's Section 12 examiner, Dr. Williams, agreed that Petitioner had bilateral carpal tunnel syndrome.

Dr. Williams opined that Petitioner's work activities did not aggravate or contribute to the carpal tunnel syndrome condition because the amount of force in turning keys was insufficient to aggravate or contribute to that condition and that Petitioner had other risk factors, specifically, diabetes and an increased BMI.

While Dr. Wottowa opined that Petitioner's forceful extension and flexion of the wrist in turning keys would be an aggravating factor, Dr. Wottowa had minimal information regarding what repetitive activities Petitioner engaged in while at work. Specifically, Dr. Wottowa did not have any knowledge about the number of times Petitioner used a Folger-Adams key or the amount of force required to turn it.

The Arbitrator acknowledges Dr. Wottowa to be a well qualified expert; however, Dr. Wottowa lacked sufficient details of Petitioner's work duties to give a definitive opinion as to whether there was a causal relationship between Petitioner's work activities and the carpal tunnel syndrome condition.

The Arbitrator finds the opinion of Respondent's Section 12 examiner, Dr. Williams, to be more persuasive than that of Petitioner's treating physician, Dr. Wottowa.

In regard to disputed issues (E), (J), (K) and (L) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issues (C) and (F).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Javier Perez,

Petitioner,

vs.

NO: 11 WC 36565
11 WC 36475
11 WC 43292
11 WC 36403

State of Illinois-DHS,

Respondent,

16IWCC0157

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner, herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, medical, prospective medical, causal connection, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 26, 2015 is hereby affirmed and adopted.

No bond is required for State of Illinois cases.

DATED: MAR 4 - 2016

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:1/7/16
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PEREZ, JAVIER
Employee/Petitioner

Case# **11WC036565**

11WC036475
11WC043292
11WC036403

STATE OF ILLINOIS-DHS
Employer/Respondent

16IWCC0157

On 5/26/2015, 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 0.08% 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:

2934 BOSHARDY LAW OFFICE PC
JOHN BOSHARDY
1610 S 6TH ST
SPRINGFIELD, IL 62703

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

5002 ASSISTANT ATTORNEY GENERAL
JOSEPH BLEWITT
500 S SECOND ST
SPRINGFIELD, IL 62706

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13 TH FL
CHICAGO, IL 60601-3227

1745 CMS - RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

MAY 26 2015

RONALD A.RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

16IWCC0157

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

Javier Perez
Employee/Petitioner

v.

State of Illinois - DHS
Employer/Respondent

Case # 11 WC 36565

Consolidated cases: 11 WC 36475
11 WC 43292 and 11 WC 36403

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 William R. Gallagher, Arbitrator of the Commission, in the city of Quincy, on April 1, 2015. 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 _____

16IWCC0157

FINDINGS

On April 8, 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 not sustain an accident that arose out of and in the course of employment.

Petitioner's current condition of ill-being is not causally related to the accident.

In the year preceding the injury, Petitioner earned $65,000.00; the average weekly wage was $1,250.00.

On the date of accident, Petitioner was 48 years of age, married with 0 dependent child(ren).

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 $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00.

Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

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.

William R. Gallagher, Arbitrator

May 20, 2015
Date

MAY 26 2015

Findings of Fact

Petitioner filed four Applications for Adjustment of Claim which alleged he sustained repetitive trauma injuries arising out of and in the course of his employment for Respondent. In cases 11 WC 36565 and 11 WC 36475, Petitioner alleged dates of accident (manifestations) of April 8 and April 21, 2011, respectively, and that Petitioner sustained repetitive trauma to the right upper extremity. In cases 11 WC 43292 and 11 WC 36403, Petitioner alleged dates of accident (manifestations) of August 1 and September 13, 2011, respectively, and that Petitioner sustained repetitive trauma to the left upper extremity (Petitioner's Exhibit 1). In all four cases, Respondent disputed liability on the basis of accident, notice and causal relationship.

Petitioner began working for Respondent at the Joliet Treatment and Detention Facility in August, 2002. He was subsequently transferred to the Rushville Treatment and Detention Facility in August, 2006.

Petitioner testified that during the time he worked at the Joliet facility, he used Folger-Adams keys on cell doors, chuckholes and gates. Petitioner estimated that during a typical shift he would perform more than 100 Folger-Adams key turns. Petitioner stated that, because his hands would get tired during a shift, he would alternate using the Folger-Adams keys between his right and left hands. Joliet was an old facility and did not have any doors operated by a computer.

In addition to the preceding, when Petitioner was working at the Joliet facility, he also performed other duties that involved the repetitive use of his hands. This included doing "takedowns" which was physically restraining combative residents, cuffing/uncuffing residents and typing of reports.

Petitioner testified that his job duties at the Rushville facility were essentially the same as what they were at the Joliet facility. Petitioner continued to use Folger-Adams keys at Rushville but not to the same extent that he did at Joliet. Rushville is a newer facility then Joliet, so most of the doors were opened/closed via computer. Petitioner stated that he still used Folger-Adams keys to open/close chuckholes.

Petitioner also stated that he used "medium" sized keys which were larger than house keys but smaller than Folger-Adams keys to gain access to various pods in the Rushville facility. These pods could be opened by computer, but they could also be opened with a key. Petitioner stated that he would many times use a key to open a door instead of waiting for the control room to open the door via computer.

Kevin Winters, Assistant Security Director, at Rushville, testified at the trial of this case. Winters reviewed the Demands of the Job form dated October 13, 2011, which he completed and signed (Petitioner's Exhibit 3). Winters agreed that the form stated that Petitioner used his hands for gross manipulation or activities that required grasping, twisting and handling four to six hours per day.

Winters also testified that 80% of the doors in Rushville were computer controlled and only 20% required the use of Folger-Adams keys. He did agree that the use of Folger-Adams keys was not limited to doors and could also be used on hatches, chuckholes, etc.

Dale Kunkel, the Assistant Facility Director, also testified at the trial. Kunkel confirmed that Petitioner used Folger-Adams keys and that he generally carried 40 keys with him. He agreed Petitioner would use Folger-Adams keys on both doors and chuckholes. Kunkel also acknowledge that Petitioner informed him of having sustained a left hand injury and the report of October 6, 2011, regarding same (Petitioner's Exhibit 2).

Greg Scott, the Program Director at Rushville, also testified at the trial. Scott confirmed that he had notice that Petitioner sustained a right hand injury and identified the injury report dated April 27, 2011 (Petitioner's Exhibit 4).

Petitioner testified that he began to experience symptoms of sharp pain in his right hand/wrist and that it was getting tired upon active use sometime in February, 2011. Petitioner was initially seen by Dr. Jennifer Schroeder, on February 4, 2011. At that time, Petitioner had complaints of tingling in the right hand, primarily in the thumb and first two fingers of approximately one month. Dr. Schroeder opined Petitioner had right carpal tunnel syndrome and prescribed a splint. She also ordered an EMG/nerve conduction study (Petitioner's Exhibit 5).

On April 8, 2011, Petitioner was seen by Dr. David Gelber, who performed an EMG/nerve conduction study which confirmed that Petitioner had moderately severe right carpal tunnel syndrome (Petitioner's Exhibit 6). Petitioner subsequently reported his injuries as swelling/pain in the right wrist from repetitious locking/unlocking of gates/doors on April 21, 2011 (Petitioner's Exhibit 4).

At the direction of Respondent, Petitioner was examined by Dr. James Williams, an orthopedic surgeon, on July 6, 2011. In connection with his examination of Petitioner, Dr. Williams reviewed medical records provided to him by Respondent. Dr. Williams opined that Petitioner may have had right and left carpal tunnel syndrome; however, he also opined that the carpal tunnel syndrome was not related to Petitioner's turning keys at his work because Petitioner's job duties did not involve vibration or significant repetition (Respondent's Exhibit 1).

On August 29, 2011, Petitioner was again seen by Dr. Schroeder, primarily for left hand symptoms. At that time, Petitioner attributed his hand symptoms to repetitive typing and turning locks at work. Dr. Schroeder again ordered an EMG/nerve conduction study (Petitioner's Exhibit 5).

On September 13, 2011, Petitioner was again seen by Dr. Gelber, who performed an EMG/nerve conduction study on the left hand which confirmed that Petitioner had moderately severe left carpal tunnel syndrome (Petitioner's Exhibit 6). On October 7, 2011, Petitioner informed Respondent that he had left carpal tunnel syndrome as a result of repetitive motion of locking/unlocking doors (Petitioner's Exhibit 4).

Petitioner subsequently sought treatment from Dr. Christopher Wottowa, an orthopedic surgeon, on March 12, 2012. At that time, Petitioner informed Dr. Wottowa that he did a significant amount of keying at work and that he had been having progressive symptoms of numbness/tingling in both hands. Dr. Wottowa opined that Petitioner had bilateral carpal tunnel syndrome, the right being worse than the left and he recommended Petitioner undergo carpal

tunnel release surgeries, initially recommending that they proceed with doing the right hand first (Petitioner's Exhibit 6).

Dr. Wottowa performed right and left carpal tunnel release surgeries on May 22 and June 12, 2012, respectively. When Dr. Wottowa saw Petitioner on June 25, 2012, he stated that Petitioner would be released to return to work in one weeks time (Petitioner's Exhibit 6).

Dr. Williams was deposed on November 1, 2012, and his deposition testimony was received into evidence at trial. Dr. Williams' testimony was consistent with his medical report and he reaffirmed the opinions contained therein. While he agreed that Petitioner had bilateral carpal tunnel syndrome, he opined that Petitioner's work activities neither aggravated nor contributed to the condition. Dr. Williams stated that the force required in turning keys was insufficient to aggravate or contribute to the condition. Further, Dr. Williams noted that Petitioner had other risk factors that predisposed him to the condition, specifically, that Petitioner was an insulin dependent diabetic and that he had increased BMI (Respondent's Exhibit 2; pp 14-17).

On cross-examination, Dr. Williams agreed that he did not know precisely how much key turning Petitioner did on a day-to-day basis and that repetitive use of the hand is a known causative factor of carpal tunnel syndrome. He also agreed that causality of carpal tunnel syndrome is based upon a combination of an individual's personal predispositions or risk factors, genetic factors and environmental exposures at work (Respondent's Exhibit 2; pp 23-26).

Dr. Wottowa was deposed on April 7, 2014, and his deposition testimony was received into evidence at trial. Dr. Wottowa's testimony in regard to his diagnosis and treatment of Petitioner's bilateral carpal tunnel syndrome condition was consistent with his medical records (Petitioner's Exhibit 9; pp 7-11).

Dr. Wottowa acknowledged that Petitioner was predisposed to development of carpal tunnel syndrome because Petitioner had type II diabetes and his BMI put him in the obese range. When questioned about Petitioner's work activities, Dr. Wottowa opined that Petitioner's forceful extension and flexion of the wrist in opening doors and closing locks would be an aggravating factor (Petitioner's Exhibit 9; pp 11-15).

On cross-examination, Dr. Wottowa agreed that he did not have specific information about how many times Petitioner would turn a key in an hour, that he did not know what a Folger-Adams key was, and that he had no knowledge as to how much force was required to turn such a key (Petitioner's Exhibit 9; pp 21-25).

At trial, Petitioner testified that he still experiences some pain, numbness and stiffness in both hands, more so in the right than left. Petitioner acknowledged that he did return to work to his regular job for Respondent.

At trial, Petitioner's counsel made a hearsay objection to Respondent's Exhibit 1, the narrative report of Respondent's Section 12 examiner, Dr. Williams. At that time, the Arbitrator sustained the objection and rejected the exhibit. However, it was subsequently determined that Petitioner's

counsel had waived his hearsay objection and withdrew same. Accordingly, Respondent's Exhibit 1 is part of the record in this case.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner did not sustain a repetitive trauma injury to his right upper extremity arising out of and in the course of his employment for Respondent that manifested itself on April 8, 2011, and that his present condition of ill-being is not related to his work activities.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified that he used both Folger-Adams keys and what he described as "medium" size keys in a repetitive nature while working at the Rushville facility. However, it was noted that unlike the Joliet facility, the Rushville facility had computer controlled doors that did not require the use of Folger-Adams keys.

The testimony of both Kevin Winters and Dale Kunkel confirmed Petitioner's repetitive use of both hands/wrists while performing his job duties.

Both Petitioner's treating physician, Dr. Wottowa, and Respondent's Section 12 examiner, Dr. Williams, agreed that Petitioner had bilateral carpal tunnel syndrome.

Dr. Williams opined that Petitioner's work activities did not aggravate or contribute to the carpal tunnel syndrome condition because the amount of force in turning keys was insufficient to aggravate or contribute to that condition and that Petitioner had other risk factors, specifically, diabetes and an increased BMI.

While Dr. Wottowa opined that Petitioner's forceful extension and flexion of the wrist in turning keys would be an aggravating factor, Dr. Wottowa had minimal information regarding what repetitive activities Petitioner engaged in while at work. Specifically, Dr. Wottowa did not have any knowledge about the number of times Petitioner used a Folger-Adams key or the amount of force required to turn it.

The Arbitrator acknowledges Dr. Wottowa to be a well qualified expert; however, Dr. Wottowa lacked sufficient details of Petitioner's work duties to give a definitive opinion as to whether there was a causal relationship between Petitioner's work activities and the carpal tunnel syndrome condition.

The Arbitrator finds the opinion of Respondent's Section 12 examiner, Dr. Williams, to be more persuasive than that of Petitioner's treating physician, Dr. Wottowa.

In regard to disputed issues (E), (J), (K) and (L) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issues (C) and (F).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

☐ Affirm and adopt (no changes)	☒ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify down	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nicholas Novickis,
Petitioner,

vs.

NO: 11 WC 37038

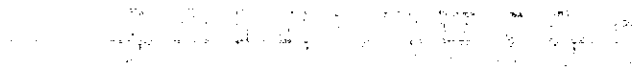
16IWCC0166

Barry Metz/IWBF,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of employer/employee relationship, accident, causation, temporary total disability benefits, permanent disability benefits and whether Petitioner is entitled to reasonable and necessary medical expenses and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission vacates the Spengel Chiropractic Center medical bill having found that the Spengel Chiropractic medical records were not submitted evidence and that there is no basis to support the medical bill. The Commission further notes that while the Arbitrator took into consideration the fracture of the pubis ramis in making his permanency finding, Petitioner's attorney clearly indicated in the Arbitration transcript that the pubis ramis condition is not part of the workers' compensation claim. As such, the Commission strikes and discounts this portion of the Arbitrator's decision. Additionally, while Petitioner testified that he continued to treat with a chiropractor, Petitioner's attorney did not submit these records into evidence. Thus, it is unclear if Petitioner obtained any relief from the chiropractic treatment. The last medical record the Commission has is Dr. Graf's March 7, 2012 record in which the doctor found Petitioner continued to complain of pain throughout the thoracic and lumbar spine. On physical examination, it was noted that Petitioner had good range of motion but he experienced pain on hyperextension and flexion of his back. Approximately three years later, Petitioner testified at the April 20, 2015 Arbitration hearing that he was experienced back and neck pain. He reported he experienced discomfort in his back while standing for a length of time and his back hurt while



working. He further said he takes Advil during the day and uses a pillow under his legs at night. Having taken into consideration the above, the Commission finds Petitioner is permanently disabled to the extent of 7-1/2% man as a whole under Section 8(d) 2 of the Illinois Workers' Compensation Act. Lastly, the Commission refers this claim to the Insurance Compliance Department to check the current status of Respondent/Barry Metz's workers' compensation insurance and to determine if the department wishes to pursue Respondent/Barry Metz's noncompliance with the Illinois Workers' Compensation Act and specifically in regard to this claim.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $220.00 per week for a period of 32-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $220.00 per week for a period of 37.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 7-1/2% loss of a man as a whole under Section 8(d)2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $34,951.70 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

IT IS FURTHER ORDERED BY THE COMMISSION that this award is hereby entered against the Injured Workers' Benefit Fund, as a co-respondent in this claim, to the extent permitted and allowed under Section 4(d) of this Act. In the event that the Respondent/ Barry Metz fails to pay the benefits, the Injured Workers' Benefit Fund has to right to recover the benefits paid due and owing to the Petitioner pursuant to Sections 5(b) and 4(d) of this Act. Respondent/ Barry Metz shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/ Barry Metz that are paid to the Petitioner from the Injured Workers' Benefit Fund.

IT IS FURTHER ORDERED BY THE COMMISSION that this claim be referred to the Insurance Compliance Department to check the current status of Respondent/Barry Metz's workers' compensation insurance and to determine if the department wishes to pursue Respondent/Barry Metz's noncompliance with the Illinois Workers' Compensation Act and specifically in regard to this claim.

16IWCC0166

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $50.500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 9 - 2016

MB/jm

O: 2/25/16

JM

43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NOVICKIS, NICHOLAS
Employee/Petitioner

Case# **11WC037038**

16IWCC0166

BARRY METZ AND THE IWBF
Employer/Respondent

On 5/28/2015, 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 0.08% 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:

1767 FREEMAN TUTAJ LLC
JAMES P TUTAJ
170 CENTER ST SUITE 2
GRAYSLAKE, IL 60030

0445 RODDY LAW LTD
CHRIS TOMCZYK
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

5199 ASSISTANT ATTORNEY GENERAL
MELISSER HINTERHAUSER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF Lake)

16IWCC0166

X 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

Nicholas Novickis
Employee/Petitioner

v.

Barry Metz and the IWBF
Employer/Respondent

Case # **11** WC **37038**

Consolidated cases: _____

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 **Falcioni**, Arbitrator of the Commission, in the city of **Waukegan**, on **April 20, 2015**. 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 **Did Respondent have Workers' Compensation Insurance**

16IWCC0166

FINDINGS

On **July 22, 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 $**295.00**; the average weekly wage was $**295.00**.

On the date of accident, Petitioner was **19** years of age, ***single*** with **0** 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.

ORDER

Respondent shall pay reasonable and necessary medical services of $34,951.70, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $220.00/week for 32 5/7 weeks, commencing 7-23-2011 through 3-7-2012, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $220.00/week for 62.5 weeks, because the injuries sustained caused the 12.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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.

Signature of Arbitrator

May 8, 2015
Date

MAY 28 2015

MEMORANDUM OF DECISION OF ARBITRATOR

In regard to Issue A, Was Respondent operating under and subject to the Illinois Workers' Compensation, the Arbitrator finds as follows:

Respondent testified that on July 22, 2011 he was the owner and operator of a sole proprietorship entitled Barry Metz construction and that he had contracted to provide carpentry services at a private residence located at 2144 Linden Avenue, Highland Park, Illinois. Respondent further testified that he had conducted business under the name of Barry Metz construction for many years prior to July 22, 2011. Respondent further testified that the scope of work he was to perform at 2144 Linden Ave included the demolition and remodeling of the residence. Metz's exhibit #1 is a delineation of the scope of work performed by Respondent at the residence.

Section 3 of the Illinois Workers Compensation Act provides in part:

> *The provisions of this Act hereinafter following shall apply automatically and without election to the State, county, city, town, township, incorporated village or school district, body politic or municipal corporation, and to all employers and all their employees, engaged in any department of the following enterprises or businesses which are declared to be extra hazardous, namely:*
>
> *1. The erection, maintaining, removing, remodeling, altering or demolishing of any structure.*

Based upon the testimony of Respondent and Respondent's exhibit #1, the Arbitrator finds that on July 22, 2011 Respondent was operating under and subject to the provisions of the Illinois Workers Compensation Act.

In regard to issue B, Was there an employee-employer relationship, the Arbitrator finds as follows:

Section 1 of the Workers' Compensation Act: provides in part:

> *(a) The term "employer" as used in this Act means:*
>
> *2. Every person, firm, public or private corporation, including hospitals, public service, eleemosynary, religious or charitable corporations or associations who has any person in service or under any contract for hire, express or implied, oral or written, and who is engaged in any of the enterprises or businesses enumerated in Section 3 of this Act, or who at or prior to the time of the accident to the employee for which compensation under this Act may be claimed, has in the manner provided in this Act elected to become subject to the provisions of this Act, and who has not, prior to such accident, effected a withdrawal of such election in the manner provided in this Act.*

Petitioner and Respondent testified consistently that Petitioner was hired to perform services for Respondent at the Linden Avenue residence. Respondent testified he hired Petitioner to perform cleanup work only; to remove debris from the worksite and keep the worksite orderly and clean. Petitioner testified that in addition to those duties, he was hired to perform demolition work at the residence. Petitioner testified he was hired as an employee of Respondent. Respondent contends Petitioner was an independent contractor or subcontractor of Respondent.

Although Respondent initially testified that Petitioner was hired only to perform cleanup work, and disputed that Petitioner was hired to perform demolition work, Respondent ultimately admitted that at the time of the occurrence, he had directed Petitioner to remove the kitchen cabinets and kitchen countertop. He characterized this work as demo work. Respondent's Exhibit 1, confirms Respondent was retained to perform demolition work in the kitchen, basement and other portions of the residence including demolition of interior and exterior walls of the residence.

Respondent testified that he directed and controlled the work performed by Petitioner at the residence. He told Petitioner when to show up, what to do and when to do it. He testified that he was the only person on the job site responsible for Petitioner and that neither the homeowner nor any of the other numerous contractors on-site had the right to direct or control any aspect of Petitioner's work. Petitioner had no tools or equipment of his own. Respondent provided him with all of the tools and equipment he needed to perform his job duties at the residence. The sledge hammer Petitioner was using at the time the ceiling collapsed upon him was provided by Respondent.

Petitioner did not own his own business or operate as a business in July 2011. He did not hold himself out as having any specialized training or expertise in debris removal, clean up or demolition work. He had never worked at a construction site prior to being retained by Respondent. He was a recent high school graduate with no training, education or experience in construction, carpentry, demolition work, and most importantly job site safety, protocol or the customs and practices of the construction industry. He was completely dependent upon Respondent for direction and guidance. The Arbitrator notes the fact that Respondent was an experienced carpenter who held himself out as an experienced contractor and had operated as a sole proprietor for many years prior to July 2011.

The Arbitrator also notes the testimony of Steve Billirakis, the only witness other than Petitioner and Respondent to testify at trial. Mr. Bilirakis was a painter working at a job site a short distance from the Linden residence. Mr. Bilirakis was an employee of Howard Katz, a designer/general contractor who was also involved in the Linden remodeling project. After the occurrence, Mr. Katz directed Mr. Bilirakis to go to the Linden

Avenue residence and assist Respondent in cleaning up the debris caused by the collapse of the kitchen ceiling. Like Petitioner, Mr. Billirakis had no prior experience in job site cleanup, debris removal or demolition work. Mr. Bilirakis testified that while working at the Linden Avenue residence he considered himself an employee of Respondent because Mr. Katz had "loaned" him to Respondent. Like Petitioner, he was dependent upon Respondent to tell him what to do, when to do it, how to do it, and for Respondent to provide him with the tools necessary to complete his job tasks. He did not consider himself an independent contractor, or subcontractor of Respondent but rather understood himself to be a loaned employee of Respondent.

Based upon the testimony of Respondent, Respondent's witness Steve Billirakis, and Petitioner's testimony, the Arbitrator finds that on July 22, 2011 an employer-employee relationship existed between Respondent and Petitioner.

In regard to issue C, Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds as follows:

The Arbitrator incorporates as if fully set forth herein his findings of fact and conclusions of law set forth in paragraph B above.

The testimony of Petitioner and Respondent regarding the circumstances surrounding the occurrence of July 22, 2011 are consistent and do not represent a real disputed issue. Both parties testified that while performing demolition or cleanup work in the kitchen of the residence, the ceiling of the kitchen collapsed upon Petitioner causing him to be knocked to the ground and pinned under the debris. Respondent testified he had directed Petitioner two remove the kitchen cabinets and a countertop in the residence. Petitioner testified that he was in the process of removing the kitchen cabinets and countertop when the ceiling collapsed upon him. The testimony of Petitioner establishes that Petitioner was in the kitchen at the direction of Respondent, performing his assigned duties or a task associated with his duties. The undisputed evidence establishes that he was both in the course of his employment and performing a task that arose from his employment at the time the ceiling collapsed upon him. The Arbitrator finds that the occurrence of July 22, 2011 was an accident that arose out of and in the course of Petitioner's employment by Respondent

In regard to issue D, What was the date of the accident, the Arbitrator finds as follows:

All of the testimony and relevant medical records establish that the date of the accident was July 22, 2011. The Arbitrator therefore finds that the date of accident was July 22, 2011.

In regard to issue E, Was timely notice of the accident given to Respondent, the Arbitrator finds as follows:

Respondent was present on the jobsite at the time of the occurrence and assisted in extracting Petitioner from underneath the collapsed ceiling. Respondent also testified that he and the homeowner directed Petitioner to the hospital to be evaluated and treated. Respondent also testified that within a week after the occurrence he met with Petitioner and Petitioner's father, and was advised Petitioner was injured. Based upon Respondent's undisputed testimony, the Arbitrator finds that Respondent had timely notice of the July 22, 2011 accident.

In regard to issue F, Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

Petitioner testified that as of the date of the occurrence, he had no difficulty performing his activities of daily living or his job duties. He had no limitations on account of any cervical, thoracic, lumbar or pelvic condition. There is no medical evidence to indicate that Petitioner had any limitations or conditions of ill being prior to the date of the occurrence. Petitioner's testimony regarding the injuries sustained on July 22, 2011 is consistent with the documentation set forth in Petitioner's medical records. Evidence showing a prior condition of good health, an occurrence resulting in accidental injuries, and a course of subsequent medical treatment is sufficient to establish causal connection under the Worker's Compensation act. In addition, all of Petitioner's medical providers attribute Petitioner's condition, and the medical treatment a provided for those conditions, to the occurrence of July 22, 2011. Accordingly, based upon Petitioner's credible testimony and the unrefuted medical evidence, the Arbitrator finds that Petitioner's current condition of ill being is causally related to the accidental injuries sustained on July 22, 2011 period

In regard to Issue G, What were Petitioner's earnings, the Arbitrator finds as follows:

Respondent testified that he agreed to pay Petitioner $10 per hour. Petitioner's Exhibit 10, is a check from Respondent in the amount of $295. Metz Exhibit 2 confirms that Petitioner was paid for 29.5 hours of work. Petitioner also testified that he was to be paid $10 per hour and that he expected to work 40 or more hours per week. Petitioner was injured during his first week of employment and was unable to return to his job after the occurrence. The Petitioner has alleged an average weekly wage of $400.00 an hour. Respondent, Mr. Metz, testified that the Petitioner was to be paid $10.00 an hour but that the work would vary depending upon the job and work that needed to performed. There is a paystub and hour ledger provided by the parties (Petitioner's Exhibit 10 and Respondent's Exhibit 2). Based upon the review of the evidence in question the Arbitrator finds that the Petitioner's average weekly wage in accordance with Section 10 of the Act is $295.00.

In regard to issues H and I, What was Petitioner's age and marital status at the time of the accident, the Arbitrator finds as follows:

Petitioner testified his date of birth is December 27, 1991 and that at the time of the occurrence, he was 19 years old, single with no dependent children. The medical records offered into evidence also reflect Petitioner's date of birth as being December 27, 1991. Therefore, based upon this undisputed and uncontested testimony, the Arbitrator finds that at the time of the July 22, 2011 occurrence, Petitioner was 19 years old, single with no dependent children.

In regard to issue J, Were the medical services that were provided to Petitioner reasonable and necessary, the Arbitrator trying time as follows:

Petitioner's medical records reflect that as a result of the occurrence, he sustained injuries to his head, cervical, thoracic and lumbar spines, and his pelvis. He was appropriately evaluated by both an orthopedic surgeon and spine surgeon for his pelvic and back injuries. He underwent a conservative course of physical therapy and an epidural steroid injection in an effort to treat and cure the effects of these accidental injuries. He was subsequently referred by his spine surgeon to a chiropractic physician for a short course of treatment. Petitioner testified that his condition improved while under the care of his physicians and that as a result of the course of treatment prescribed by his positions, he was released from the care of Dr. Graf on March 7, 2012. Respondent offered no contrary medical evidence or testimony to establish that any of Petitioner's medical treatment was unnecessary or unreasonable. Accordingly, based upon Petitioner's credible testimony and Petitioner's medical records and bills, the Arbitrator finds that the medical services provided to Petitioner following the July 22, 2011 were reasonable and necessary and awards same.

In regard to issue K, What temporary benefits are in dispute, the Arbitrator finds as follows:

Petitioner's medical records reflect that Petitioner was unable to work from July 23, 2011 through March7, 2012 the day he was released from Dr. Graf's care. Respondent admitted he did not pay Petitioner any wage or temporary total disability benefits. Petitioner likewise testified he did not receive any Worker's Compensation benefits during the time that he was under the care of his physicians and temporarily disabled from his employment duties. Accordingly, based upon Petitioner's medical records, Petitioner's credible testimony, and Respondent's admission regarding nonpayment of benefits, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits from July 23, 2011 through his release March 7, 2012, a total of 32 and 5/7 weeks of benefits.

In regard to issue L, What is the nature and extent of the injury, the Arbitrator finds as follows:

Petitioner's Exhibit 5 is the records of the Illinois Spine Institute and Dr. Carl Graf.

Dr. Graf first saw Petitioner on August 19, 2011. Petitioner presented with complaints of neck pain into his shoulders, thoracic pain, as well as in pain the low back. Petitioner also had complaints of pain throughout his left lower extremity. Dr. Graf noted the pain originally was *10/10,* and currently was an 8/10. Petitioner related difficulty with walking secondary to severe neck pain, lumbar pain and lateral leg pain.

Dr. Graf's physical examination revealed that Petitioner had a very antalgic gait, he could not ambulate without a crutch; he could not toe walk, heel walk, perform a tandem gait or squat or rise from a squatting position

Petitioner had limited range of motion of the cervical spine; pain with extension in the posterior aspect of the neck; pain to palpation throughout the neck paraspinal musculature and into the upper thoracic spine.

Muscle strength in the left lower extremity revealed reduced strength of 4/5 with hip flexion secondary to pain in the groin and lateral hip.

Dr. Graf ordered additional diagnostic studies and initiated a course of physical therapy.

On August 26, 2011 Dr. Graff reports that a bone scan of the pelvis found a likely pubis fracture. He ordered a CT scan for further evaluation.

On October 14, 2011 Dr. Graff reports that the MRI of the thoracic spine showed no evidence of a fracture. Dr. Graf recommended continued physical therapy.

On November 4, 2011 Dr. Graf referred Petitioner to Dr. Holly Carobene for pain management.

Petitioner was last scene by Dr. Graf on March 7, 2012. Dr. Graf reported that Petitioner had persistent thoracolumbar pain. He instructed Petitioner to follow up if Chiropractic treatment was not helpful in relieving his pain.

Petitioner's Exhibit 8 are the records of Majercik Physical Therapy. Petitioner was treated at Majercik Physical Therapy from August 26, 2011 through November 11, 2011. Petitioner was seen 27 times for treatment to his cervical, thoracic and lumbar spine as well as for his pelvis. Mr. Majercik's office note dated November 11, 2011 reflects Petitioner continued to have pain in his thoracic spine. Petitioner advised Mr. Majercik that he had been referred to a pain specialist for injections. Petitioner was discharged pending further physician evaluation.

Petitioner's Exhibit 4 is the records of McHenry County orthopedics. On September 12, 2011 Petitioner was evaluated by Dr. Jablonsky for complaints of left groin and left pelvic pain. He provided a history of being injured on July 22, 2011 a portion of a ceiling collapsed on him. He also had complaints of back pain, and neck pain which were being treated by Dr. Carl Graf. Dr. Jablonsky's physical examination revealed discomfort with range of motion, and palpable tenderness in multiple aspects of his pelvis. Dr. Jablonsky also reviewed the x-ray and CT scan of Petitioner's pelvis. His diagnosis was left anterior column and inferior occult ramus fractures. He instructed Petitioner to remain off work and to begin a course of physical therapy.

Petitioner's Exhibit 6 are the records of Comprehensive Pain Care and Dr. Holly Carobene. Petitioner was referred to Dr. Caribbean by Dr. Carl Graf. On November 14, 2011 Petitioner presented to Dr. Carobene with a

history of thoracic pain that radiates to the posterior and anterior chest wall. He also reported pain in the lower aspect of the cervical spine with radiation into the right shoulder. He described the pain as continuous, sharp, dull, and burning. He rated the pain as a six out of 10 at its best and a nine out of 10 at its worst. Lifting, use of his arms, increased activity, walking, and cold weather aggravated his pain.

Her physical examination revealed limited range of motion in his cervical spine, tenderness in the mid thoracic spine area and increased tone in the cervical, thoracic and lumbar spine area. Her impression was cervical radiculopathy and thoracic radiculopathy. She prescribed a Medrol dose pack and directed Petitioner to follow up in two weeks.

On November 23, 2011 Dr. Carobene reports Petitioner obtained no benefit from the Medrol dose pack and therefore recommended an epidural steroid injection.

On November 28, 2011 Dr. Carobene performed a thoracic epidural steroid injection and an epiduralogram at Centegra Hospital.

On December 21, 2011 Dr. Caribbean reports that Petitioner obtained minimal relief from the epidural injection. Her physical exam remained unchanged. She discharged Petitioner with a prescription for tramadol. Her diagnosis remained thoracic radiculopathy

Petitioner testified he made a full recovery from his neck and low back and pelvis injuries. In regard to his mid thoracic back pain, Petitioner stated he continues to feel discomfort in his mid back with certain activities. He is now a student at McHenry County College and does notice the onset of discomfort after sitting for extended periods of time.

The medical records reflect that Petitioner sustained multiple contusions and soft tissue injuries to his cervical, thoracic and lumbar spines as well as a fracture of his pubis ramis. Except for his thoracic spine, Petitioner has made a complete recovery. Dr. Carobene's diagnosis for Petitioner's thoracic condition is thoracic radiculopathy. He does continue to experience mid back discomfort with activity and with prolonged sitting. Based upon Petitioner's young age, Dr. Carobene's diagnosis of thoracic radiculopathy, the ongoing thoracic spine pain, the significant period of temporary disability following the occurrence, and the significant trauma sustained in the occurrence, the Arbitrator finds that Petitioner has sustained a 12.5% loss of use of a person as a whole.

In regard to issue N, Is Respondent due any credit, the Arbitrator finds as follows:

Petitioner testified that the medical expenses itemized in Petitioner's group Exhibit 1 were paid by his father's group health insurance plan. Respondent admitted he did not have workers compensation insurance as of the day of the occurrence and did not pay any benefits to Petitioner nor pay his medical expenses. Accordingly, the Arbitrator finds that the Respondent is not entitled to any credit as provided by section 8(j) of the Worker's Compensation Act.

In regard to Issue O, Whether Respondent had Workers' Compensation Insurance as of the day of the occurrence, the Arbitrator finds as follows:

Respondent testified he did not have workers compensation insurance as of July 22, 2011. Petitioner's Exhibit 9 is a Certificate of No Insurance issued by the National Council on Compensation. Based upon Respondent's admission and Petitioner's Exhibit 9, the Arbitrator finds that Respondent did not have Workers Compensation Insurance on July 22, 2011

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☒ Affirm with computational corrections	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kevin Puckhaber,

Petitioner,

vs.

NO: 11 WC 38520

16IWCC0154

Village of Lake Zurich,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, extent of temporary total disability, medical expenses and prospective medical care and being advised of the facts and law, corrects the computational errors of the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322 (1980).

The Commission notes that while Petitioner did not specifically report to physical therapist Ms. Smith that he injured his left knee or that he had left knee pain during the FCE, it is documented in the FCE report that he had a subjective complaint of right knee giving way on his attempt to descend on the right leg during the category of repetitive kneeling. The FCE was on June 14, 2012. Petitioner did call Dr. Anderson's office on June 19, 2012 and the following telephone encounter was noted: "He was doing his FCE last Thursday and he fell on his right knee. Also stated his left knee hurts too. He wanted this documented in his medical records." Another telephone encounter was noted on June 22, 2012 by Dr. Anderson: "I spoke with Kevin

today. He had spoken with the nursing staff last week to let us know that during his Functional Capacity Evaluation, he fell onto both knees. The right knee took the brunt of the fall but his left knee has also been sore. He has not improved very much since that incident. Kevin has an appointment to see me in about two weeks." On his July 9, 2012 office visit, Dr. Anderson noted: "Kevin Puckhaber is here in follow up for the right knee but also injured his left knee during his functional capacity evaluation (FCE). During his FCE he was squatting, and the right knee gave out, and he fell onto his right knee and also noted left posterolateral knee pain. He did note some swelling in the left knee. He denies any locking, catching, or any instability of either knee." §12 Dr. Bare's opinion of no causal connection for the left knee is based on the lack of reporting of a left knee injury during the FCE. Dr. Anderson opined causal connection for the left knee, based on Petitioner's reporting to him that he injured his left knee during the FCE. Based on the above, the Commission affirms the Arbitrator's finding that a causal relationship exists between the accidental injuries sustained on June 20, 2011 and Petitioner's current condition of ill-being for his right and left knees.

The Commission corrects the computational errors in the Arbitrator's award of TTD and TPD benefits. The Arbitrator found Petitioner temporarily totally disabled for the following periods: September 8, 2011 through April 2, 2012 (a period of 29-5/7 weeks), April 23, 2012 through October 1, 2013 (a period of 75-2/7 weeks), December 21, 2013 through January 5, 2014 (a period of 2-2/7 weeks), June 7, 2014 through August 20, 2014 (a period of 10-5/7 weeks) and December 20, 2014 through January 4, 2015 (a period of 2-2/7 weeks). The Arbitrator found the total of the above periods to be 118 weeks. The Commission finds the correct total of the above periods is 120-2/7 weeks, not 118 weeks (29-5/7 + 75-2/7 + 2-2/7 + 10-5/7 + 2-2/7). Therefore, the Commission finds that Petitioner was temporarily totally disabled for a total period of 120-2/7 weeks at $971.67 per week.

The Arbitrator also found Petitioner temporarily partially disabled for the following periods: October 2, 2013 through December 20, 2013 (a period of 11-3/7 weeks), January 6, 2014 through June 6, 2014 (a period of 21-5/7 weeks), August 21, 2014 through December 19, 2014 (a period of 17-2/7 weeks) and January 5, 2015 through April 21, 2015 (a period of 15-2/7 weeks). The Arbitrator found the total of the above periods to be 65-1/7 weeks. The Commission finds the correct total of the above periods is 65-5/7 weeks, not 65-1/7 weeks (11-3/7 + 21-5/7 +17-2/7 + 15-2/7). Therefore, the Commission finds that Petitioner was temporarily partially disabled for a total period of 65-5/7 weeks at $642.67 per week. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 3, 2015 is hereby affirmed and adopted with the above noted correction of computational errors.

16IWCC0154

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $971.67 per week for a period of 120-2/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $642.67 per week for a period of 65-5/7 weeks, that being the period of temporary partial incapacity for work under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $508.00 for reasonable, necessary and related medical expenses under §8(a) of the Act, subject to the Medical Fee Schedule under §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to prospective medical care and orders Respondent to authorize and pay for treatment prescribed by Dr. Anderson.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury. The Commission notes that Respondent paid $44,035.63 in TTD benefits.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

No bond for the removal of this cause to the Circuit Court by Respondent is due pursuant to §19(f)(2) of the Act. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 4 - 2016
MB/maw
o01/21/16
43

Mario Basurto

Stephen J. Mathis

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

PUCHHABER, KEVIN
Employee/Petitioner

Case# **11WC038520**

16IWCC0154

VILLAGE OF LAKE ZURICH
Employer/Respondent

On 6/3/2015, 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 0.07% 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:

2573 MARTAY LAW OFFICE
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134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

0507 RUSIN & MACIOROWSKI LTD
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CHICAGO, IL 60606

16IWCC0154

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Kevin Puckhaber
Employee/Petitioner

v.

Village of Lake Zurich
Employer/Respondent

Case # **11** WC **38520**

Consolidated cases: _____

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 **Arbitrator Falcioni**, Arbitrator of the Commission, in the city of **Waukegan**, on **April,23, 2015**. 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. [x] 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. [x] 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. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[x] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **June 20, 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 $**75,790.00**; the average weekly wage was $**1,457.50**.

On the date of accident, Petitioner was **45** years of age, ***married*** with **1** dependent children.

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

Respondent shall be given a credit of $**45,035.63** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**45,035.63**.

Respondent is entitled to a credit of $**0.00** under Section 8(j) of the Act.

ORDER

F.
The Arbitrator finds Petitioner has proven by a preponderance of the evidence that he continues to suffer bilateral knee pain and that his current condition of ill-being for the right knee is directly related to his work-injury on June 20, 2011 while employed by Respondent and his left knee pain is related to a fall he suffered during an FCE while treating his right knee injury.

J.
Having found Petitioner's current condition of ill-being is related to his work-injury on June 20, 2011, all medical care provided to Petitioner in order to resolve his bilateral knee issues has been reasonable and necessary. Respondent shall be responsible for medical bills of $508.00, owed to Dr. David Anderson. His bill shall be paid per the statutory medical fee schedule.

K.
The Arbitrator awards prospective medical care which is reasonable and necessary to relieve Petitioner of his pain per the direction of Dr. David Anderson and as set forth more fully herein. Respondent is ordered to provide same.

L.
The arbitrator finds Petitioner is entitled to 118 weeks of temporary total disability benefits at the rate of $971.67 . Respondent is entitled to a credit of $44,035.63. The Arbitrator further finds Petitioner is entitled to 65 and 1/7th weeks of temporary partial disability at the rate of $642.67. Respondent is ordered to pay same.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

Signature of Arbitrator

June 2, 2015
Date

ICArbDec19(b)

JUN 3 - 2015

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KEVIN PUCKHABER Petitioner, vs. VILLAGE OF LAKE ZURICH Respondent.	)	No. 11 WC 38520

ARBITRATOR'S FINDINGS OF FACT

Petitioner, Kevin Puckhaber, was a 45 year old married man with one child under the age of 18, and employed by the Village of Lake Zurich June 20, 2011. Petitioner testified he was employed by Respondent as a firefighter, paramedic and engineer and had been working in that capacity for Respondent for several years. He was working full duty with no restrictions prior to his work-injuries.

Petitioner testified that on June 20, 2011 he injured his right knee while battling a garage fire. He testified that his job was to pull the hose to get water to the fire. He realized he needed to move the fire engine and as he went back to the fire engine, his right foot went into a hole twisting his right knee. He noticed a sharp pain in the front part of his right knee. He reported the injury to his engine chief.

Petitioner presented to Advocate Occupational for an examination on July 20, 2011 (Px 4). He provided a history consistent with that to which he testified to at trial (*id.*). He was diagnosed with a right knee sprain and advised to return to work with no working at height and no squatting (*id.*). He was also given a knee brace (*id.*).

Petitioner was next examined by Dr. Warren Jablonsky on July 25, 2011 (Px 5). He presented with right knee pain from the work-injury and an MRI of the right knee was ordered

(*id.*). Petitioner underwent a right knee MRI on July 26, 2011 which revealed a chondral fissure with chondral flap in the lateral femoral trochlea/femoral trochlear groove, mild patellofemoral degenerative changes and a degenerative signal at the medical meniscus (*id.*).

On July 28, 2011 Dr. Jablonsky injected Petitioner's right knee with 2 cc of Depo-Medrol and 4 cc of Xylocaine to reduce inflammation and help with his pain (*id.*). Dr. Jablonsky saw Petitioner for a follow up on August 10, 2011 and recommended he undergo right knee surgery (*id.*).

Petitioner saw Dr. David Anderson for an examination on August 19, 2011 with similar right knee complaints related to his work-injury (Px 1 at 7-8). Dr. Anderson recommended Petitioner undergo surgery for the right knee and remain off work (Px 1 at 11). Petitioner underwent surgery on September 8, 2011 and the procedures included a right knee arthroscopy with chondroplasty and a Carticel biopsy (Px 1 at 12). Dr. Anderson testified the findings in Petitioner's right knee were consistent with his subjective complaints (Px 1 at 13).

Dr. Anderson saw Petitioner for follow up visits on September 16, 2011, October 10, 2011, November 4, 2011 and December 6, 2011. At all of those visits he recommended Petitioner attend physical therapy and remain off work (Px 1 at 13-15). On December 27, 2011 it was recommended Petitioner progress to work conditioning and remain off work (Px 1 at 15-16). On January 30, 2012 Dr. Anderson recommended Petitioner continue work conditioning and remain off work (Px 1 at 16). Work hardening lasted until March 29, 2012. The discharge note from the physical therapist who conducted the work hardening noted the following:

"...his knee continues to have episodes of giving out while...squatting..Pt demonstrated a squat three times and knee gave out two times..with significant pain reported on the three attempts.."

Petitioner followed up with Dr. Anderson on March 26, 2012 and Petitioner still had some issues with the right knee giving out with full squatting (Px 1 at 16-17). He was advised to do home exercises and return to light duty work on April 2, 2012 (Px 1 at 17). Dr. Anderson saw Petitioner again on April 23, 2012 and Petitioner was still having issues with squatting and kneeling (Px 1 at 17-18). Petitioner was advised to remain off work and see Dr. Verma for a second opinion (Px 1 at 18).

Dr. Nikhil Verma examined Petitioner on May 21, 2012 (Px 2). Dr. Verma noted Petitioner's continuing right knee issues with weakness and difficulty squatting and kneeling (*id.*). He recommended Petitioner undergo a functional capacity evaluation (hereinafter "FCE"). Petitioner underwent an FCE with Christina Smith at Accelerated Rehabilitation on June 14, 2012 (Px 2). The FCE showed Petitioner gave full effort and demonstrated the ability to work at the very heavy physical demand level (*id.*).

Petitioner testified that during the FCE he had an incident early on where he fell on to both knees when his right knee gave out on him. Following the fall, he was suffering some pain to both the right and left knee. He testified that after the FCE was done, the therapist Ms. Smith, brought him ice packs for both his knees. Ms. Smith did not have any recollection of his fall and did not note anything regarding a fall in her FCE report.

Dr. Anderson noted that he had a telephone conversation with Petitioner on June 22, 2012 (Px 1 at 18). His note from that call makes reference to Petitioner speaking with one of his nurses, Diana Birkey, the week prior (*id.*). Petitioner had called with a complaint that he fell during his FCE onto both knees and that "the right knee took the brunt of the fall, but his left

knee has also been sore" (Px 1 at 19). This was Petitioner's first complaint of any left knee issues (*id.*).

Petitioner followed up with Dr. Anderson on July 9, 2012 and again described to him right knee pain and left knee pain from a fall during the FCE (Px 1 at 19-20). Petitioner mentioned that he was squatting during the FCE and his right knee gave out causing him to fall on both knees (Px 1 at 20). Dr. Anderson also noticed some swelling in the left knee (*id.*). After performing a physical examination of the knees, Dr. Anderson recommended Petitioner undergo an MRI of the left knee (Px 1 at 20-21

Petitioner saw Dr. Anderson for a follow up on July 23, 2012 with both right and left knee pains (Px 1 at 21-22). Petitioner noted that the left knee was locking up, clicking and popping causing him to put additional stress on the right knee (Px 1 at 22). Dr. Anderson also noted some swelling in the left knee. Dr. Anderson recommended Petitioner remain off work, have an MRI of the left knee and take medications for both knees (Px 1 at 22-23). The same recommendations were made at a follow up on August 6, 2012 (Px 1 at 23).

An MRI for Petitioner's left knee was done on August 16, 2012 (Px 1 at 24). Petitioner followed up with Dr. Anderson on August 20, 2012 and he believed Petitioner most likely suffered a tear of the posterior horn of the medial meniscus (Px 1 at 25). He testified that the MRI findings were consistent with Petitioner's pain complaints (*id.*). When asked if there was a causal relationship between the fall during the FCE and Petitioner's current left knee issues Dr. Anderson testified, "without having symptoms before and then the reported incident, and then the symptoms after, I would associate at least his symptoms more likely than not from that" (Px

1 at 26). He gave Petitioner a left knee cortisone injection, recommended physical therapy and they discussed the possibility of left knee surgery (*id.*).

At the August 20, 2012 visit Dr. Anderson also looked at Petitioner's right knee (Px 1 at 27). Petitioner was still complaining of difficulty trying to squat, crawl, kneel and using stairs and ladders (*id.*). Based upon Petitioner's ongoing right knee issues as well as the results of the FCE, Dr. Anderson believed Petitioner required permanent work restrictions (Px 1 at 27-28). Dr. Anderson noted in his report that, "I do not feel he is safe with himself or helping others as a full-duty unrestricted firefighter/paramedic" (Px 1 at 28).

Also on August 20, 2012 Petitioner underwent a Section 12 examination with Dr. Aaron Bare (Rx 3 at 6). Dr. Bare opined Petitioner was at maximum medical improvement (hereinafter "MMI") for his right knee and could return to work at full duty (Rx 3 at 11). As for the left knee, Dr. Bare did not believe any injury to the left knee ever occurred during the FCE and that Petitioner simply has some underlying left knee issues (Rx 3 at 13). He did opine that the left knee did require further examination and that Petitioner needed work restrictions related to his left knee (*id.*).

Petitioner saw Dr. Anderson for the left knee again on September 7, 2012 (Px 1 at 28). Dr. Anderson believed Petitioner needed continued physical therapy (Px 1 at 29). Dr. Anderson saw Petitioner for the right knee on September 17, 2012 and recommended Petitioner remain off work (*id.*).

Dr. Anderson saw Petitioner for both knees on October 15, 2012 and he still had complaints with stairs, climbing, kneeling, squatting and stooping (Px 1 at 30). Dr. Anderson prescribed continue physical therapy for the left knee and gave permanent restrictions for the

right knee which precluded Petitioner from returning to work as a firefighter/paramedic (Px 1 at 30-31). When asked why Petitioner could not return to work Dr. Anderson testified, "I didn't feel that he could do that on a consistent basis if needed, especially on a job that may not be – it's not predictable" (Px 1 at 31).

Petitioner saw Dr. Anderson again on November 12, 2012 and December 14, 2012 and he recommended Petitioner continue physical therapy for the left knee, remain off work and discussed possible surgery for the left knee as well (Px 1 at 32). Dr. Anderson saw Petitioner again on January 14, 2013 and injected his left iliotibial band due to the knee pains Petitioner was having (Px 1 at 32-34).

Dr. Anderson saw Petitioner again on February 25, 2013 and Petitioner was still having issues with his left knee locking up (Px 1 at 34-35). Dr. Anderson recommended Petitioner undergo a left knee diagnostic arthroscopy (Px 1 at 35). This was Petitioner's last visit with Dr. Anderson prior to trial (Px 1 at 35-36). Petitioner does have a history of left knee surgery in 1999 and last treated for his left knee in 2005.

Petitioner testified he still has problems with both knees, although his left knee is now worse than the right knee. He testified that he has issues with climbing and descending stairs, and he is forced to use the railings when doing so. He also notices that his right knee still buckles and gives out at lease once per week. In terms of doing his work as a firefighter/paramedic, he testified he cannot kneel down or crawl in order to get to patients. He also noted that his left knee swells often and is very painful. In order to treat his pains, he is currently on 600 mg of Motrin which he takes twice per day. He would also like to undergo the left knee diagnostic arthroscopy recommended by Dr. Anderson.

Regarding the issue (F), is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds the following:

There is no dispute that Petitioner suffered a right knee injury on June 20, 2011 when he stepped in a hole battling a garage fire. His initial right knee injury led him to undergo a right knee arthroscopy with chondroplasty and a Carticel biopsy (Px 1 at 12). Following surgery, Dr. Anderson had Petitioner undergo several months of physical therapy and work conditioning (Px 2 & 3). At the conclusion of therapy and work conditioning, Dr. Verma recommended Petitioner undergo a FCE (Px 2). The dispute in this claim is about what did or did not happen at the FCE.

Petitioner underwent an FCE with Christina Smith at Accelerated Rehabilitation on June 14, 2012 (Px 2). The FCE showed Petitioner gave full effort and demonstrated the ability to work at the very heavy physical demand level (*id.*). It is of note that the FCE report states Petitioner "demonstrated the ability to perform 100% of the physical demands of his job as a firefighter/paramedic" (*id.*). The issue with that statement is that pages 2 and 3 of the FCE report note that Petitioner can only occasionally do several tasks (*id.*).

Petitioner testified that during the FCE he had an incident early on where he fell on to both knees when his right knee gave out on him. Following the fall, he was suffering some pain to both the right and left knee. He testified that after the FCE was done, the therapist Ms. Smith, brought him ice packs for both his knees.

Dr. Anderson noted that his office had a telephone conversation with Petitioner on June 22, 2012 (Px 1 at 18). His note from that call makes reference to Petitioner speaking with one of

his nurses, Diana Birkey, the week prior (*id.*). Petitioner had called with a complaint that he fell during his FCE onto both knees and that "the right knee took the brunt of the fall, but his left knee has also been sore" (Px 1 at 19). This was Petitioner's first complaint of any left knee issues (*id.*).

Petitioner followed up with Dr. Anderson on July 9, 2012 and again described to him right knee pain and left knee pain from a fall during the FCE (Px 1 at 19-20). Petitioner mentioned that he was squatting during the FCE and his right knee gave out causing him to fall on both knees (Px 1 at 20). Dr. Anderson also noticed some swelling in the left knee (*id.*).

Ms. Smith, who testified per subpoena and was paid for her time by Respondent, testified that she did not have any recollection of Petitioner falling and did not note anything regarding a fall in her FCE report. When questioned on cross examination, Ms. Smith admitted that the FCE test was performed in an open gym where several other people were present. She also admitted that she was speaking with other people during Petitioner's FCE about unrelated matters. She stated that this did not distract her from observing Petitioner during the FCE. Following the FCE, Ms. Smith did not perform the standard post FCE testing including questioning Petitioner about how he was feeling physically. She also never discussed the results of the FCE with Dr. Anderson at any time. She testified that she had no independent recollection of what had occurred during the FCE but relied on her notes as to what had occurred. She testified that she did note that Petitioner's ".right knee was giving way during the kneeling portion of the exam.." and that Petitioner had to support himself by leaning on a table on his way down to the floor to perform the kneeling portion of the FCE.

The Arbitrator notes that the present case involves contraqdictory testimony given by two apparently credible witnesses. The Arbitrator begins his analysis of said testimony by first noting the evidence relevant to the issue of whether Petitioner sustained a fall while undergoing an FCE related to his injured right knee, that is undisputed. It is undisputed that Petitioner had suffered a right knee injury for which he had undergone surgery. It is also undisputed that Petitioner had undergone work hardening and physical therapy following the surgery. It is undisputed that the discharge note from work hardening had noted that Petitioner had demonstrated that his right knee had given out two of the three times he had attempted squatting for the therapist who had conducted the work hardening. It is undisputed that physical therapist Christine Smith had no independent recollection of the FCE she performed on Petitioner. It is undisputed that she noted that Petitioner's right knee was giving out during certain portions of the exam. It is undisputed that she did not conduct, or at least did not record, a post FCE pain survey of Petitioner. It is undisputed that she did not record Petitioner's knee giving out and him falling on both knees. It is undisputed that Petitioner had made no complaints of left knee pain or problems prior to the FCE. It is undisputed that Petitioner called Dr. Anderson's office shortly after the FCE and reported the fall that he claims had occurred during the FCE in substantially the same terms as those he testified to at trial.

Given the above undisputed facts, the Arbitrator finds that is more likely than not that Petitioner's testimony regarding his fall during the FCE was in fact credible and based on that finding, the Arbitrator finds that Petitioner did in fact suffer a fall during his FCE as he described in his testimony. On the issue of a causal connection between said fall and the current condition of ill being with regard to Petitioner's left knee, the Arbitrator notes the following:

When asked if there was a causal relationship between the fall during the FCE and Petitioner's current left knee issues Dr. Anderson testified, "without having symptoms before and then the reported incident, and then the symptoms after, I would associate at least his symptoms more likely than not from that" (Px 1 at 26). The Arbitrator notes that Dr. Bare, Respondent's IME, opined that Petitioner did not in fact sustain a fall during the FCE and that based on this opinion, found that there was no causal connection between said non existent fall and Petitioner's current condition of ill being.

Wherefore, based on the record as a whole, the Arbitrator finds Petitioner has proven by a preponderance of the evidence that he continues to suffer bilateral knee pain and that his current condition of ill-being for the right knee is directly related to his work-injury on June 20, 2011 while employed by Respondent and his left knee pain is related to a fall he suffered during an FCE while treating his right knee injury and is therefore compensable.

Regarding issue (J), were medical services provided reasonable and necessary, the Arbitrator finds the following:

Having found Petitioner's current condition of ill-being is related to his work-injury on June 20, 2011, all medical care provided to Petitioner in order to resolve his bilateral knee issues has been reasonable and necessary, per the testimony of Dr. Anderson. Respondent shall be responsible for medical bills of $508.00, owed to Dr. David Anderson. His bill shall be paid per the statutory medical fee schedule.

Regarding the issue (K), Is Petitioner entitled to any prospective medical care, the Arbitrator finds the following:

All of Petitioner's medical care to date has been reasonable and necessary. Petitioner testified he still has problems with both knees although his left knee is now worse than the right knee. He testified that he has issues with climbing and descending stairs, and he is forced to use the railings when doing so. He also notices that his right knee still buckles and gives out at least once per week. In terms of doing his work as a firefighter/paramedic, he testified he cannot kneel down or crawl in order to get to patients. He also noted that his left knee swells often and is very painful. In order to treat his pain, he is currently on 600 mg of Motrin which he takes twice per day. He would also like to undergo the left knee diagnostic arthroscopy recommended by Dr. Anderson.

Dr. Anderson saw Petitioner on February 25, 2013 and Petitioner was still having issues with his left knee locking up (Px 1 at 34-35). Dr. Anderson recommended Petitioner undergo a left knee diagnostic arthroscopy (Px 1 at 35). This was Petitioner's last visit with Dr. Anderson prior to trial (Px 1 at 35-36).

Noting the findings as set forth above regarding causal connection and reasonableness and necessity of past medical care, and based on the record as a whole, the Arbitrator awards prospective medical care consisting of the surgery as diagnosed by Dr. Anderson.

Regarding the issue (L), what temporary benefits are in dispute, the Arbitrator finds the following:

Having found Petitioner's current condition of ill-being is related to his June 20, 2011 work-injury, he is entitled to any unpaid temporary total disability benefits and temporary partial disability benefits he should have been paid while he was authorized off work or working light duty.

Based upon Petitioner's ongoing right knee issues as well as the results of the FCE, Dr. Anderson believed Petitioner required permanent work restrictions (Px 1 at 27-28). Dr. Anderson noted in his report that "I do not feel he is safe with himself or helping others as a full-duty unrestricted firefighter/paramedic" (Px 1 at 28). The Arbitrator notes the stipulations made on the Request for Hearing form (Arbx1) and the testimony of Dr. Anderson regarding Petitioner's ability to work full or light duty, and Petitoiner's testimony, undisputed, that he did not feel he could safely engage in his occupation of firefighter/paramedic given the permanent work restrictions given him by Dr. Anderson as well as the evidence entered into the record regarding Petitioner's attempts to work at other jobs during this period of time, and finds as follows:

Petitioner is entitled to TTD benefits from September 8, 2011 through April 2, 2012, April 23, 2012 through October 1, 2013, December 21, 2013 through January 5, 2014, June 7, 2014 through August 20, 2014 and December 20, 2014 through January 4, 2015, or 118 weeks of temporary total disability benefits at the rate of $971.67 06. Respondent is entitled to a credit of $44,035.63.

Petitioner is entitled to TPD benefits from October 2, 2013 through December 20, 2013, January 6, 2014 through June 6, 2014, August 21, 2014 through December 19, 2014 and January 5, 2015 through April 21, 2015. Petitioner was making $16.45 per hour for thirty hours per week during those times meaning his wages were $493.50 per week. Petitioner returned to work as a

school bus driver during the TPD periods. Basd on this evidence the Arbitrator finds that Petitioner is entitled to 65 and 1/7th weeks of temporary partial disability at the rate of $642.67.

ARCHIVE

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Causal connection	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

EVA WINTERS,

Petitioner,

vs. NO: 11 WC 41259

HARDIN COUNTY GENERAL HOSPITAL,

Respondent,

16IWCC0136

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, temporary total disability, and nature and extent, and being advised of the facts and law, reverses the Decision of the Arbitrator on the issue of causation but adopts the Findings of Fact, which is attached hereto and made a part hereof, with the additions and modifications outlined below.

Petitioner sustained an accidental injury to her left knee on October 22, 2009, while transporting an obese patient into a bariatric bed. Respondent does not dispute that certain medical expenses, including arthroscopic surgery on January 28, 2011, are causally related to this injury. However, Respondent argues that Petitioner's need for a total knee replacement is causally related to her underlying osteoarthritis and not related to her work injury.

Petitioner testified that she had no history of left knee pain or treatment prior to her work injury and there are no medical records to dispute this. Dr. Young, who performed cortisone injections, an arthroscopy with tricompartmental chondroplasty and partial lateral meniscectomy on January 28, 2011, and a series of five Supartz injections, opined on October 13, 2011, that it is possible that Petitioner may have had some underlying arthrosis and this might have been exacerbated by her work injury.

Dr. Morgan, who Petitioner was referred to by Dr. Young, opined on November 4, 2011, that Petitioner has "at least aggravated her degenerative arthritis to the point that she needs a total knee." He performed the total knee replacement on December 19, 2011. He affirmed his

opinion in his deposition testimony that Petitioner's work injury aggravated her arthritis to the point that she became significantly more symptomatic necessitating surgery. He testified that Petitioner was "rather vague" in terms of her mechanism of injury but he thought it was during a lifting activity. He admitted that it could be very conceivable that Petitioner had an aggravation of her symptoms but not an actual change in her condition when she moved the patient. However, when asked if Petitioner could have had a temporary aggravation, he stated that Petitioner's symptoms were not temporary but, rather, ongoing and did not respond to therapy, arthroscopy, and viscoelastic therapy.

Respondent argues that Dr. Morgan did not have an adequate understanding of Petitioner's mechanism of injury to credibly opine that it had aggravated her osteoarthritis. Interestingly, Respondent had Petitioner examined, pursuant to §12 of the Act, by Dr. Odegard on April 26, 2010, about six months after her injury. He opined that Petitioner sustained a mild left knee injury and had knee pain consistent with mild osteoarthritis. He wrote, "Her current complaints do seem to be directly related to her injury of 10/22/09 as she had no symptoms prior to that point. She may have had some mild osteoarthritic changes, but we have no documentation of this." He felt that Petitioner had not reached maximum medical improvement and recommended another cortisone injection, continued physical therapy, and possible viscosupplementation injections "or eventually a knee arthroscopy as her symptoms do sound like they could be related to a meniscus tear despite her MRI," which only showed degenerative changes without a definite tear. In other words, Dr. Odegard found a causal connection between Petitioner's work injury and her increased symptoms after the work injury.

Instead of having Petitioner examined again by Dr. Odegard after her arthroscopic surgery on January 28, 2011, Respondent had her examined by a different §12 physician, Dr. Gross, on May 12, 2011. Dr. Gross opined that Petitioner sustained only a temporary aggravation of her pre-existing osteoarthritis and that her need for a total knee replacement is not related to the work injury. He believed that Petitioner lifting the patient with her left knee braced against the bed would not change the natural course of her arthritis and is similar to many activities of daily living such as putting groceries on your knee, opening your door with your knee, bringing groceries up the stairs, and taking a grocery bag and bracing it on your knee as you close the car door. He did not see any signs of acute trauma on Petitioner's MRI that would indicate a serious enough injury to permanently aggravate her arthritis.

We find two major problems with Dr. Gross' opinion. First, Petitioner's mechanism of injury at work is much more forceful than any of the activities of daily living that Dr. Gross compared it to. Second, it is undisputed that Petitioner did not have any left knee problems, pain, or treatment prior to her work injury. After the injury, she treated continually with physical therapy, medications, cortisone injections, and arthroscopic surgery (debriding and shaving the lateral meniscus, medial femoral condyle, and proximal tibia). These did not alleviate her condition and the records show that Petitioner's pain increased during "aggressive therapy" after the arthroscopy. (See Dr. Young, 3/24/11). When a series of five Supartz injections also gave no improvement, the next step was a total knee replacement. Dr. Gross admitted that it would be speculative to say that Petitioner would have needed treatment for her left knee in the absence of the work injury. The bottom line is that there was nothing "temporary" about her aggravation. Therefore, we find that Petitioner's work injury was a contributing factor in her need for the total knee replacement and reverse the Arbitrator's decision on the issue of causation.

Based on our finding regarding causation, we find that Petitioner is entitled to 70-1/7 weeks of temporary total disability from January 28, 2011, when Petitioner underwent her first

16IWCC0136

surgery, through June 1, 2012, which is the date that she was released by Dr. Morgan after her total knee replacement. We also award the outstanding medical bills contained in Petitioner's Exhibit 12, subject to the fee schedule in §8.2 of the Act. Finally, we find that Petitioner's injury has caused permanent partial disability to the extent of 45% loss of use of the left leg under §8(e) of the Act. Petitioner testified that standing makes her knee more painful and swells. Her pain is normally about a 4 or 5 out of 10. She takes prescribed pain medications occasionally when the pain is bad. Petitioner testified that she has issues with mobility and going up and down steps. She has difficulty squatting, pivoting, and running, which makes her unable to return to her previous job as an emergency room nurse. However, she is still able to work as a nurse in a different department.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $711.41 per week for a period of 70-1/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $640.27 per week for a period of 96.75 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 45% loss of use of the left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the outstanding medical expenses contained in Petitioner's Exhibit 12 under §8(a) of the Act, subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 29 2016

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

SE/
O: 2/10/16
49

[illegible]

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WINTERS, EVA
Employee/Petitioner

Case# **11WC041259**

HARDIN COUNTY GENERAL HOSPITAL
Employer/Respondent

16IWCC0136

On 2/25/2015, 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 0.06% 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:

5236 CULLEY FEIST KUPPART & TAYLOR
KREIG B TAYLOR
617 E CHURCH ST SUITE 1
HARRISBURG, IL 62946

1109 GAROFALO SCHREIBER & STORM
JAMES CLUNE
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

☐ 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

Eva Winters
Employee/Petitioner

v:

Hardin County General Hospital
Employer/Respondent

Case # **11** WC **41259**

Consolidated cases: _____

16IWCC0136

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 **Ed Lee**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **1/8/2015**. 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 **10/22/2009**, 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, in part,** causally related to the accident.

In the year preceding the injury, Petitioner earned **$55,489.72**; the average weekly wage was **$1,067.11**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **0** dependent children.

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$37,298.73** for TTD, $ for TPD, $ for maintenance, and **$5,000.00** for other benefits, for a total credit of **$42,298.73**.

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

ORDER

The petitioner is entitled to an award of 40% loss of use of her left leg due to cartilage damage to the knee related to the accident in question. The ongoing condition of the left knee, the degeneration prompting the prescription for an additional surgery (knee replacement) beyond the surgery of January 28, 2011 is related to a preexisting degenerative condition personal to the petitioner, to which she returned to baseline; the degenerative condition not being caused or permanently aggravated by the accident. The petitioner is entitled to 51 & 3/7 weeks of temporary total disability from January 28, 2011 through January 23, 2012. The respondent shall receive credit for all benefits paid and all related medical care associated with the conclusions of the Arbitrator in the attached findings under paragraph "J" shall be subject to the provisions of Sections 8(a) and 8.2 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.

Signature of Arbitrator

2/17/15
Date

FEB 25 2015

Findings of Fact:

The petitioner, Eva Winters, was working as a registered nurse at Hardin County General Hospital, on October 22, 2009. She was assisting in the movement of a patient when she felt pain in her left knee. The specific mechanism of injury was that the petitioner had her left leg on the ground and her knee pushed against the bed. Her right knee was on the bed itself.

The incident was at the end of her shift. She continued to work for months thereafter while she treated. She received as many as five injections and received therapy. The treatment did not restore the knee to be symptom-free so surgery was recommended.

On January 28, 2011 underwent a left knee arthroscopy by Dr. Young. This included a tricompartmental chondroplasty with partial lateral menisectomy. At the time of the surgery it was noted that the petitioner had significant degeneration and wear of the cartilage.

Subsequent steroid injections and viscosupplementation injections were prescribed post surgery. The petitioner continued to have discomfort. Dr. Morgan (PX 9) saw the petitioner on June 1, 2011 and concluded that a knee replacement would be an option for the petitioner.

The petitioner was evaluated by Dr. Gross (RX 1) pursuant to Section 12 of the Act. Dr. Gross reviewed all of the medical records and diagnostic films associated with the petitioner's care. Gross concluded that the petitioner's ongoing condition was related to her personal, degenerative, osteoarthritic condition and that she had fully recovered from the temporary aggravation she had experienced due to the minor accident of October 22, 2009. (RX 1, pp. 14, 16 -17, 18 -19)

The petitioner was referred to Dr. Morgan by Dr. Young. Dr. Morgan concluded that the petitioner aggravated her preexisting degenerative arthritis when she was transferring the patient. (PX 9, pp. 8 – 9) Dr. Morgan agreed that the cartilage tears he saw on the MRI film could have resulted from the petitioner's degenerative condition. (PX 9, pp. 18 – 19) Dr. Morgan did not know the mechanism of the petitioner's claimed injury when moving the patient, only that the petitioner complained of pain thereafter. (PX 9, pg. 19) Dr. Morgan could not distinguish between what the accident allegedly caused and what the degenerative process caused. (PX 9, pg. 21) Dr. Morgan also agreed that the petitioner could have had an increase in symptoms without a change in her degenerative condition. (PX9, pp. 22 – 23)

On December 19, 2011 the petitioner had a knee replacement. (PX 9, pg. 9) The petitioner has since returned to work as a registered nurse, but in a capacity as a psychiatric nurse with less physical activity.

Legal Standard:

A decision by the Commission cannot be based upon speculation or conjecture. Deere and Company v Industrial Commission, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. Illinois Institute of Technology v. Industrial Commission, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a casual connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. Three "D" Discount Store v Industrial Commission, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

The burden is on the Petitioner seeking an award to prove, by a preponderance of credible evidence, all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. Martin vs. Industrial Commission, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. Smith v Industrial Commission, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. U.S. Steel v Industrial Commission, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).

It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. Board of Trustees of the University of Illinois v. Industrial Commission, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); see also Hansel & Gretel Day Care Center v Industrial Commission, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991). "[A]lthough medical testimony as to causation is not necessarily required, where the question is one within the knowledge of experts only, and not within the common knowledge or comprehension of laymen, expert testimony is necessary to show that a claimant's work activities caused the condition complained of." Interlake Steel v. Industrial Commission, 136 Ill. App. 3d 740 (1985). See also Ledbetter v State of Illinois, 13 IWCC 0131, regarding the relative knowledge of testifying experts.

The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred.

However, that testimony must be proved credible. Caterpillar Tractor vs. Industrial Commission, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. Neal vs. Industrial Commission, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances [emphasis added] support the decision. See generally, Gallentine v. Industrial Commission, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), see also Seiber v Industrial Commission, 82 Ill.2d 87, 411 N.E.2d 249 (1980), and Caterpillar v Industrial Commission, 73 Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. O'Dette v. Industrial Commission, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); Hosteny v Workers' Compensation Commission, 397 Ill.App. 3d 665, 674 (2009).

Conclusions of Law:

F.
Is Petitioner's current condition of ill-being causally related to the injury of October 22, 2009?

The petitioner sustained a knee strain on October 22, 2009 when she pressed her knee up against a bed while helping to move a patient. Conceivably this may have aggravated some underlying cartilage damage associated with the petitioner's preexisting left knee osteoarthritis. However, the nature of the alleged accident was so minor that her treating physician, Dr. Morgan (PX 9), agreed that she may merely have caused a symptom aggravation and did not necessarily aggravate her preexisting condition. In fact, Dr. Morgan conceded that he did not even know the nature or mechanism of her injury to give an opinion as to whether the accident could have aggravated her condition. Her relied on the petitioner's conclusion that she had injured herself in that fashion, having no independent knowledge of the accident himself from the petitioner or from other records.

Dr. Gross (RX 1) was very clear in his testimony about the lack of significant trauma and the nature of the significant trauma necessary to aggravate or permanently change a preexisting arthritic condition. Gross concluded that simply pressing one's knee against a hospital bed is an insufficient mechanism to aggravate a preexisting arthritic condition.

The Arbitrator agrees with the conclusions of Dr. Gross. The petitioner may have sustained a temporary exacerbation of her knee symptoms, but did not aggravate her arthritic condition. While the conservative care and the arthroscopy may have been related to the work event, the need for a knee replacement was not.

The preponderance of the evidence favors the opinions of Dr. Gross who had a greater knowledge of the facts associated with the accident and the diagnostics associated with the petitioner. The Arbitrator finds that the petitioner may have sustained an aggravation of some preexisting meniscal tears, but did not sustain an aggravation of the underlying arthritic condition. The degenerative process in the petitioner's knee was not aggravated or accelerated, but continued on and, independent of the work incident, was the precipitating factor in the need for the petitioner's knee replacement two years later.

J.

Were the medical services provided to the petitioner reasonable and necessary? Has respondent paid all appropriate charges for all reasonable and necessary medical services?

The Arbitrator agrees with the conclusions of Dr. Gross regarding the treatment needed for the results of the accident of October 22, 2009. The arthroscopic surgery, the steroid injections, and the physical therapy are all related to the effort to diagnose and treat the petitioner's knee injury and possible meniscal aggravations. The viscosupplementation is a treatment for arthritis which, in this petitioner, was a preexisting condition which was not permanently changed or altered, nor permanently aggravated, nor accelerated as a result of the minor work accident.

K.

What temporary benefits are in dispute?

The petitioner lost time from work, but only after her arthroscopy on January 11, 2011. She continued to treat thereafter, but any lost time after December 19, 2011 appears to have been related to the knee replacement surgery and not to the residuals of the original accident of October 22, 2009. The parties stipulated to lost time from January 28, 2011 to January 23, 2012, with the petitioner seeking additional lost time thereafter. Temporary total disability is confined to 51 & 3/7ths weeks from January 28, 2011 to January 23, 2012.

L.

What is the nature and extent of the injury?

The petitioner, per the testimony of Dr. Gross, may have aggravated, on a temporary basis, her preexisting knee condition that may have had within it some meniscal tears. Both Dr. Gross and Dr. Morgan agreed that the petitioner's symptoms could have manifested or been aggravated by the work accident. However, the preexisting degenerative condition accounted for the need for the knee replacement.

The petitioner appears to have sustained some meniscal fraying and tears that could have been related to the arthritic condition in her knee and could have

been aggravated by the work accident without an aggravation of the underlying osteoarthritis. The Arbitrator concludes that the petitioner sustained a 40% loss of use of her left knee as a result of the aggravation of the preexisting soft tissue damage in her left knee, but does not conclude that the petitioner aggravated the degenerative osteoarthritic condition itself.

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Javier Perez,

Petitioner,

vs.

NO: 11 WC 43292
11 WC 36403
11 WC 36565
11 WC 36475

State of Illinois-DHS,

Respondent,

16IWCC0156

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner, herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, medical, prospective medical, causal connection, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 26, 2015 is hereby affirmed and adopted.

No bond is required for State of Illinois cases.

DATED: MAR 4 - 2016

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:1/7/16
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PEREZ, JAVIER
Employee/Petitioner

Case# **11WC043292**

11WC036403
11WC036565
11WC036475

STATE OF ILLINOIS-DHS
Employer/Respondent

16IWCC0156

On 5/26/2015, 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 0.08% 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:

2934 BOSHARDY LAW OFFICE PC
JOHN BOSHARDY
1610 S 6TH ST
SPRINGFIELD, IL 62703

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

5002 ASSISTANT ATTORNEY GENERAL
JOSEPH BLEWITT
500 S SECOND ST
SPRINGFIELD, IL 62706

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

1745 CMS - RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

CERTIFIED as a true and correct copy pursuant to 820 ILCS 305/14

MAY 26 2015

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

16IWCC0156

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

Javier Perez
Employee/Petitioner

v.

State of Illinois - DHS
Employer/Respondent

Case # 11 WC 43292

Consolidated cases: 11 WC 36403
11 WC 36565 and 11 WC 36475

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 William R. Gallagher, Arbitrator of the Commission, in the city of Quincy, on April 1, 2015. 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 August 1, 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 not sustain an accident that arose out of and in the course of employment.

Petitioner's current condition of ill-being is not causally related to the accident.

In the year preceding the injury, Petitioner earned $65,000.00; the average weekly wage was $1,250.00.

On the date of accident, Petitioner was 48 years of age, married with 0 dependent child(ren).

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 $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00.

Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

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.

William R. Gallagher, Arbitrator

May 20, 2015
Date

MAY 26 2015

Findings of Fact

Petitioner filed four Applications for Adjustment of Claim which alleged he sustained repetitive trauma injuries arising out of and in the course of his employment for Respondent. In cases 11 WC 36565 and 11 WC 36475, Petitioner alleged dates of accident (manifestations) of April 8 and April 21, 2011, respectively, and that Petitioner sustained repetitive trauma to the right upper extremity. In cases 11 WC 43292 and 11 WC 36403, Petitioner alleged dates of accident (manifestations) of August 1 and September 13, 2011, respectively, and that Petitioner sustained repetitive trauma to the left upper extremity (Petitioner's Exhibit 1). In all four cases, Respondent disputed liability on the basis of accident, notice and causal relationship.

Petitioner began working for Respondent at the Joliet Treatment and Detention Facility in August, 2002. He was subsequently transferred to the Rushville Treatment and Detention Facility in August, 2006.

Petitioner testified that during the time he worked at the Joliet facility, he used Folger-Adams keys on cell doors, chuckholes and gates. Petitioner estimated that during a typical shift he would perform more than 100 Folger-Adams key turns. Petitioner stated that, because his hands would get tired during a shift, he would alternate using the Folger-Adams keys between his right and left hands. Joliet was an old facility and did not have any doors operated by a computer.

In addition to the preceding, when Petitioner was working at the Joliet facility, he also performed other duties that involved the repetitive use of his hands. This included doing "takedowns" which was physically restraining combative residents, cuffing/uncuffing residents and typing of reports.

Petitioner testified that his job duties at the Rushville facility were essentially the same as what they were at the Joliet facility. Petitioner continued to use Folger-Adams keys at Rushville but not to the same extent that he did at Joliet. Rushville is a newer facility then Joliet, so most of the doors were opened/closed via computer. Petitioner stated that he still used Folger-Adams keys to open/close chuckholes.

Petitioner also stated that he used "medium" sized keys which were larger than house keys but smaller than Folger-Adams keys to gain access to various pods in the Rushville facility. These pods could be opened by computer, but they could also be opened with a key. Petitioner stated that he would many times use a key to open a door instead of waiting for the control room to open the door via computer.

Kevin Winters, Assistant Security Director, at Rushville, testified at the trial of this case. Winters reviewed the Demands of the Job form dated October 13, 2011, which he completed and signed (Petitioner's Exhibit 3). Winters agreed that the form stated that Petitioner used his hands for gross manipulation or activities that required grasping, twisting and handling four to six hours per day.

Winters also testified that 80% of the doors in Rushville were computer controlled and only 20% required the use of Folger-Adams keys. He did agree that the use of Folger-Adams keys was not limited to doors and could also be used on hatches, chuckholes, etc.

Dale Kunkel, the Assistant Facility Director, also testified at the trial. Kunkel confirmed that Petitioner used Folger-Adams keys and that he generally carried 40 keys with him. He agreed Petitioner would use Folger-Adams keys on both doors and chuckholes. Kunkel also acknowledge that Petitioner informed him of having sustained a left hand injury and the report of October 6, 2011, regarding same (Petitioner's Exhibit 2).

Greg Scott, the Program Director at Rushville, also testified at the trial. Scott confirmed that he had notice that Petitioner sustained a right hand injury and identified the injury report dated April 27, 2011 (Petitioner's Exhibit 4).

Petitioner testified that he began to experience symptoms of sharp pain in his right hand/wrist and that it was getting tired upon active use sometime in February, 2011. Petitioner was initially seen by Dr. Jennifer Schroeder, on February 4, 2011. At that time, Petitioner had complaints of tingling in the right hand, primarily in the thumb and first two fingers of approximately one month. Dr. Schroeder opined Petitioner had right carpal tunnel syndrome and prescribed a splint. She also ordered an EMG/nerve conduction study (Petitioner's Exhibit 5).

On April 8, 2011, Petitioner was seen by Dr. David Gelber, who performed an EMG/nerve conduction study which confirmed that Petitioner had moderately severe right carpal tunnel syndrome (Petitioner's Exhibit 6). Petitioner subsequently reported his injuries as swelling/pain in the right wrist from repetitious locking/unlocking of gates/doors on April 21, 2011 (Petitioner's Exhibit 4).

At the direction of Respondent, Petitioner was examined by Dr. James Williams, an orthopedic surgeon, on July 6, 2011. In connection with his examination of Petitioner, Dr. Williams reviewed medical records provided to him by Respondent. Dr. Williams opined that Petitioner may have had right and left carpal tunnel syndrome; however, he also opined that the carpal tunnel syndrome was not related to Petitioner's turning keys at his work because Petitioner's job duties did not involve vibration or significant repetition (Respondent's Exhibit 1).

On August 29, 2011, Petitioner was again seen by Dr. Schroeder, primarily for left hand symptoms. At that time, Petitioner attributed his hand symptoms to repetitive typing and turning locks at work. Dr. Schroeder again ordered an EMG/nerve conduction study (Petitioner's Exhibit 5).

On September 13, 2011, Petitioner was again seen by Dr. Gelber, who performed an EMG/nerve conduction study on the left hand which confirmed that Petitioner had moderately severe left carpal tunnel syndrome (Petitioner's Exhibit 6). On October 7, 2011, Petitioner informed Respondent that he had left carpal tunnel syndrome as a result of repetitive motion of locking/unlocking doors (Petitioner's Exhibit 4).

Petitioner subsequently sought treatment from Dr. Christopher Wottowa, an orthopedic surgeon, on March 12, 2012. At that time, Petitioner informed Dr. Wottowa that he did a significant amount of keying at work and that he had been having progressive symptoms of numbness/tingling in both hands. Dr. Wottowa opined that Petitioner had bilateral carpal tunnel syndrome, the right being worse than the left and he recommended Petitioner undergo carpal

tunnel release surgeries, initially recommending that they proceed with doing the right hand first (Petitioner's Exhibit 6).

Dr. Wottowa performed right and left carpal tunnel release surgeries on May 22 and June 12, 2012, respectively. When Dr. Wottowa saw Petitioner on June 25, 2012, he stated that Petitioner would be released to return to work in one weeks time (Petitioner's Exhibit 6).

Dr. Williams was deposed on November 1, 2012, and his deposition testimony was received into evidence at trial. Dr. Williams' testimony was consistent with his medical report and he reaffirmed the opinions contained therein. While he agreed that Petitioner had bilateral carpal tunnel syndrome, he opined that Petitioner's work activities neither aggravated nor contributed to the condition. Dr. Williams stated that the force required in turning keys was insufficient to aggravate or contribute to the condition. Further, Dr. Williams noted that Petitioner had other risk factors that predisposed him to the condition, specifically, that Petitioner was an insulin dependent diabetic and that he had increased BMI (Respondent's Exhibit 2; pp 14-17).

On cross-examination, Dr. Williams agreed that he did not know precisely how much key turning Petitioner did on a day-to-day basis and that repetitive use of the hand is a known causative factor of carpal tunnel syndrome. He also agreed that causality of carpal tunnel syndrome is based upon a combination of an individual's personal predispositions or risk factors, genetic factors and environmental exposures at work (Respondent's Exhibit 2; pp 23-26).

Dr. Wottowa was deposed on April 7, 2014, and his deposition testimony was received into evidence at trial. Dr. Wottowa's testimony in regard to his diagnosis and treatment of Petitioner's bilateral carpal tunnel syndrome condition was consistent with his medical records (Petitioner's Exhibit 9; pp 7-11).

Dr. Wottowa acknowledged that Petitioner was predisposed to development of carpal tunnel syndrome because Petitioner had type II diabetes and his BMI put him in the obese range. When questioned about Petitioner's work activities, Dr. Wottowa opined that Petitioner's forceful extension and flexion of the wrist in opening doors and closing locks would be an aggravating factor (Petitioner's Exhibit 9; pp 11-15).

On cross-examination, Dr. Wottowa agreed that he did not have specific information about how many times Petitioner would turn a key in an hour, that he did not know what a Folger-Adams key was, and that he had no knowledge as to how much force was required to turn such a key (Petitioner's Exhibit 9; pp 21-25).

At trial, Petitioner testified that he still experiences some pain, numbness and stiffness in both hands, more so in the right than left. Petitioner acknowledged that he did return to work to his regular job for Respondent.

At trial, Petitioner's counsel made a hearsay objection to Respondent's Exhibit 1, the narrative report of Respondent's Section 12 examiner, Dr. Williams. At that time, the Arbitrator sustained the objection and rejected the exhibit. However, it was subsequently determined that Petitioner's

counsel had waived his hearsay objection and withdrew same. Accordingly, Respondent's Exhibit 1 is part of the record in this case.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner did not sustain a repetitive trauma injury to his left upper extremity arising out of and in the course of his employment for Respondent that manifested itself on August 1, 2011, and that his present condition of ill-being is not related to his work activities.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified that he used both Folger-Adams keys and what he described as "medium" size keys in a repetitive nature while working at the Rushville facility. However, it was noted that unlike the Joliet facility, the Rushville facility had computer controlled doors that did not require the use of Folger-Adams keys.

The testimony of both Kevin Winters and Dale Kunkel confirmed Petitioner's repetitive use of both hands/wrists while performing his job duties.

Both Petitioner's treating physician, Dr. Wottowa, and Respondent's Section 12 examiner, Dr. Williams, agreed that Petitioner had bilateral carpal tunnel syndrome.

Dr. Williams opined that Petitioner's work activities did not aggravate or contribute to the carpal tunnel syndrome condition because the amount of force in turning keys was insufficient to aggravate or contribute to that condition and that Petitioner had other risk factors, specifically, diabetes and an increased BMI.

While Dr. Wottowa opined that Petitioner's forceful extension and flexion of the wrist in turning keys would be an aggravating factor, Dr. Wottowa had minimal information regarding what repetitive activities Petitioner engaged in while at work. Specifically, Dr. Wottowa did not have any knowledge about the number of times Petitioner used a Folger-Adams key or the amount of force required to turn it.

The Arbitrator acknowledges Dr. Wottowa to be a well qualified expert; however, Dr. Wottowa lacked sufficient details of Petitioner's work duties to give a definitive opinion as to whether there was a causal relationship between Petitioner's work activities and the carpal tunnel syndrome condition.

The Arbitrator finds the opinion of Respondent's Section 12 examiner, Dr. Williams, to be more persuasive than that of Petitioner's treating physician, Dr. Wottowa.

In regard to disputed issues (E), (J), (K) and (L) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issues (C) and (F).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Causal connection	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Valerie Kement,

Petitioner,

vs.

NO: 11 WC 45356

16IWCC0178

State of Illinois – Illinois Veterans [Veterans'] Home,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident and nature and extent, reverses the Decision of the Arbitrator and denies Petitioner's claim for compensation, for the reasons stated below.

Findings of Fact

Petitioner, a 39 year old CNA, testified that on 10/22/11 she went to grab a resident's dentures "... and when [she] turned [she] tripped over his box of belongings that was on the floor and fell backwards and hurt – [she] had a bruise on [her] back but then [her] [right] ankle was starting to swell and hurt." (T.10). She stated that she was going to rinse the dentures off and put adhesive on them before placing them in the resident's mouth. (T.12). Petitioner testified that the registered nurse she works under wasn't available at the time of the accident, but that she did notify the LPN who was her supervisor at the time about the incident. (T.12).

When asked why her original injury report did not mention tripping over any boxes, Petitioner testified that "[t]hey told me not to at the Vets home." (T.11). Specifically, she indicated that her supervisor "Art" told her not to put that in the report. (T.11). She later agreed on cross examination that this individual's name is Art Brown and that he was not on duty on the date of the incident. (T.25). She noted that she told him that she fell the next day when she saw

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him. (T.25). Petitioner noted that the box was about 2' x 1' and was positioned next to the night stand. (T.11). She explained that her supervisor did not want her to mention the box in the accident report because "[t]hey said that we [the aides] were supposed to have those boxes put away." (T.22). Petitioner noted that the resident had had someone bring the box up from the basement and that "... we hadn't had time to move the box." (T.23). She indicated that she had seen the box when she entered the room, and that it was located to the right of the dresser on top of which were the dentures she went to retrieve. (T.23-24). She stated that at the time she was walking backwards a little bit because the dentures were behind her, and that she fell backwards to the ground, landing on her butt. (T.24-25).

Petitioner testified that following the incident she noticed pain and swelling in her right ankle. (T.12). She noted that when she later stood up after her break she had sharp pain shooting through the inside part of the top of her ankle and "couldn't even walk on it." (T.12-13). She denied having had any problems with her right foot prior to the incident in question. (T.17).

Petitioner indicated that she did not finish out her shift and instead went to the emergency room at Blessing Hospital. (T.13). She stated that she told them about the incident at that time. (T.14). The Blessing Hospital records dated 10/22/11 do not appear to contain any history. (PX2). X-rays of the right ankle and foot performed on that date revealed no indication of any fracture or dislocation. (PX2). Petitioner noted that they placed her foot in a boot, gave her some pain medications, took her off work and referred her to Respondent's workers' compensation physician. (T.14).

On 10/27/11, Petitioner visited Dr. Muller, the workers' compensation doctor at Blessing Physician Services. (T.14). She indicated that at that time she told the doctor what had occurred and that her right ankle was examined. (T.15). Petitioner also noted that she was still experiencing swelling and sharp pain in her ankle at the time of this visit. (T.15). She stated that she was not allowed to continue working and that the doctor restricted her to sitting 75% of the time. (T.15).

Dr. Muller's office note dated 10/27/11 reflects that "[l]ast Saturday, 5 days ago, while working @ 0745 in the AM she fell backwards and landed on her buttocks. She is unsure what happened to her right ankle and foot. She was initially able to walk on the [sic] this foot and ankle with some difficulty. Then as her discomfort increased – she was sent to the ER for evaluation. She had xrays of the right ankle and foot and was treated for a right ankle sprain with an Ace Wrap, Air splint and post-op shoe. She was given Lortab and told to ice the area for the next 48 hours. She has been off from work due to the restrictions place on her by the ER..." (PX3). The assessment was ankle sprain, ankle joint pain. (PX3). Petitioner was instructed to ice the area for 10 to 15 minutes at a time 3 to 4 times a day and to follow up in one week. (PX3). She was also given a "work ability note" restricting her to sit 75% of her work time with no climbing of stairs or ladders and no kneeling or squatting. (PX3).

Petitioner returned to Dr. Muller on 11/3/11. (T.18). She stated that she had not really noticed any improvement in her right ankle at that time. (T.18). She indicated that she was told to begin physical therapy and to remain on restricted duty. (T.18).

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An Advance Physical Therapy & Sports Medicine "Initial Evaluation" dated 11/3/11 notes the following under history of injury: "Patient states she fell at work and sprained ankle. Is unable to recall if she tripped over something, but states she fell back. X-rays were negative." (RX4).

Petitioner noted that she underwent physical therapy for about a month. (T.18-19). She indicated that physical therapy helped, but that she continued to have problems with swelling and pain. (T.19). She eventually finished physical therapy on 12/2/11. (T.19).

Petitioner saw Dr. Muller again on 12/5/11 at which time she was released to return to work without restrictions. (T.19). She agreed that she visited Dr. Muller on one more occasion on 12/19/11 at which time she was still having a lot of swelling and a sharp pain on the inside of her ankle particularly when the weather would change. (T.20). Petitioner indicated that Dr. Muller released her from his care at that time with instructions to return if she had additional problems. (T.21). Currently, Petitioner notices that she still has the swelling and pain, especially if she stands too long, about 3 or 4 hours, and due to the weather, such as rain and snow. (T.21-22). She indicated that she takes ibuprofen when she experiences these symptoms. (T.22).

On cross examination, Petitioner stated that the first time she told her supervisor, Art Brown, that she fell at work was the next day. (T.25). She noted that she filled out the accident report and put it in his box. (T.26). She indicated that at the time she filled out the report she had not talked to Mr. Brown. (T.26). When asked why she did not mention the resident's box of belongings in this report, Petitioner responded: "[b]ecause the other supervisor, which I don't remember her name at the time, the nurse, they said not to put [it] on there since we were – Art Brown told them to move it the night before." (T.26). She indicated that both Mr. Brown and this other supervisor told her not to mention the box of belongings. (T.27). Petitioner could not recall the other supervisor's name "off the top of [her] head." (T.27).

On re-direct examination, Petitioner agreed that she spoke to Mr. Brown the day after the incident (10/23/11) and actually filled out the paperwork on 10/24/11. (T.27-28). In an attempt to explain her prior testimony along these lines, Petitioner noted that she "... get[s] confused on [her] dates." (T.28). She agreed that it was at that time (10/23/11) that Mr. Brown told her not to mention anything about the boxes "... because he said they should have been moved." (T.29). She denied telling anyone that her foot or leg just gave out. (T.29).

On re-cross examination, Petitioner was shown RX3, the Veterans' Home Incident Report. (T.30). Petitioner agreed that it was her handwriting on the report and that she signed it on 10/22/11. (T.30). When asked if the description of the accident contained in RX3 was accurate, Petitioner responded: "I fell backwards, but there was a box there and I tripped on it." (T.30). No box is mentioned in any of the descriptions contained in any of the incident reports submitted at RX1-RX3.

RX1 is a CMS "Workers' Compensation Employee's Notice of Injury" report signed by Petitioner on 10/24/11. This report shows a date of accident of 10/22/11 and notes that "[s]upervisor wasn't available reported to Donnita Jensen LPN." (RX1). In response to the question as to what duty she was performing at the time of the injury, this report indicates:

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"[G]etting resident[']s dentures, turn[ed] to take dentures to bathroom, lost balance[,] hit closet[,] landed on floor." (RX1). When asked to detail how the injury occurred, Petitioner recorded "[g]etting resident[']s dentures[,] turn[ed] to take dentures to bathroom, started going backwards[,] hit closet with back, tried to break fall with hands but still landed on floor. When I got up back, arm and right ankle was [sic] hurting." (RX1). Under body parts affected it was noted -- "[r]ight ankle & foot sprang [sic]." (RX1).

RX2 is a "Worker's Compensation Claim – An Occupationally Connected Injury" form signed by Petitioner on 10/24/11. This form reflects a date of injury of 7:45 am on 10/22/11. (RX2). In response to the request to describe what happened, this form reflects: "picked up resident[']s dentures[,] turn[ed] to walk to bathroom and lost balance, hit closet with back." (RX2). The "type of injury" was noted as "spranged [sic] ankle & foot, sore back." (X2). This form also shows that the supervisor was not available and that the accident was reported to LPN Donnita Jensen." (RX2).

RX3 is a two-page "Veteran's Home Incident Report" signed by Petitioner on 10/22/11 shows a "date of report" and a "date of accident" of 10/22/11, separately stated. (RX3). When asked to describe the incident, Petitioner recorded: "I, Valerie, was getting Jack's (the resident's) dentures to rinse them off in the bathroom, when I turned to walk to bathroom my right ankle went out and I lose my balance backwards[,] tried to break fall with arms and fell back into Jack's closet and drawers. My right ankle is hurting bad, and arms feels [sic] jolted." (RX3).

Conclusions of Law

An injury is said to "arise out of" one's employment if it originates from a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury. *Nascote Industries v. Industrial Commission*, 353 Ill.App.3d 1056, 1060, 820 N.E.2d 531, 289 Ill.Dec. 755 (2004). A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his or her duties. *Tinley Park Hotel & Convention Center v. Industrial Commission*, 356 Ill.App.3d 833, 839, 826 N.E.2d 1043, 292 Ill.Dec. 607 (2004). However, where, by virtue of his or her employment, an employee is exposed to a common risk to a greater degree than the general public, an injury is also considered to have arisen out of the employment. *Nascote Industries*, 353 Ill.App.3d at 1061.

The "arising out of" element is usually satisfied in the case of an unexplained fall. *Builders Square, Inc. v. Industrial Commission*, 339 Ill.App.3d 1006, 1010, 791 N.E.2d 1308, 274 Ill.Dec. 897 (2003). However, before this element is satisfied, an employee must put forth "evidence which supports a reasonable inference that the fall stemmed from a risk related to the employment." *Baldwin v. Workers' Compensation Commission*, 409 Ill.App.3d 472, 478, 949 N.E.2d 1151, 351 Ill.Dec. 56 (2011). Where an injury results from a risk to which the employee is exposed no more than the general public, the injury does not arise out of the employment. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill.2d 52, 59, 541 N.E.2d 665, 133 Ill.Dec. 454 (1989). Along these lines, it has been held that the act of traversing a flight of stairs does not expose a claimant to a greater risk of harm than that faced by the general public. See *Baldwin*, 409 Ill.App.3d at 478.

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The Arbitrator noted that the injury was compensable as an "unexplained fall" in that Petitioner "... was performing her work duties when she picked up the resident's dentures and, while turning around to take them to the bathroom to be rinsed, she fell sustaining a right ankle injury." (Arb.Dec. [Addendum], p.2). The Arbitrator went on to note that he "... decline[ed] to make a conclusion as to whether there was a box on the floor containing papers belonging to the resident because the case is compensable whether there was a box present or not." (Arb.Dec. [Addendum], p.3).

The Commission notes that more is required than simply finding that an "unexplained fall" occurred at work, and that the Arbitrator erred by refusing to make a finding of fact relative to the presence or absence of the claimed box and its relation to the fall. As noted above, even in cases involving "unexplained falls", one must still prove that the fall stemmed from a risk related to the employment and that the employee was exposed to a risk of injury to a greater degree than members of the general public by virtue of her employment. In the present case, Petitioner claims that this increased risk of injury was present in the form of a resident's box of belongings that was supposedly on the floor and that she allegedly tripped over. However, none of the incident reports or medical histories reference any such box. Instead, these records reflect a history of falling backwards and landing on her buttocks while attempting to retrieve a resident's dentures. There is no indication that there was any defect or hazard on the floor that would have contributed to the fall. Moreover, Petitioner did not even testify that she had retrieved the dentures and was in possession of same at the time of the fall, on the slim chance that holding the item may have somehow increased the risk of injury. Instead, Petitioner claims that she turned with the intention of going to rinse the dentures off and put adhesive on them before placing them in the resident's mouth when she "...tripped over [the resident's] box of belongings that was on the floor and fell backwards ..." (T.10,12).

In addition, the Commission finds Petitioner's claim that she was instructed by her supervisors not to mention the presence of the box in any the incident reports as not credible. Specifically, Petitioner testified that the LPN to whom she reported the incident on the date of the occurrence, as well as her supervisor Art Brown, instructed her not to mention the box because staff had been told to put "... those boxes away." (T.22). The Commission finds such an explanation dubious, without further evidence that would suggest the failure to remove these boxes would result in some discernible consequence, such as a reprimand or write-up. Otherwise, the Commission sees no reason any such instruction would have been communicated to Petitioner or any other employee. Furthermore, such instructions would not explain why Petitioner likewise failed to provide a history involving the tripping over a box to any her medical care providers. As a result, the Commission is not persuaded by Petitioner's attempt at trial to explain the absence of any such history in any of the incident reports or medical records.

Respondent's Ex.3 states that Petitioner's ankle went out, causing her to lose her balance and fall. This is clearly not an unexplained fall. Rather, it was explained by Petitioner and was idiopathic at best.

Accordingly, based on the above, and the record taken as a whole, the Commission finds that Petitioner failed to prove by a preponderance of the credible evidence that she sustained accidental injuries arising of her employment on October 22, 2011. As a result, the Arbitrator

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decision is reversed and Petitioner's claim for compensation is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's award is vacated and Petitioner's claim for compensation is hereby denied.

DATED: MAR 14 2016
o: 2/22/16
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☒ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elijah Locher,

Petitioner,

vs. No. 11 WC 45577

David Stanley Consultants,

16IWCC0161

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical care and permanent disability, and being advised of the facts and law, corrects and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

In the Conclusions section, on page 11 of the Decision, the Arbitrator stated: "Petitioner then had his pain management evaluation [with Dr. Malla at the Pain Management Center of Marion] in May of 2014 but, again, failed to follow up after that visit." However, in the Findings of Fact, on page 6 of the Decision, the Arbitrator noted that Petitioner did follow up with Dr. Malla on June 9, 2014, and July 29, 2014. The Commission corrects the Arbitrator's decision accordingly—to reflect that Petitioner did follow up with Dr. Malla. Having carefully considered the entire record, the Commission otherwise affirms and adopts the Arbitrator's Decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 22, 2015, is hereby corrected as stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

No bond is required for removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 4 - 2016
o-02/11/2016
SM/sk
44

Stephen Mathis

Maria Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

LOCHER, ELIJAH
Employee/Petitioner

Case# **11WC045577**

16IWCC0161

DAVID STANLEY CONSULTANTS
Employer/Respondent

On 7/22/2015, 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 0.13% 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:

1312 BEMENT & STUBBLEFIELD
GARY BEMENT
PO BOX 23926
BELLEVILLE, IL 62223

1454 THOMAS & ASSOCIATES
ROBERT A HOFFMAN
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

16IWCC0161

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

# ILLINOIS WORKERS' COMPENSATION COMMISSION
# ARBITRATION DECISION
19(b)

Elijah Locher
Employee/Petitioner

v.

David Stanley Consultants
Employer/Respondent

Case # 11 WC 45577

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 **Herrin**, on **6/10/15**. 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. [x] 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. [x] 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. [x] Is Petitioner entitled to any prospective medical care?
L. [ ] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Nature and Extent (if prospective care is denied)**

FINDINGS

On the date of accident, **7/11/11**, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$27,225.64**; the average weekly wage was **$523.57**.

On the date of accident, Petitioner was **28** years of age, ***married*** with **1** dependent child.

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

Respondent shall be given a credit of **$99.73** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$99.73**.

Petitioner was temporarily totally disabled from **7/15/11** through **7/19/11**, a period of **5/7** weeks.

Respondent is entitled to a credit of **$0** for any medical bills paid by its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay the following reasonable and necessary medical services as provided in Section 8(a) and 8.2 of the Act, subject to the Medical Fee Schedule: Orthopaedic Center of Southern Illinois -- $4,140; Fairfield Memorial Hospital bills of $585.60 (0 bal.), $4,173.95 (0 bal.), and $540.00 (0 bal.); Wabash General Hospital - $5,799.07 (d/s – 11.1.11, 0 bal.) and $232.93 (d/s – 1.23.12, 0 bal.); Christopher Rural Health Planning - $246.83 (4.1.12 and 9.8.12 – 0 bal.); and Harrisburg Medical Center -- $230.00 (0 bal.).

Respondent shall pay Petitioner permanent partial disability benefits of **$314.14/week** for **25** weeks, because the injuries sustained caused **5% loss of use of a man as a whole** pursuant to Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued between **7/11/11** and **6/10/15** and shall pay the remainder of the award, if any, in weekly installments.

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.

Signature of Arbitrator

July 13, 2015
Date

ICArbDec19(b)

JUL 22 2015

Elijah Locher v. David Stanley Consultants,11-WC-45577 (19(b))

FINDINGS OF FACT AND CONCLUSIONS OF LAW

At the time of arbitration Respondent's counsel requested leave to submit a response to Petitioner's 19(b) Petition contemporaneously with the submission of his proposed decision. Leave was granted without objection. The Arbitrator notes that she did not receive a written Response and, therefore, one is not included as part of the record. The parties also stipulated that if prospective medical care was denied, permanency could be addressed in the Arbitrator's Decision.

The Arbitrator finds:

Petitioner was a 26-year-old individual who worked for Respondent in a coal mine. On July 11, 2011 he was injured when part of the roof of the mine fell and struck him in the neck, shoulder, and upper back. Accident was not disputed. Petitioner testified that he had no previous problems regarding pain in his left shoulder, upper back, neck, or head.

Petitioner was "re-examined" by N.P. Loni Banks (Dr. Alexander's office) on July 20, 2011, due to left shoulder pain and headaches. On examination Petitioner's left shoulder was tender on palpation but improved. Motion was described as "abnormal decreased" and "resistant to passive range of motion." Pain was elicited during impingement testing and on active cross-chest adduction without resistance. Petitioner's thoracic spine and thoracolumbar spine examination noted no positive findings. Petitioner's conditions were described as thoracic and lumbar strains. He also had a shoulder contusion. Petitioner was to undergo physical therapy for increasing his range of motion and was told he could return to work without restrictions. Petitioner felt ready to do so. (PX 4; RX 1)

On August 17, 2011 Petitioner presented to Fairfield Memorial Hospital with a puncture wound to his right foot. He was treated and released. (PX 1)

On August 26, 2011 Petitioner's wife contacted the office of Petitioner's family physician (Dr. Williams) regarding pain as a result of a rock hitting Petitioner while in the coal mine. Petitioner's wife thought Petitioner needed an x-ray and wanted him seen that day. When someone from the doctor's office finally reached Petitioner's family by phone, the office was advised that Petitioner no longer needed an appointment. (PX 6)

Approximately two months later, Petitioner presented to the office of Dr. Mitchell on October 14, 2011 where he was examined by Lisa Fritcher, PA-C, due to complaints of back pain. He also complained of numbness and tingling in the fingers. According to the history, "He said he believes in July of 2011 while in the coal mines, a rock fell from about 15 feet and him in the back of the head and neck. Petitioner could not recall the weight of the rock but it took two people to move it. Petitioner reported being seen by the company physician who gave him Lortab and Flexeril which he had been taking up until about a month earlier. He also reported headaches that were often quite severe. On physical examination Petitioner was noted to have somewhat palpable muscle

fasciculation in the right thoracic area and he was tender to palpation along the paraspinous processes. PA-C Fritcher diagnosed him with a cervical sprain and thoracic sprain, gave hima Prednisone taper dose and scheduled a follow-up visit. (PX 6)

Petitioner followed up with PA-C Fritcher on October 28, 2011, for cervical and thoracic pain and reporting that the Prednisone upset his stomach and he could not take it. PA-C Fritcher had obtained Petitioner's earlier medical records and x-rays and noted everything was normal. Petitioner reported daily pain and more frequent headaches. He also reported some photophobia and sensitivity to loud noises. His headaches ranged from 10 minutes to several hours in length. They discussed medication for the headaches but Petitioner declined anything preferring to take Excedrin Migraine. He also reported pain in his left shoulder and numbness and tingling in his arms and fingers. Finally, Petitioner reported pain from his neck to underneath his shoulder blades with popping and cracking in his spine in those areas. PA-C Fritcher diagnosed cervical and thoracic sprains and ordered an MRI and prescribed Lortab and Mobic. He was to return in one week. (PX 6)

Petitioner presented to Wabash General Hospital on October 29, 2011 for a neck sprain. Notes pertaining to the visit are limited. (PX 3)

Petitioner underwent an MRI of his cervical and thoracic spine at Wabash General Hospital on November 1, 2011, per the order of PA-C Fritcher. (PX 3)

Petitioner returned to see PA-C Fritcher on November 4, 2011 at which time they reviewed the MRI results which showed mild degenerative disc bulges at C4/5 and C5/6 without cord compression or stenosis and moderate bulging at T8/9 without cord compression. She ordered physical therapy. (PX 6)

On November 10, 2011 Petitioner called in to PA-C Fritcher requesting a refill of hydrocodone which was provided. (PX 6)

Petitioner signed his Application for Adjustment of Claim in this matter on November 15, 2011 claiming head, neck, back, and arm injuries after a rock fell on him on July 11, 2011. (AX 2)

Petitioner called PA-C Fritcher's office on November 23, 2011 requesting a refill on Melexocom and hydrocodone. The nurse was advised to call Petitioner and see if this was related to his emergency room visit as PA-C Fritcher had just given Petitioner narcotics ten days earlier and he had not been seen in the clinic for over a year. Petitioner was given 15 pills until PA-C Fritcher returned to the office and then he was to see her. (PX 6)

PA-C Fritcher re-examined Petitioner on November 28, 2011 at which time Petitioner reported he had not yet started his physical therapy as he had been unable to get to appointments but would plan on doing so. Petitioner reported a lot of evening pain which was keeping him up and making it difficult for him to sleep. He was reportedly taking Lortab every 4-6 hours as needed for pain but still having significant episodes of pain. Petitioner was advised he needed to get into physical therapy. He was given some Elavil to help with sleeping. (PX 6)

Petitioner returned to see PA-C Fritcher again on January 10, 2012 regarding his back pain. He still had not gone to physical therapy. Petitioner reported calling the Mt. Carmel physical therapy multiple times but being unable to get through. He still reported significant mid back and neck pain. On examination Petitioner had full range of motion of the upper extremities and equal strength in the upper extremities. He was somewhat tender to palpation in the upper thoracic area. Petitioner was again instructed he needed to go to physical therapy. He was also referred to a pain clinic. The therapy order was faxed to Mt. Carmel and Petitioner was instructed to go directly to the hospital to make an appointment. (PX 6)

Petitioner presented to the emergency room at Wabash General Hospital on January 23, 2012 for a physical therapy evaluation. Petitioner reported chronic neck and upper back pain following at incident at work six months earlier. His examination was consistent with cervical spine and thoracic spine hypomobility. It was anticipated he should have significant reduction of pain in the next 24 hours. It was noted that Petitioner might have some symptom magnification based on poor quality of "MMT" consistency. (PX 3) Petitioner cancelled his appointments for January 25, February 1, February 10, and February 15, 2012. Petitioner was discharged from therapy as a result. (PX 3)

Petitioner presented to Fairfield Memorial Hospital on March 13, 2012 regarding severe stomach pain and vomiting. It was believed Petitioner was suffering from abdominal pain and/or a hernia. He was to follow-up for both. (PX 1)

Petitioner was examined by Dr. Mitchell on March 16, 2012. According to the records, Petitioner had been referred to the pain clinic but he had not yet finished the paper work and returned it to the clinic. Petitioner was also noted to not be attending physical therapy consistently. Petitioner reported his stomach was bothering him and had been doing so "for months." Petitioner had been seen at the Carmi office on March 9th and was at the emergency room on March 13th regarding his abdominal pain. Lab work was essentially normal. Petitioner's back examination was positive for tenderness to palpation in the paraspinous processes of the thoracic area and he had some palpable muscle vesiculations but equal strength in the upper extremities. Further work-up for Petitioner's abdominal issues was discussed and Petitioner was prescribed Flexeril and given another order for physical therapy as Petitioner knew a therapist closer to where he lived. (PX 6)

Over five and one-half months later, Petitioner presented to the emergency room at Fairfield Hospital on August 30, 2012 complaining of pain due to a mine accident. Petitioner reported being told he needed a pain doctor and being out of his medication. He was diagnosed with chronic neck pain and told to not engage in any heavy lifting. He was given prescriptions for Relafen and Flexeril. (PX 1)

Petitioner next saw Dr. Kovalsky on September 6, 2012 with complaints of pain in his neck with radiation to his fingertips and numbness and tingling bilaterally. According to a questionnaire completed by Petitioner he was referred by the emergency room in Fairfield, Illinois. Petitioner gave a history of being hit by a rock that fell 15 feet from above hitting him on the head in the back of his neck. Petitioner reported wearing a hard

hat and being knocked to the ground. Subsequent to the event Petitioner developed neck pain with numbness and tingling into his fingertips bilaterally. To date he had been treated by his family physician with no improvement. Petitioner was currently unemployed having been terminated from his previous job. He denied any prior history of neck pain or bilateral arm numbness or tingling. Dr. Kovalsky's clinical diagnosis was bilateral cervical radiculopathy, axial neck pain, right greater than left, with minimal degenerative changes. He ordered a repeat MRI and scheduled Petitioner to come back in six to seven weeks. Given the mechanism of injury the doctor felt Petitioner could have sustained a soft tissue injury analogous to a whiplash. His symptoms were noted to be over a year old and if it was just a soft tissue injury he would have expected symptom resolution within 12 to 14 months. (PX 2)

Petitioner underwent the cervical spine MRI on September 11, 2012. It was negative for any disc herniation, central canal spinal stenosis, or neural foraminal encroachment. (PX 2)

Petitioner next saw Dr. Kovalsky on October 12, 2012. Dr. Kovalsky read the MRI scan as showing no specific injury. Slight dehydrations at C4/5 and C5/6 was noted but no disc space narrowing. Petitioner was reporting intermittent mid-thoracic pain starting to radiate around his chest wall. Petitioner was working at a Champion Store doing grease and oil changes and using a forklift. He noted bending and lifting increased his thoracic pain. He occasionally noted numbness and tingling in his legs but no lower back pain. He was put on a Prednisone taper and was then to start Relafen. He was also given a script for Zanaflex and Nortriptyline at bedtime as well as Hydrocodone, the latter of which was only to be used when absolutely needed as he would build up a tolerance to it. Dr. Kovalsky ordered a thoracic MRI to rule out a herniation as Petitioner has pain in his mid-thoracic area around T7-8. Petitioner was to follow up with the doctor in ten weeks. (PX 2)

Petitioner was seen at the emergency room at Fairfield Hospital on November 7, 2012. According to hospital records, Petitioner was working for Champion Laboratories as a fork lift worker and was under treatment by an orthopedist in Mt. Vernon. He was scheduled for an upcoming thoracic MRI. Petitioner was diagnosed with a muscle strain and given prescriptions for Relafen, Flexeril, and Ultram. (PX 1)

Per the referral of Dr. Kovalsky, Petitioner underwent a thoracic spine MRI on November 12, 2012 that revealed no disc herniation or abnormal signal intensity or fracture or bone destruction. (PX 2) Petitioner did not follow up with Dr. Kovalsky thereafter.[1] (PX 2)

On January 30, 2013 Petitioner presented to the office of Dr. Fred Smith, a chiropractor, having been referred by his mother. Petitioner's complaints included back pain going back to August 19, 2011 or "around then." The doctor's notes reference a rock falling on Petitioner in 2010 at a coal mine with complaints of constant mid thoracic interscapular pain and pain and numbness in his arms and shoulders. Petitioner

[1] It appears that Petitioner was to return to see the doctor on 12/19/12 (PX 2, work slip); however, no visit is found in PX 2 nor was a bill for a visit on that date submitted.

reported that the only doctor he had seen was a company doctor. X-rays were taken and various tests performed. No diagnosis or treatment recommendations were given. (PX 5)

Nearly six months later Petitioner was seen at Carmi Community Health Center (PA-C Schweiss) on June 6, 2013 regarding chronic upper back and neck pain. Petitioner gave a three year history of back pain that began suddenly with an injury. Petitioner denied any radiating pain but noted an ache in his upper back and neck with shooting pain. On exam, Petitioner displayed tenderness and moderate pain with motion. Petitioner was assessed with chronic upper back pain and neck pain. He was to call his pain management doctor and see if "he [would] take [him] back." Petitioner was to follow up in three weeks. (PX 7)

Petitioner returned to Carmi Community Health Center on July 25, 2013 for an acute upper respiratory infection. Petitioner also reported back pain of four days onset. The symptoms were associated with a history of allergies and smoking. (PX 7)

Approximately four months later, Petitioner presented to Fairfield Memorial Hospital on November 17, 2013 complaining of pain after being hit by a large rock in August of 2010. Petitioner was diagnosed with thoracic post spinal bursitis, told to refrain from heavy lifting and given prescriptions for Relafen and Flexeril. Petitioner was noted to be working for Trelleborg Vibracous. (PX 1)

Petitioner returned to Albion Community Health Center on November 26, 2013 where he was seen by PA-C Fritcher for neck and back pain. Petitioner described a three year history of same. He complained of constant and fluctuating pain and additional symptoms of decreased mobility, difficulty initiating sleep, nocturnal pain, spasms and tingling in the arms. It was noted that Petitioner had been experiencing this pain since a coal mining injury in August of 2010. The record also references "There was no trauma." (PX 7) Petitioner's employment history was noted to include being a janitor. On examination Petitioner had tenderness about the cervical and thoracic spine with mildly reduced range of motion of his neck and moderate pain in the thoracic spine with motion. Petitioner was referred for pain management. (PX 7)

Approximately five months later Petitioner was seen at the emergency room at Deaconess Health System in Evansville, Indiana on April 4, 2014 regarding neck and back pain which was described as chronic, severe, gradual in onset and worse that day. "New paresthesias of both hands" was noted. Petitioner's pain in his thoracic back was noted to be worse than his neck. Dr. Gilbert's impression was a disc bulge and he recommended steroids and pain medication and a referral to "NSGY." A discharge note indicated Petitioner was to follow up with Dr. Goebel in Evansville. (PX 8)

A CT of Petitioner's cervical and thoracic spine was taken on April 4, 2014. The cervical spine CT was normal; the thoracic spine CT revealed a moderate sized central disc protrusion at T8/9. (PX 8)

Petitioner underwent a comprehensive initial evaluation with the Pain Management Center of Marion on May 15, 2014. Petitioner presented with complaints

of neck pain that radiated into both shoulders and both upper extremities along with radiating pain up to the bilateral occipital areas causing severe headaches 1-2 times per week. Petitioner gave a history of working in a coal mine when a large rock fell and hit him in the back of the head. The "work comp" doctor examined him and told him he had pulled a muscle and he was released and returned to work; however, his pain had never gone away. Petitioner reported seeing PA-C Fritcher for several years and she had referred him for pain management. He also reported recently going to the ER in Evansville and undergoing a CT scan that showed disc problems. Petitioner acknowledged he had orders for physical therapy but hadn't been followed through. Petitioner stated he had only had two small prescriptions of Lortab which helped along with a muscle relaxant. Petitioner complained of "pushing pain" in between his scapula as though someone was pushing with one's finger. He described episodic deep pain in the cervical area radiating to both shoulders and his upper extremities along with episodic numbness and tingling in the upper extremities. Petitioner also reported going to numerous emergency rooms but receiving no help and he had last seen PA-C Fritcher in December of 2013. Petitioner reported he was unemployed due to pain. Petitioner reported being unable to participate in his hobbies of fishing, golf, sports, and hunting due to pain. He felt he needed more medication than what he has been given and denied seeing more than one doctor to get pain or relaxation medication. Petitioner was given a psychosocial evaluation. A functional assessment was given as well as a physical examination. Petitioner was diagnosed with cervical disc displacement, cervical facet joint arthropathy, cervical radicultis, thoracic displacement, thoracic facet joint arthropathy, myofascial syndrome, cervicogenic headaches, occipital neuritis, overweight, and tobacco abuse. Home exercises were discussed. Medication was prescribed. (PX 9)

Petitioner returned to the Pain Management Center on June 9, 2014 reporting his neck and shoulder blade were hurting again. He was given a cervical epidural injection and bilateral mid and upper trapezius trigger point injections. He was discharged in good condition to return on July 29th. (PX 9)

At his July 29, 2014 Pain Management visit Petitioner reported onoing neck and mid back pain with the preceding treatment lasting about half a month with more than 60% pain relief and the next half a month with more than 50% pain relief. Due to increased pain they discussed increasing his Norco and Petitioner underwent additional injections. (PX 9)

Petitioner initiated chiropractic treatment with Dr. Gholson on September 17, 2014 for neck and upper back pain radiating into his head. Petitioner gave a history of an August 2011 rock falling on him. (PX 10)

Petitioner underwent chiropractic treatment with Dr. Gholson on September 18, 2014 reporting he was always in pain with lots of stiffness and soreness in his neck and shoulders. (PX 10)

Petitioner underwent chiropractic treatment with Dr. Gholson on September 19, 2014 reporting some relief in his neck and shoulders but still a "6/10" when inflamed and a "3-4/10" at rest. (PX 10)

Petitioner underwent chiropractic treatment with Dr. Gholson on September 22, 2014 reporting improvement. (PX 10)

Petitioner was again seen by Dr. Gholson on September 25, 2014 reporting a lot of pain in his neck and "MB" over the past couple of days. He had a severe headache on Tuesday night and vomited. He also vomited the night before but experienced no headache. (PX 10)

Petitioner underwent chiropractic treatment with Dr. Gholson on September 29, 2014 again reporting episodes of headaches and vomiting. (PX 10)

Petitioner underwent chiropractic treatment with Dr. Gholson on October 2, 2014 reporting less severe pain in his neck and shoulders and no headaches. (PX 10) At the October 7, 2014 visit Petitioner reported the same. (PX 10)

Petitioner underwent chiropractic treatment with Dr. Gholson on October 17, 2014 reporting he was "really sore" that day. (PX 10)

Petitioner underwent chiropractic treatment with Dr. Gholson on October 30, 2014 reporting he had been having trouble in his upper thoracic spine for the last few days with pain radiating into his chest and up in to the trapezial muscles. Some headache but he was "better overall." (PX 10) Petitioner's history was the same when examined on November 12, 2014. (PX 10)

Petitioner underwent chiropractic treatment with Dr. Gholson on November 13, 2014 complaining of lots of pain from the night before in his left neck and shoulder and also referring into his right shoulder and arm. He had difficulty sleeping and woke up really stiff with a headache. (PX 10)

Petitioner underwent chiropractic treatment with Dr. Gholson on November 14, 2014 reporting upper thoracic spine trouble for the past few days with radiating into his chest and up into the trapezial muscles. (PX 10)

Petitioner underwent chiropractic treatment with Dr. Gholson on November 18, 2014 reporting the same complaints as those on the 14th. (PX 10)

Petitioner underwent chiropractic treatment with Dr. Gholson on November 19, 2014 for the same complaints as on the last two visits. (PX 10)

Petitioner underwent chiropractic treatment with Dr. Gholson on December 10, 2014 reporting a flare up for no known reason with pain and tenderness along his entire spine but mostly in "MB" and neck. Some headaches were reported but no migraine. (PX 10)

Petitioner underwent chiropractic treatment with Dr. Gholson on January 22, 2015 reporting he had been busy starting a new job managing a Road Ranger on swing shifts and holidays and helping coach "upwards basketball." He reported lots of pain in his neck and upper thoracic spine and more frequent headaches lately. He also reported numbness and tingling in his feet, especially right foot pain. Petitioner had

gone to the emergency room because of neck and "MB" pain twice in the past month and they wanted a consultation with a neurosurgeon which was being scheduled. (PX 10)

Petitioner presented to Dr. Gornet on April 9, 2015 for an examination. Petitioner had pain in his neck, at the base of the neck with headaches, pain between is shoulder blades, bilateral trapezius pain to both shoulders, down both arms and into his forearms and hands, right greater than left. He has some tingling into his hands, right greater than left. He also stated that he has low back pain to both sides with tingling in both feet. He stated that his current problems started in August 2011 while working at American Coal, a rock fell from about 10-15 feet and struck him in the hard hat down the back of his neck, causing him to forward flex into his upper back. Petitioner reported leaving his shift early that day. Petitioner reviewed some of his treatment history with the doctor noting that Petitioner was a poor historian on the timing of the events. Petitioner did tell the doctor that he had returned to work but had ongoing pain and had stopped working at the coal mine in October of 2011 due to his symptoms. He was then off work for seven to eight months and then referred for injections, ultimately being placed on a 35 lb. lifting restriction. Petitioner had begun working at a truck stop most recently in August of 2014 but noting continued pain. Petitioner described his symptoms as constant with the neck being the biggest issue and his symptoms were reportedly worse with arm activity or fixed head positions and better with changed positions. Petitioner also reported bilateral arm pain but denied any persistent or significant numbness or weakness. Assuming Petitioner's history was factually correct Dr. Gornet felt that the symptoms related to Petitioner's neck and upper back appeared to be causally connected to the original accident in 2011, assuming that he had had no other slips, falls, or any other trauma. He wanted to look at additional medical records and he ordered a new MRI scan of Petitioner's cervical vertebrae. He felt Petitioner could work light duty with a 35 pound weight restriction and should come back to see him in eight weeks. (PX 11)

Petitioner has undergone no further treatment.

Petitioner's case proceeded to arbitration on June 10, 2015. Petitioner testified that a rock came down and "smashed" his neck and back and hit his right shoulder. Petitioner also testified that he was rendered unconscious as a result of the accident. He did not know how much the rock weighed. Petitioner then stayed in the mine for another two hours so he wouldn't lose his bonus. Thereafter, Petitioner was taken to Harrisburg Hospital with Respondent's "safety guy." He was given a sling for his arm. Petitioner testified he was then sent to Dr. Alexander, Respondent's doctor, who had him off work for one week and then released him to return to work. According to Petitioner, Dr. Alexander didn't take any x-rays or order any MRIs. He told him he had some bruising.

Petitioner could not recall how long he returned to work but he believed he did so on and on a light duty basis. Regardless, he still hurt. Petitioner testified that he had a sharp pain between his shoulder blades which the doctor attributed to swelling. Petitioner testified that this pain has never gone away.

Petitioner believed that he continued to work for Respondent maybe a month or two more after returning to work. He went to his family doctor who initially treated him with pain medication and the referred him to pain management and had him undergo an MRI. Petitioner testified he was then referred to Dr. Kovalsky but stopped treating at that time due to his "money situation."

Petitioner could not recall when he went to Pain Management in Marion. He also recalled undergoing chiropractic care in Carmi, Illinois but "nothing helped." According to Petitioner, the chiropractic care sometimes made things worse. Petitioner testified that PA-C Fritcher referred him to the chiropractor.

Petitioner testified that PA-C Fritcher referred him to Dr. Gornet.

Petitioner denied any incidents or accidents since July 11, 2011.

Petitioner testified that he continues to have pain at the neck, upper back and left shoulder. He testified to inflammation in his neck and "supposedly" limited mobility. If Petitioner has his hands above his head or is bending over to lift, he feels pain between his shoulder blades and has to apply ice for swelling. His neck feels very tender. Petitioner described nightly pain that is sometimes so bad he cannot sleep and is nauseated. He has some radiating numbness in both hands although the upper back and neck pain is the most problem for him.

Petitioner testified that he lost his job with Respondent but has since found full-time employment driving a forklift.

Petitioner testified that Respondent has never had him undergo an independent medical exam. He acknowledged that his last visit with Dr. Kovalsky was in November of 2012. Petitioner believed the visit with Chiropractor Smith in January of 2013 was a free consultation. He acknowledged that six months went by after that visit before he presented to Carmi Community Health Center. He acknowledged several visits to Fairfield Hospital due to pain. On redirect examination Petitioner explained that the hospital visits were due to "his situation" and limited funds as he had to go somewhere to get relief when it was two in the morning and he couldn't sleep.

The Arbitrator concludes:

Issue (F) Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner failed to prove that his current condition of ill-being in his neck, shoulders, arms, upper thoracic back area and low back are causally connected to his July 11, 2011 accident. In so concluding the Arbitrator notes significant credibility concerns regarding Petitioner as well as significant gaps in treatment.

There were many inconsistencies between Petitioner's testimony and what the medical records actually reveal. Petitioner testified he returned to work in July of 2011 on a light duty basis. That is contradicted by the records of Dr. Alexander. No further explanation or corroboration for Petitioner's testimony was provided. Petitioner testified that Dr. Alexander did not order any x-rays or MRIs and the doctor put his arm in a

sling. No corroborating records were provided by Petitioner but PA-C Fritcher's records indicate she obtained records and x-rays and they were normal. Petitioner testified that PA-C Fritcher referred him to numerous doctors as well as pain management. The records of the doctors don't corroborate all that testimony. Petitioner was not referred by PA-C Fritcher to Dr. Smith or Dr. Kovalsky. The former was a referral by Petitioner's mother and the latter a referral by Fairfield Hospital. Petitioner testified that due to the loss of his job and limited funds he frequently had to stop treating with various doctors; however, Petitioner could have filed a Section 8(a)/19(b) petition at various times throughout the course of his claim in an effort to have treatment authorized. He didn't.

It is of some concern that the initial emergency room visit Petitioner testified regarding was not included as part of the record. It could have corroborated Petitioner's testimony has to being rendered unconscious when the rock fell. Prior to arbitration, Petitioner never gave such a history to any of his providers – at least their records don't record such a history. The Arbitrator does believe there was a visit to the emergency room with one of Respondent's "safety guys" and the July 20th visit with PA-C Fritcher was described as a "re-examination" and PA-C Fritcher obtained the early records and reviewed them. In order for the Arbitrator to conclude that Petitioner was rendered unconscious at the time of the accident it was Petitioner's burden, in this instance, to produce those records to corroborate his testimony. While Respondent may have had equal access to the records, Respondent had no reason to believe (from the record as a whole) that Petitioner was going to claim he had a period of unconsciousness at the time of the accident.

Regardless of Petitioner's testimony as to how he has felt since the accident, Petitioner agreed with Nurse Practitioner Banks on July 20, 2011 that he was ready to return to work. Despite being in "unrelenting pain" since the July 20, 2011 accident, Petitioner made no mention of it when seen at the emergency room on August 11, 2011 for a foot injury and when his wife attempted to schedule an appointment for him on August 26, 2011, Petitioner did not follow through as the message was left that he no longer needed to be seen. Regardless of Petitioner's testimony as to unrelenting pain since the accident, Petitioner sought no further medical treatment after July 20, 2011 until October 14, 2011, approximately three months after the accident. He was diagnosed with cervical and thoracic sprains. Physical therapy was ordered. Petitioner did not follow through with it. Pain management was discussed in the fall of 2011 and Petitioner did not follow up with it. Petitioner's actions during this time appear focused on pain medication. He was delinquent in his efforts to initiate pain management and physical therapy. When the latter was finally initiated he was not compliant with his visits. According to PX 6, Petitioner's last visit with PA-C Fritcher/Dr. Mitchell was March 16, 2012. Petitioner then had a supposed "free consultation" with Chiropractor Smith (to whom he was referred by his Mother, not PA-C Fritcher) but no treatment for approximately five months before presenting to an emergency room seeking pain medication. Thereafter, Petitioner repeatedly visited emergency rooms for pain medications and underwent repeated diagnostic studies that were essentially normal. When he did resume care with PA-C Fritcher in November of 2013, approximately 1 ½ years had transpired since she last saw him. The history provided to her at that time

was inconsistent regarding the date of accident (as it had been on other occasions with other providers also). Petitioner was again referred for pain management.

Thereafter, Petitioner did not seek any further medical care until he went to the emergency room on April 4, 2014. He was referred to "NSGY" but, in light of the absence of any records of that visit or testimony concerning it, it appears that Petitioner failed to follow up on that referral. Petitioner then had his pain management evaluation in May of 2014 but, again, failed to follow up after that visit.

Rather than follow up with pain management Petitioner, yet again, initiated treatment with a new provider – Dr. Gholson. Petitioner then stopped treating with Dr. Gholson in January of 2015 and waited three months before presenting to Dr. Gornet. Dr. Gornet's records refer to an emergency room visit in the interim but no record of such a visit is included in the record. While Dr. Gornet opined in his office notes that Petitioner's condition could be causally related to his work accident, he qualified his opinion noting that Petitioner was a poor historian. The Arbitrator concurs and, therefore, is not persuaded by Dr. Gornet's opinion. It is not well-informed or based upon a thorough and accurate understanding of everything that had transpired in the years since Petitioner's accident. Even Dr. Gornet noted he needed to review all of Petitioner's medical records.

The Arbitrator is also unable to conclude that Petitioner has established causation based upon a chain of events. Given Petitioner's significant credibility issue, this is an instance when an expert medical opinion is necessary to establish causation. There are simply too many gaps in treatment and inconsistencies between Petitioner's testimony and the medical records. The Arbitrator also notes that while Petitioner submitted a bill for a visit with PA-C Fritcher on September 18, 2012, there is no office note for such a visit contained within Petitioner's exhibits. Therefore, what, if anything, transpired at that visit is unknown.

Petitioner did sustain an accident on July 11, 2011. That is not disputed. However, Petitioner failed to prove a causal connection between his injuries and that accident after November 12, 2012, the date Petitioner underwent the thoracic MRI ordered by Dr. Kovalsky. Thereafter, Petitioner underwent no treatment[2] for approximately seven months and when he did so, it was with yet another provider. The Arbitrator further finds and concludes that any low back complaints Petitioner may be experiencing are not causally related to his accident whatsoever. Petitioner failed to testify to any low back complaints at the time of the accident. While he reported low back pain and bilateral foot tingling to Dr. Gornet at that time of their initial examination, the medical records fail to corroborate Petitioner's history to Dr. Gornet that those complaints began with the accident.

Issue (K) Is Petitioner entitled to any prospective medical care?

[2] The Arbitrator is aware Petitioner saw Dr. Smith in January of 2013; however, those records don't detail a diagnosis or explain what, if any, treatment was provided.

Petitioner failed to prove he is entitled to any prospective medical care. Petitioner did not testify that he is seeking an award of any particular, or specific, treatment. Furthermore, consistent with her causation determination above, Petitioner has failed to prove he needs any further medical care as a result of a causally related work injury. Prospective medical care is denied.

Issue (J) Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all reasonable and necessary medical services?

The Arbitrator finds that all treatment after November 12, 2012, is neither reasonable nor necessary to cure or relieve the effects of Petitioner's work-related injury. Petitioner has been non-compliant with treatment and the treatment has been sporadic. There are gaps of months in his treatment with no explanation and when he has sought care he has, on occasions, been non-compliant. The best examples of this are the prescriptions for physical therapy by Dr. Alexander that was never complied with and PA-C. Fritcher's prescription for physical therapy and pain management. Petitioner failed to start physical therapy for over 2½ months and when he did start it he failed to attend after just three appointments. PA-C Fritcher suggested pain management in 2011 and 2012. Petitioner did not start it until May, 2014. There is no evidence that Respondent had anything to do with any delays in treatment.

The treatment at Fairfield Memorial Hospital on the dates of August 17, 2011 and March 13, 2012 are clearly not related to this accident. The treatment on the first date was for a puncture wound to the foot and the treatment on the second date was for abdominal/bladder/pelvic problems. There is no evidence causally realting these problems or this treatment to the work accident in question.

Petitioner is awarded his medical bills for care and treatment up through and including November 12, 2012 except for the August 17, 2011 ER visit and March 13, 2012 ER visit at Fairfield Memorial Hospital. While there is no accompanying medical record for the visit with Dr. Alexander on July 12, 2011, the Arbitrator notes that his bill has been paid and reflects a zero balance. The Arbitrator also notes that there is no accompanying medical record for a visit between Petitioner and PA-C Fritcher on September 18, 2012 (as itemized in the Christopher Rural Health Planning Corp. billing found in PX 12); however, said billing reflects a zero balance due and owing. In summary, the following bills are awarded: Orthopaedic Center of Southern Illinois -- $4,140; Fairfield Memorial Hospital bills of $585.60 (0 bal.), $4,173.95 (0 bal.), and $540.00 (0 bal.); Wabash General Hospital - $5,799.07 (d/s – 11.1.11, 0 bal.) and $232.93 (d/s – 1.23.12, 0 bal.); Christopher Rural Health Planning - $246.83 (4.1.12 and 9.8.12 – 0 bal.); and Harrisburg Medical Center -- $230.00 (0 bal.).

Issue (O) Other – Nature and Extent (but only if prospective medical care is denied)

The parties stipulated and agreed that if prospective medical care was denied, then "Nature & Extent" was in issue and should be decided upon. The Arbitrator notes

that Petitioner was released without restrictions within two weeks of the work accident and there is little or no evidence that any of Petitioner's treating physicians ever restricted his activities until Petitioner saw Dr. Gornet almost five years after the accident. Consistent with her causation determination above, Petitioner has been diagnosed with thoracic and cervical sprains/strains. While Petitioner testified that he lost consciousness, he was not diagnosed with a concussion and the contemporaneous records do not mention any loss of consciousness. Petitioner's primary diagnoses were of cervical and thoracic strains and shoulder pain. Every diagnostic test was essentially within normal limits except for findings that could be attributed to degenerative changes. Petitioner was released without restrictions to return to work 9 days after the accident. The Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of 5% man as a whole as a result of his accident.

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STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify: Up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOHN CARPENTER,

Petitioner,

16IWCC0147

vs.

NO: 11 WC 47766

JOLIET HIGH SCHOOL DISTRICT #204,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of the nature and extent of Petitioner's permanent partial disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Findings of Fact and Conclusions of Law

1. Petitioner testified he was currently 61 years old and on November 10, 2011, he was maintenance custodian for Respondent and had been for five months. He graduated high school in 1982, was in the Army from 1982 to 1985, and was discharged honorably as a private first class. He was custodian at another school prior to working for Respondent.

2. Petitioner had previous work-related injuries to his back in 2003 and 2004. He was treated for those injuries by Dr. Espinosa who performed a laminectomy at L4-5. He was released from care around 2007 but Dr. Espinosa did not impose any work restrictions. He did not receive any additional treatment from 2007 to the instant accident and was able to perform his duties for Respondent which involved physical labor. He had no problems with his back during that period.

3. On November 10, 2011, a fight broke out outside their break room. Petitioner went to assist his supervisor who was struggling to separate the combatants. "Two girls jumped on the pile" and pushed him into a locker. The metal handle went into his back and he twisted. He began to experience a lot of pain. After an MRI, Petitioner was referred to Dr. Espinosa, who performed fusion surgery on March 15, 2012.

4. Eventually, Dr. Espinosa imposed permanent restrictions of no lifting more than 20 lbs, no bending, no stooping, no climbing ladders, and no sitting/standing for more than an hour. Respondent was not able to accommodate his restrictions and he was terminated on January 7, 2013.

5. Respondent provided vocational rehabilitative services. The counselor, Ms. Hoevel, recommended Petitioner take computer classes and look for office jobs, customer service jobs, janitorial jobs, and supervisory jobs. Petitioner testified he never worked in customer service or had a supervisory job.

6. Petitioner began a job search on February 19, 2013, which was still ongoing. He contacted about 1,200 prospective employers and got one interview. The Commission notes that Petitioner's job search log spans February 18, 2013 through July 8, 2015 and includes 243 pages apparently with 1,215 entries.

7. Petitioner testified he received no job offers. He met with Ms. Hoevel weekly, he contacted all prospective employer leads she provided, he attended job fairs, he took computer classes, and he underwent vocational testing administered by Coventry. Petitioner also met with Mr. Blumenthal, at the request of his lawyer.

8. On December 20, 2012, Respondent's vocational rehabilitation agency, Coventry, prepared its initial report. Petitioner reported he believed he could and wanted to return to work, but he was not sure what he could do. Based on his educational and work experience, Ms. Hoevel believed Petitioner exhibited the transferable skills of "cleaning, janitorial, and portering services."

9. The Counselor identified job titles of assembler, ticketing clerk, and building maintenance supervisor. She thought Petitioner was employable and his probability of obtaining employment was good and would improve with computer training.

10. In a labor market survey prepared contemporaneously with the initial report, five jobs involving customer service, assembling, and security were identified which were believed to be suitable for Petitioner. The salary range was between $11.03 and $16.43 an hour.

11. On July 13, 2015, Ms Hoevel issued a "closing letter." In it she indicated Petitioner had been compliant with vocational rehabilitation since the beginning in March 2012. She still thought he was employable in jobs averaging about $12.00 an hour. His job search was hindered by his age, the length of time he was off work, reduced wage from his previous job, and his restrictions. All of her reports in the interim indicated that Petitioner had been fully compliant with all of her vocational counseling requests.

12. On April 1, 2014, Mr. Blumenthal issued his vocational rehabilitation report. In it he noted Dr. Espinosa's permanent restrictions. He interpreted vocational testing administered by Coventry as showing that Petitioner had low average reasoning ability, high school level reading ability, grade school level spelling and arithmetic ability, below average fine dexterity ability with a much below average assembly dexterity, above average mechanical aptitude, average word knowledge, and he "scored well below average across the remaining aptitudes tested. Of specific interest were the low manual speed and dexterity" and "low perceptual speed and accuracy which are related to clerical aptitude."

13. Mr. Blumenthal also indicated that Petitioner reported 3-4/10 pain on a day to day basis which could increase to 4-5/10 with prolonged standing/walking. He reported the job search process with Coventry since December of 2012 was stressful to him because he could not perform many of the jobs he was asked to apply for. Petitioner indicated he had no face-to-face interviews and had not been offered a job in the about 15 months of the job search. He was directed not to accept any job which paid less than $10 an hour, but was recently told it was now acceptable to seek part-time work.

14. Mr. Blumenthal pointed out that Petitioner was never a supervisor and had no experience maintaining physical structure of buildings, let alone supervising others performing that type of work. He operated trucks in the Army. Petitioner reported earning $17.09 an hour at the time of his work accident and worked 20-25 hours of overtime a week. Prior to working as a custodian he worked as a forklift/machine operator and as an apprentice mechanic, but was told he did not have the mechanical aptitude for that job.

15. Mr. Blumenthal indicated the Coventry labor market survey included jobs of assembler, telemarketer, customer service dispatcher, and security guard. He also noted that Petitioner had no experience in sales, telemarketing, customer service, or performing repetitive physical assembly. In addition, the vocational testing indicated he did not have the manual dexterity for assembly, aptitude for clerical work, and he did have related previous work experience.

16. Mr. Blumenthal thought the Coventry's conclusions as to Petitioner's employment potential were not reasonable. In particular he noted that the job of security guard involved prolonged standing/walking which was not compliant with his permanent restrictions.

17. Mr. Blumenthal concluded that Petitioner could work as an usher, lobby attendant, ticket taker, or in certain security positions such as manning a guard station at a gated community which would be within his restrictions. He estimated Petitioner could earn between $8.74 and $11.03 an hour. According to the most recent union contract Petitioner's base salary would be $18.62 an hour with a $.50 cent premium for working second shift for a total salary of $19.12.

16IWCC0147

The Arbitrator awarded Petitioner a weekly wage differential award of $232.31. In arriving at this wage differential, the Arbitrator considered the opinions of both Mr. Blumenthal and Ms. Hoevel, and noted that Mr. Blumenthal opined Petitioner could earn $11.03, (which was actually his top potential salary), and Ms. Hoevel opined he could obtain a job with an average salary of $12.00 an hour. The Arbitrator placed greater weight on the opinion of Ms. Hoevel because of her extensive contact with Petitioner.

The Commission finds that Petitioner was commendable in his compliance with vocational rehabilitation efforts and his private job search. Respondent's vocational counselor noted his complete compliance throughout the process. The failure of even getting a single offer for more than three years despite his and Ms. Hoevel's best efforts would tend to mitigate the persuasiveness of her opinion regarding his employability, the jobs he could perform, and his earning potential.

Therefore, the Commission finds the opinions of Mr. Blumenthal more persuasive than those of Ms. Hoevel regarding Petitioner's earning potential. Mr. Blumenthal opined that Petitioner could earn potentially between $8.74 and $11.03 an hour, which translates into a wage differential of between $258.18 a week and $319.25 a week with a median wage differential of $288.71. The Commission finds awarding the median wage differential posited by Mr. Blumenthal to be appropriate in this case and modifies the Decision of the Arbitrator according.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $288.71 per week commencing July 16, 2015, as proved in §8(d)(1) of the Act because the injuries sustained caused Petitioner's inability to pursue his usual and customary line of employment resulting in a wage loss.

The party commencing the proceeding for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: MAR 2 - 2016

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0147

CARPENTER, JOHN
Employee/Petitioner

Case# 11WC047766

JOLIET TOWNSHIP HIGH SCHOOL DISTRICT #204
Employer/Respondent

On 7/28/2015, 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 0.14% 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:

1987 RUBIN LAW GROUP LTD
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CHICAGO, IL 60603

1454 THOMAS & ASSOCIATES
STEVEN COSTELLO
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STATE OF ILLINOIS)
)SS.
COUNTY OF **WILL**)

16IWCC0147

- ☐ 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
NATURE AND EXTENT ONLY

John Carpenter
Employee/Petitioner

v.

Joliet Township High School District #204
Employer/Respondent

Case # **11** WC **47766**

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. 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 **Gerald Granada**, Arbitrator of the Commission, in the city of **New Lenox**, on **7/16/15**. By stipulation, the parties agree:

On the date of accident, **11/10/11**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

On this date, Petitioner sustained 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 $**43,080.18**, and the average weekly wage was $**828.47**.

At the time of injury, Petitioner was **48** years of age, ***married*** with **1** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

Respondent shall be given a credit of $**98,548.67** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $**98,548.67**.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner the sum of $**232.31**/week commencing 7/16/15, as provided in Section **8(d)(1)** of the Act, because the injuries sustained caused **Petitioner's inability to pursue his usual and customary line of employment resulting in a wage loss.**

RULES REGARDING APPEALS Unless a Petition for Review is filed within 30 days after receipt of this decision, and a review is perfected 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.

Signature of Arbitrator

7/24/15
Date

JUL 28 2015

16IWCC0147

FINDINGS OF FACT

On November 10, 2011, Petitioner was working as a maintenance custodian for Respondent. Petitioner sustained an injury to his back when he broke up a fight between two students. Petitioner was pushed up against a locker and the metal part of the lock went into his back. Petitioner twisted as he pulled away from the locker.

As a result of the work-related accident, Petitioner sought medical treatment at Edwards Medical Group on November 15, 2011. (PX 1). At the recommendation of the physician, Petitioner underwent an MRI study of the back on January 21, 2011. (PX 2). The MRI study revealed a laminectomy at L4, right paracentral disc protrusion of the L4-L5 impinging on the traversing nerve root and postero-lateral disc protrusion at the L5-S1 level causing ipsilateral forminal narrowing. (PX 2). Petitioner was referred to Dr. Espinosa for further treatment. (PX 1). Dr. Espinosa performed surgery, including a fusion at L4-L5 on March 3, 2012. (PX 4). Petitioner remained under the post-operative care of Dr. Espinosa, which included follow up visits, physical therapy, MRI studies and CT scans. (PX 3). On July 13, 2012, Dr. Espinosa documented that the CT scan revealed significant degenerative disc disease at the L5-S1 level with collapse of disc space likely due to the fusion. (PX 3). He discussed a L5-S1 fusion with Petitioner. (PX 3). Dr. Espinosa released Petitioner to return to work with the permanent restrictions of sedentary to light duty work with no lifting over 20 pounds, no bending at waist level, no stooping and avoid prolonged sitting or standing over one hour. (PX 3). Petitioner was last examined by Dr. Espinosa on August 21, 2013. (PX 3). Petitioner testified that he has not scheduled a follow up appointment with Dr. Espinosa; however, if his back pain increases, he will schedule an appointment.

Respondent was not able to accommodate Petitioner's permanent restrictions and terminated Petitioner's employment on January 7, 2013 due to its inability to accommodate the restrictions. (PX 8). Respondent provided vocational rehabilitation to Petitioner. (RX 3). Petitioner participated in vocational rehabilitation, which included a job search and computer classes, with Samantha Hoevel, from December 18, 2012 through the date of the hearing. (RX 8). Under the direction of Ms. Hoevel, Petitioner contacted over 1200 employers and did not obtain employment. (PX 6). Ms. Hoevel set forth that Petitioner was compliant in vocational rehabilitation services. (RX 8). Ms. Hoevel opined that Petitioner could earn $12 per hour in suitable employment. (RX 6).

At the request of his attorney, Petitioner was evaluated by Steven Blumenthal on April 1, 2014. (PX 7). Mr. Blumenthal set forth that based on the vocational testing performed by Respondent's vocational rehabilitation counselor, work restrictions, work experience and aptitude, Respondent's counselor was not targeting appropriate employers. (PX 7). Further, the unsuccessful job search supports his opinion. (PX 7). Mr. Blumenthal opined that Petitioner could earn between $8.74 and $11.03 per hour in suitable employment. (PX 7). As of the time of the hearing, Petitioner had not obtained employment within his restrictions.

At the arbitration hearing, the parties initially indicated the issues in dispute to be causation and nature and extent. Following the hearing, the parties agreed that the sole issue in dispute is the nature and extent of the Petitioner's injuries.

CONCLUSIONS OF LAW REGARDING NATURE AND EXTENT

Pursuant to Section 8.1b of the Act, for accidental injuries occurring after September 1, 2011, permanent partial disability shall be established using five enumerated criteria, with no single factor being the sole determinant of disability. Per 820 ILCS 305/8.1b(b), the criteria to be considered are as follows: (i) the reported level of impairment pursuant to subsection (a) [AMA "Guides to the Evaluation of Permanent Impairment"]; (ii) the

16IWCC0147

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. Applying this standard to this claim, the Arbitrator notes the findings with regard to each factor below.

(i) Level of Impairment. The Arbitrator finds that neither Petitioner nor Respondent submitted a report setting forth an AMA impairment rating. Accordingly, the Arbitrator will not consider that factor as it relates to the nature and extent of the injury.

(ii) Occupation. The Arbitrator places great weight on this factor in assessing Petitioner's disability. Petitioner's pre-injury occupation was that of a maintenance custodian for Respondent. Petitioner testified that his job for Respondent is physically demanding. Petitioner cleans the school, removes furniture and stripes and waxes the floor. The job requires him to lift up to 200 pounds with the help of a partner. Petitioner was also required to bend, stoop, climb ladders and stand and walk for six hours a day. Petitioner's testimony regarding his job duties is corroborated by the job description admitted into evidence. (RX 5). The Arbitrator finds that as a result of the work-related accident of November 10, 2011, Petitioner has permanent work restrictions of sedentary to light duty level work only with no lifting over 20 pounds, no bending at waist level, no stooping and to avoid prolonged sitting or standing over one hour. (PX 3). Based on Petitioner's unrebutted testimony and the job description (RX 5), the Arbitrator finds that Petitioner is unable to perform his pre-injury employment as a maintenance custodian. Further, Respondent was not able to provide Petitioner with work within the restrictions set forth by Dr. Espinosa. In fact, Respondent terminated Petitioner's employment on January 7, 2013 due to the fact that Respondent could not accommodate Petitioner's restrictions. (PX 8).

(iii) Age. At the time of the accident, Petitioner was 48. At the time of the hearing, Petitioner was 52 years old. Respondent's vocational rehabilitation counselor, Samantha Hoevel, documented in her reports that Petitioner's "advanced age" was a barrier to employability. (RX 6). The Arbitrator places great weight on this factor and finds that Petitioner's age would restrict his ability to obtain suitable employment.

(iv) Future Earning Capacity. The Arbitrator places significant weight on this factor and finds that as a result of his work-related accident of November 10, 2011, Petitioner sustained an impairment of future earning capacity. Both parties introduced vocational evidence. Petitioner submitted the opinions of Steven Blumenthal and Respondent submitted the opinions of Samantha Hoevel. Although the vocational counselors disagree as to how much Petitioner would be able to earn in suitable employment, both counselors agree that Petitioner would sustain a diminishment in his future earning capacity as a result of the accident. As it relates to Petitioner's future earning capacity, the Arbitrator first considered the opinions of Mr. Blumenthal, Petitioner's vocational expert. (PX 7). Mr. Blumenthal opined that based on Petitioner's age, education, training, work history and transferable skills, Petitioner would be able to earn up to $11.03 per hour in suitable employment. (PX 7). In rendering his opinion, Mr. Blumenthal relied on the aptitude testing performed by Coventry, Respondent's vocation experts, an accurate understanding of Petitioner's job as a maintenance custodian and an accurate understanding of Petitioner's work restrictions. (PX 7). Mr. Blumenthal also relied on Petitioner's unsuccessful and lengthy job search in support of his opinions. (PX 7). Mr. Blumenthal only met with Petitioner one time.

The Arbitrator also considered the opinions of Samantha Hoevel, Respondent's vocational rehabilitation counselor, who concluded that Petitioner would be able to earn on average $12 per hour in suitable employment. (PX 6). Petitioner participated in vocational rehabilitation under the direction of Ms. Hoevel from December 18, 2012 to the present. (RX 3); (RX 6); (RX 8). Ms. Hoevel specifically noted that Petitioner was compliant in vocational training. Further, Petitioner participated in a job search under Ms. Hoevel's direction from February 19, 2013 through July 8, 2015. (PX 6). During the job search, Petitioner contacted over 1200

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employers. (PX 6). Petitioner attended job fairs with Ms. Hoevel and followed up on any job leads provided to him by Ms. Hoevel. (PX 8). Despite all these efforts, Petitioner only had a few interviews and did not receive any job offers as a result of vocational services and the job search. (PX 8). Ms. Hoevel relied on a labor market survey in rendering her opinion. (RX 4). Ms. Hoevel targeted jobs of customer service representative, assembler and security. (RX 4). Petitioner has never worked as a customer service representative or assembler. In vocational rehabilitation, Petitioner only participated in computer classes. He did not participate in any other training. (RX 8). Additionally, Ms. Hoevel also targeted supervisory jobs for Petitioner. (RX 8). She set forth that an employment goal for Petitioner should be to obtain a job as a maintenance supervisor. (RX 8). Ms. Hoevel set forth that Petitioner's past history included working as a maintenance supervisor. (RX 8). However, Petitioner testified that he has never worked in a supervisory capacity.

Despite some of the problems with Ms. Hoevel's vocational rehabilitation efforts pointed out by Petitioner's expert, the Arbitrator notes that both experts are less than $1.00 apart in their assessment on how much Petitioner could earn on an hourly basis. Given the amount of time Ms. Hoevel has worked with the Petitioner, the Arbitrator places greater weight on her opinion in assessing the Petitioner's wage loss.

(v) Evidence of Disability Corroborated by Medical Evidence. Petitioner's medical records corroborate Petitioner's testimony that a work injury occurred on November 10, 2011, resulting in a right paracentral disc protrusion at L4-5 and left postero-lateral disc protrusion at the L5-S1 level, and requiring surgical intervention involving a right facetectomy, redo microdiskectomy and fusion with PEEK cage, bone graft and bilateral pedicle screws. Petitioner was eventually released from medical care with the following permanent work restrictions: sedentary to light duty level work only, no lifting over 20 lbs, no bending at waist level, no stooping, and avoid prolonged sitting or standing over 1 hour. Petitioner credibly testified that he has ongoing complaints and limitations consistent with his medical evidence. The Arbitrator places significant weight on this factor.

Based on all the factors above, the Arbitrator concludes that that Petitioner sustained a loss of earnings as a result of his work injury, and is entitled to a Wage Differential Award pursuant to Section 8(d)1 of the Illinois Workers' Compensation Act. Petitioner is entitled to a weekly wage differential of $232.31, which is two-thirds of the difference between $828.47 and $480.00. The $480.00 baseline amount is based on the evidence from Ms. Samantha Hoevel that Petitioner can expect to earn $12.00 an hour at a future employer.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Margaret Termini,
Petitioner,

vs.

16IWCC0163

NO: 12 WC 1622

Deltra Air Lines Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of nature and extent of Petitioner's permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 5, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $14,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 8 - 2016
KWL/vf
O-12/7/15
42

Kevin W. Lamborn

Joshua D. Luskin

DISSENT

To the extent that the majority opinion, in affirming and adopting the Arbitrator's award, inadequately addresses the severity of Petitioner's injuries and ongoing disability, I respectfully dissent.

While the record shows that Petitioner had previously suffered right and left rotator cuff tears, with surgical repairs in 1999 and 2004, respectively, she recovered successfully and continued to work thereafter without the need for further treatment or time off work up to the date of the accident on 8/8/11. Petitioner also testified that she had never had any problems with her low back prior to the incident in question.
With respect to her lower back, an MRI of the lumbar spine performed on 10/12/11 was interpreted as revealing mild diffuse spondylosis, mild to moderate facet arthrosis and hypertrophy, minimal/mild stenosis and a tiny central disc protrusion at L5-S1. (PX1). Petitioner was prescribed a Medrol Dosepak, underwent physical therapy and received an epidural steroid injection at L5-S1 on 12/16/11. (PX1;PX2).

Furthermore, Petitioner underwent surgery on 12/23/11 consisting of (a) right shoulder arthroscopic massive rotator cuff repair with double-row technique, (b) right shoulder arthroscopy with subacromial decompression with acromioplasty, (c) right shoulder arthroscopic loose body removal, (d) right shoulder arthroscopic distal clavicle excision, (e) right shoulder arthroscopy and biceps tenotomy with extensive debribement, (f) right shoulder open subpectoral biceps tenodesis, and (g) left shoulder subacromial cortisone injection. (PX1). The post-operative diagnoses were (a) right shoulder full-thickness rotator cuff tear with greater than 3 cm, (b) right shoulder biceps tendon tear, (c) right shoulder subacromial bursitis, (d) right shoulder multiple foreign body/loose stitches, (e) right shoulder acromioclavicular joint arthritis, and (f) left shoulder rotator cuff tendon tear. (PX1).

Petitioner subsequently underwent a second surgical procedure on 7/17/12 consisting of (a) left shoulder arthroscopic rotator cuff repair using double row technique, (b) left shoulder arthroscopic subacromial decompression with acromioplasty, (c) left shoulder arthroscopic partial synovectomy, (d) left shoulder arthroscopic extensive debridement, and (e) left shoulder arthroscopic loose body removal. (PX1). The post-operative diagnoses were (a) left shoulder full-thickness rotator cuff tear, approximately 2 cm., (b) left shoulder subacromial bursitis with a hooked acromion, (c) left shoulder multiple loose foreign bodies, and (d) left shoulder extensive synovitis. (PX1).

Thus, as a result of the injury, Petitioner sustained full-thickness rotator cuff tears of both the right and left shoulder as well as a right biceps tendon tear, all requiring extensive surgical repair. Radiographic studies also revealed a disc protrusion/herniated disc at L5-S1. However, Petitioner only received conservative treatment for her lower back injury. She underwent physical therapy and was eventually released without restrictions for her bilateral shoulder

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0163

TERMINI, MARGARET
Employee/Petitioner

Case# **12WC001622**

DELTA AIR LINES INC
Employer/Respondent

On 6/5/2015, 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 0.07% 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:

0365 BRIAN J McMANUS & ASSOC, LTD
30 N LASALLE ST
SUITE 2126
CHICAGO, IL 60602

5001 GAIDO & FINTZEN
JUSTIN KANTER
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ 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

16IWCC0163

Case # 12 WC 01622

Margaret Termini
Employee/Petitioner

v.

Delta Air Lines, Inc.
Employer/Respondent

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 **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **May 14, 2014**. 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. X 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. X 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 _____

16IWCC0163

FINDINGS

On **August 8, 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 **$19,162.00**; the average weekly wage was **$368.50.**

On the date of accident, Petitioner was **62** years of age, ***single*** with **0** dependent children.

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$8,212.39** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$8,212.39**. The agreement of the Parties is that Petitioner was entitled to TTD benefits for the time periods of **12/23/11-1/22/12 and 7/1/12-2/4/13** and all TTD benefits have been paid.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits in the amount of **$221.11/week** for **100 weeks** because the injuries sustained caused the **20 % loss of use of the person as a whole,** as provided in **§8(d)2** of the Act.

Respondent shall pay Petitioner all compensation that has accrued from 8/8/2011 through 5/14/2014, and shall pay the remainder of the award, if any, in weekly benefits.

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.

Signature of Arbitrator

June 4, 2015
Date

ICArbDec p. 2

JUN 5 - 2015

FINDINGS OF FACT

Petitioner was employed by Respondent as a Cargo Representative. She worked in the office entering freight bills. She would also work in the cargo freight area.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of her employment by Respondent on August 8, 2011. On that day, she swiped in and slipped and fell down really hard, injuring her head, back, leg and shoulders. Fellow employees, including Petitioner's supervisor, helped her up.

Petitioner did not seek immediate medical care. Petitioner asked Respondent's HR department for a doctor close to where she lived and she was referred to Midwest Bone & Joint Institute in Elgin. It took Petitioner a long time to set up an appointment.

Before the accident, Petitioner had been able to perform her current job and heavy work activities in her prior employment as a stockroom manager at a retail store and as a bartender. She had no prior back problems and her shoulder had not bothered her after surgery that took place 15 years ago.

Petitioner is right handed.

Petitioner's testimony and the medical histories in many of the records are inconsistent regarding prior shoulder problems. On Direct, Petitioner testified that she had prior left rotator cuff surgery as a result of a roller blading injury. On Cross, Petitioner said that she injured her right shoulder and had surgery as a result of the roller blading accident. She said she did not have prior left shoulder surgery. She said that she only had one prior shoulder surgery. She would disagree with medical records that said that she had left shoulder surgery in 2004. On Re-Direct, she said she did have a prior rotator cuff surgery to her right, not left, shoulder. This was due to the roller blading injury. She didn't believe that she underwent left shoulder surgery before the August 11, 2011 accident. She was not under active care for either the right or left shoulder at the time of the accident. The initial medical at Midwest Bone & Joint Institute, when Petitioner was seen by Dr. Savino for back complaints, documents that Petitioner did give a history of prior surgically repaired rotator cuff tears in both arms. Further, bilateral shoulder surgery scars were noted in the physical exam. (PetEx.1) The history given to §12 examiner Pommerance was of a prior right shoulder surgery in 1999 as a result of a roller skating accident. She did not recall the specifics of the procedure when she talked with Dr. Pommerance on July 25, 2013. She denied prior left shoulder surgery. (ResEx.2) On July 25, 2013, she told Dr. Butler of her past surgical history of a right rotator cuff repair in 1999 (she apparently omitted the several prior left knee procedures, including a TKA). (ResEx. 1) The pre-surgery clearance from Dr. Bianchi documents right shoulder surgery-2000, left shoulder surgery-2004, multiple left knee surgeries 1981-2000, left knee TKR-2010). (PetEx. 3) The operative reports for the surgeries that Dr. Alpert performed subsequent to the date of accident clearly document pathology consistent with prior surgeries to both shoulders and do mention the history of prior surgical repairs. (PetEx.1)

The Arbitrator concludes that Petitioner was not trying to be evasive in her testimony or in the histories given to the physicians. Petitioner told Dr. Pommerance that she is not good with dates and could not remember a number of events surrounding the injury and the medical care rendered. Her responses were because of confusion or nervousness and were not made with an inappropriate motive.

The Arbitrator finds that Petitioner had rotator cuff repairs to both her right and left shoulders prior to sustaining the accidental injuries of August 8, 2011. The right procedure was in 1999 and the left procedure was in 2004. The Record does not disclose continued problems or treatment regarding either shoulder after those procedures.

After the accident, Petitioner was able to work her regular job. In September of 2011, she was given a warehouse position which required more physical activities. Petitioner testified that she received help from her co-workers in performing the heavier tasks. She described her back pain as being "huge" after the accident. The shoulder pain was excrutiating, horrible, she couldn't lift her arms. Yet, there was no emergency room care, there was no immediate medical care and Petitioner waited almost two months to see an orthopedic group that Respondent suggested.

The first medical care that Petitioner received was on October 6, 2011, at Midwest Bone & Joint Institute. She was seen by Dr. Savino for low back pain, radiating to the right lower extremity, after a fall at work on 8/8/2011. Petitioner denied prior back problems. Pain in both shoulders was also noted. The impression was low back pain with sciatica. Dr. Savino recommended a medrol dosepak, physical therapy and a lumbar MRI. The MRI showed degenerative changes with a tiny central disc protrusion at L5-S1, mild diffuse spondylosis and mild to moderate facet athrosis and hypertrophy. Symptom magnification was observed in therapy. Petitioner cancelled all of the remaining PT visits at IB&JI and was discharged on November 28, 2011. Petitioner received a lumber ESI in December of 2011. Dr. Savino referred Petitioner to Dr. Stanley at Midwest for pain treatment for the low back. The last visit with Dr. Stanley was on November 2, 2012. Dr. Stanley recommended more therapy before considering another back injection. (PetEx. 1)

Petitioner first saw Dr. Alpert for shoulder complaints on November 23, 2011. Dr. Alpert's assessment was: 62 year old female with a work related injury on 8/8/2011with: 1.) Right shoulder rotator cuff tear; 2.)Right shoulder AC joint arthritis; 3.) History of previous rotator cuff tear repaired in 1999, asymptomatic prior to this new injury. An MRI of the right shoulder was ordered, as the patient was refractory to PT. Dr. Alpert wrote a letter to Respondent on November 28, 2011, wherein he requested approval for a left shoulder MRI because Petitioner was having significant pain in her left shoulder. The MRI studies were done on December 1, 2011. The right shoulder MRI was said to show a "massive" rotator cuff tear with subluxation of the long head of the biceps tendon and mild atrophy of the subscapularis and supraspinatus muscle bodies. The left shoulder study showed a small full-thickness tear of the mid supraspinatus tendon. Dr. Alpert performed surgery on the right shoulder and an injection of the left shoulder on December 23, 2011. The procedure included arthroscopic rotator cuff repair with AC joint resection and biceps tenodesis and tenotomy. Petitioner had a reaction to the injection and was taken to Sherman Hospital for emergency care. The left shoulder was surgically repaired on July 17, 2012. The procedure included rotator cuff repair with subacromial decompression and acromioplasty. Both shoulder surgeries were quite extensive and showed pathology from the prior RTC repair surgeries. The Operative Reports for the two surgeries do appear to document a causal connection opinion from Dr. Alperts. Petitioner had therapy and normal follow-up care for the shoulder surgeries. The last visit with Dr. Alpert for the shoulders was on February 25, 2013. Petitioner complained of pain in her shoulders when she lifts things. She also complained of back pain with shooting pains down her legs. Dr. Alpert noted full range of motion of the shoulders with normal strength. She was released to all activities regarding her shoulders and was referred back to Dr. Stanley regarding her back. (PetEx. 1)

Petitioner was seen by Dr. Jesse Butler on July 25, 2013 for a §12 exam regarding her back. Dr. Butler diagnosed Petitioner with a lumbar strain, resolved, and right trochanteric bursitis. The strain was related to the injury. There was no permanent impairment and no need for further treatment or any work restrictions. (ResEx. 1)

Petitioner was also seen seen by Dr. Pommerance on July 25, 2013 for a §12 exam regarding her shoulders. Two reports from Dr. Pommerance were submitted by Respondent. Dr. Pommerance noted discrepancies in the records and the history given to him. The diagnosis for the right and left shoulders was: pain, weakness and

limited range of motion after surgery. Dr. Pommerance thought that Petitioner had a significant discrepancy between her subjective complaints and the objective findings. In his first report, Dr. Pommerance stated that based upon the supplied information, there appears to be some relationship between the fall and the bilateral shoulder surgeries. Dr. Pommerance requested further information in order to complete his opinions. Some, but not all of the requested studies and records were provided, but Dr. Pommerance could only say that it was not clear whether the fall had any contribution to the findings on the 2011 MRI scans. (ResEx. 2&3)

Petitioner testified that she currently has back pain and shooting pains on her right leg. She limps. She has difficulty with stairs and walking. She has trouble standing for a long time. She has limited lifting using her arms. It is difficult for her to put dishes in a cabinet. It is hard for her to shampoo. She has decreased strength, she used to lift a ladder by herself and she can't now. Petitioner now works at Portillo's, taking orders and at Mariano's in the coffee shop.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in Support of the Conclusions of Law set forth below.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

It is axiomatic that the first medical care for a traumatic injury is very helpful in determining what conditions are related to the accident. Unfortunately, Petitioner was not sent to the emergency room or an occupational clinic by Respondent on the date of accident and she did not avail herself of her own choice of initial medical care. Petitioner chose to ask Respondent for the name of a physician that was close to her home and the first medical care for the injuries took place two months after the accident because she had difficulty in setting up an appointment. Both Parties are responsible for the lack of immediate medical to support the Arbitrator's finding on causal connection and, therefore, this does not impact the causal connection opinion.

The Arbitrator finds that Petitioner's current condition of ill-being regarding her low back is causally connected to the injury, based upon the unrebutted testimony of Petitioner and the medical evidence. The condition is lumbar strain with aggravation of degenerative conditions such that petitioner underwent therapy and a lumbar ESI. The Petitioner denied prior back problems and no evidence of any prior back problems or treatment was submitted. Dr. Butler thought that Petitioner's post lumbar strain condition was related to the fall.

The Arbitrator finds that Petitioner's current condition of ill-being regarding her left and right shoulders is causally connected to the injury, based upon Petitioner's testimony and the medical evidence. The condition is status post left and right shoulder surgical repair with pain, weakness and limited range of motion due to a fall at work that injured asymptomatic, previously surgically repaired, shoulders and degenerative conditions such that surgical repairs were necessitated.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Considering the testimony of Petitioner and the medical records, the Arbitrator finds that Petitioner sustained permanent partial disability to the person as a whole to the extent of 20% thereof. This disability is allocated as follows: 10% loss of use of a person as a whole for the injury to the right (dominant) shoulder; 8% loss of use of

a person as a whole for the injury to the left shoulder; and 2% loss of use of a person as a whole for the injury to the low back.

12 WC 09191

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brett Briney,
Petitioner,

vs. NO: 12 WC 09191

16IWCC0135

Ameren,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection and prospective medical care, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 10, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

12 WC 09191

16IWCC0135

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 2 5 2016
MJB:ell
O-11/09/15
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

BRINEY, BRETT
Employee/Petitioner

Case# **12WC009191**

16IWCC0135

AMEREN
Employer/Respondent

On 2/10/2015, 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 0.08% 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:

0225 GOLDFINE & BOWLES PC
ATTN: WORK COMP DEPT
4242 N KNOXVILLE AVE
PEORIA, IL 61614

0080 PRUSAK WINNE & McKINLEY LTD
JOSEPH WINNE
300 N MAIN ST SUITE 300
PEORIA, IL 61603

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

☐ 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
19(b)

BRETT BRINEY
Employee/Petitioner

v.

AMEREN
Employer/Respondent

Case # 12 WC 09191

Consolidated cases: _____

16IWCC0135

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 **ARBITRATOR DOUGLAS McCARTHY**, Arbitrator of the Commission, in the city of **PEORIA, ILLINOIS**, on **01/16/2015**. 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

16IWCC0135

FINDINGS

On the date of accident, **05/17/2010**, 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 $**69,086.05**; the average weekly wage was $**1,328.58**.

On the date of accident, Petitioner was **52** years of age, ***married*** with **0** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**11,893.43** for TTD, $**-0-** for TPD, $**-0-** for maintenance, and $**-0-** for other benefits, for a total credit of $**11,893.43**.

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

ORDER

Respondent shall authorize the proposed surgery recommended by Doctor Gibbons as the Petitioner's condition of ill being is causally related to his accident.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

Signature of Arbitrator

Feb. 6, 2015
Date

ICArbDec19(b)

FEB 10 2015

ATTACHMENT TO ARBITRATOR'S DECISION

Brett Briney vs. Ameren

IWCC No.: 12 WC 09191

In support of the Arbitrator's decision regarding (F) **Is Petitioner's current condition of ill-being causally related to the injury**, the Arbitrator notes as follows:

Petitioner testified he worked for Respondent as a lineman. Petitioner alleged he sustained accidental injury on May 17, 2010 to his left knee. Petitioner testified he was sent to fix a light in a backyard. After assessing that the light was out, Petitioner descended a ladder attached to a pole and felt a pop in his left knee. Petitioner testified that his equipment at the time of the incident included strap hooks attached to his legs, a belt around his waist, and shoes with spikes to allow for climbing up and down poles. Petitioner testified he felt discomfort in the left knee on the way back to the truck followed by pain and swelling. Petitioner's testimony, along with histories he provided to his medical providers, established that his job required him to climb poles and ladders as well as into and out of lift buckets. He was required to lift and carry 15 to 20 pound ladders as a regular part of his job.

Petitioner testified he first sought treatment with Dr. Ayers, his family doctor, on May 19, 2010. (PX-1). X-rays of Petitioner's left knee were obtained on this date indicating no fracture or acute osseous abnormality, moderate sized joint effusion, an entheosphyte present at the insertion of the quadriceps tendon on the patella and an impression of moderate sized joint effusion, no acute osseous abnormality. (Id.). An MRI of Petitioner's left knee was performed on May 28, 2010, indicating probable tear of

the medial meniscus, moderate sized joint effusion, contusion in the medial proximal tibia, and degenerative arthritis. The history obtained by the radiologist at that visit was that petitioner had noticed his left knee popping while climbing down a power pole, with medial pain and instability since the occurrence. (Id)

The Petitioner was referred by his family physician, Dr. Clyde Grady to Dr. Michael Gibbons at Midwest Orthopedic Center. The Petitioner was first seen by Dr. Gibbons on June 7, 2010 and gave a history consistent with his testimony at Arbitration. (Petitioner Exhibit 2) Dr. Gibbons concluded that the Petitioner had a left knee medial meniscus tear and recommended a left knee arthroscopy. (Petitioner Exhibit 2) That procedure was authorized and performed by Dr. Gibbons on July 23, 2010. (Petitioner Exhibit 2)

Following the surgery, the Petitioner continued to have pain and swelling in his left knee and continued to treat with Dr. Gibbons. The Petitioner had his knee aspirated and received injections on multiple occasions throughout the following three months. (Petitioner Exhibit 2) On October 26, 2010 the Petitioner had a visit with Dr. Gibbons, during which he stated that his knee was feeling a lot better and that he had less pain and swelling. Dr. Gibbons still noted small effusion during his examination. He was still doing light duty work and had not been climbing any ladders or polls. Dr. Gibbons felt that the Petitioner had a favorable response to the previous Synvisc injection. The Petitioner stated he was anxious to get back to regular duty work and therefore Dr. Gibbons allowed him to return to work on October 27, 2010 without restrictions. Dr. Gibbons further stated that he felt that the Petitioner would be at maximum medical

improvement in about four weeks and the Petitioner was to follow-up with Dr. Gibbons as needed for any recurrent symptoms. (Petitioner Exhibit 2)

Unfortunately, the Petitioner required additional treatment following the October 26, 2010 release to work due to continued pain and swelling in the knee. On January 20, 2011 and again on February 14, 2011 he was given the same treatment of aspiration and injection that he received prior to his full duty release. (Petitioner Exhibit 2) On a May 23, 2011 visit a knee replacement procedure was discussed but ultimately decided that the Petitioner was not far enough along to consider. Instead, Dr. Gibbons recommended a repeat arthroscopy. On his next visit, August 22,2011, Dr. Gibbons had x-ray's performed which showed progression of his arthritis. The medial aspect of the knee was now graded at moderate to severe. Accordingly, Dr. Gibbons recommended conservative care as opposed to a repeat arthroscopy. (Petitioner Exhibit 2)

During his treatment with Dr. Gibbons the Petitioner also saw Dr. Myron Stachniw, an orthopedic surgeon, for a second opinion. The Petitioner saw Dr. Stachniw on February 20, 2012 and gave a history consistent with his testimony at arbitration. (Petitioner Exhibit 4) Dr. Stachniw stated that the Petitioner was doing as well as he could, was receiving full conservative treatment, and that the next modality would be a knee replacement. In his report Dr. Stachniw wrote that the Petitioner's torn meniscus had a significant role in aggravating and accelerating his knee problem. (Petitioner Exhibit 4) After some further continued treatment with Dr. Gibbons, in a May 12, 2014 visit it was finally decided that a knee replacement was appropriate. (Petitioner Exhibit 2)

The Petitioner testified at arbitration that he had no prior left knee complaints or treatment sought before the date of accident of May 17, 2010 and this is consistent with

his treatment records of the previous ten years with his family physician Dr. Grady. (Petitioner Exhibit 1) There is some mention of rheumatoid arthritis in a note from Dr. Grady dated June 4, 2014. The petitioner was being seen at the time for right knee pain. The doctor's note states " He has known rheumatoid arthritis that has affected multiple joints, including his knees." (RX 6) The petitioner denied treating for rheumatoid arthritis and, again, there is nothing in any of the medical records of treatment pre-dating the accident to rebut his denial.

In his evidence deposition, Dr. Gibbons was asked if he felt the incident caused the need for the knee replacement surgery to which he responded:

> Again, I think that would, based on the information I have, be the trigger or the first domino to start this process. So that would likely be the start of this or the cause of the subsequent problems, yes.
> (Petitioner Exhibit 5, p.31)

In his evidence deposition, Dr. Stachniw was asked, presuming the Petitioner had no prior knee problems and that he has had problems ever since the incident and surgery, whether he had an opinion as to whether the recommendation for a knee replacement is related to the incident on May 17th, 2010 and stated that he thought it was related. (Petitioner Exhibit 6, p.15) Dr. Stachniw went on further to state that if the Petitioner was asymptomatic before this injury, that the accident was an aggravating and accelerating cause. (Petitioner Exhibit 6, p.15) He also referenced dominos in explaining his opinion. He said that the accident was like knocking over the first domino in a line of dominos that kept going. (Id at 36) Upon repeated questioning by Respondent's attorney aimed at establishing that the accident was a temporary aggravation at best, the doctor said that once the first domino fell, the subsequent dominos, like the progression of the

Petitioner's arthritis, did not stop. (Id at 42) He was questioned again as to whether the Petitioner had returned to his pre accident baseline after his arthroscopic surgery. Dr. Stachniw said that while the Petitioner's abilities and ability to work had returned to baseline, his knee did not. His knee, he said, was worse as he was now without a medial meniscus. (Id at 37-38) The need for surgery, he opined, was due to both the accident and the pre existing arthritis. (Id at 44)

At the request of the Respondent, the Petitioner was examined by a Dr. John Hoffman on September 15, 2011. It was Dr. Hoffman's opinion that the Petitioner had arthritic changes to the knee prior to the incident at work and that the incident may have exacerbated his pain but did not lead to his arthritic changes. (Respondent Exhibit 3) Dr. Hoffman also stated that with the Petitioner being 53 years old he should continue with conservative care as long as possible and that the next surgery would be a total knee replacement arthroplasty. (Respondent Exhibit 3)

At the request of the Respondent, the Petitioner was examined by a Dr. Richard Rende on August 16, 2012. It was Dr. Rende's opinion that the Petitioner had longstanding severe degenerative osteoarthritis of the left knee predating the alleged work injury. (Respondent Exhibit 9) Dr. Rende stated that he found it inconceivable that someone with that degree of degenerative osteoarthritis could be asymptomatic prior to May 17, 2010. (Respondent Exhibit 9, p.33-34) This is in direct conflict with the testimony of the Petitioner who stated that he never had problems with his knee prior to the incident on May 17, 2010. The Petitioner also provided treatment records from his primary care physician going back roughly ten years which show absolutely no treatment or complaints pertaining to his left knee. (Petitioner Exhibit 1) Petitioner also provided

two contrasting opinions from Dr. Gibbons and Dr. Stachniw who both stated it was possible to have this level of degeneration and remain asymptomatic. (Petitioner Exhibit 5 and 6)

A large part of Dr. Rende's deposition testimony involved his interpretation of the MRI which was performed on the petitioner just ten days after his accident. Dr. Rende maintained that the MRI contained only chronic findings which predated the accident. The radiologist who actually performed the test noted findings of edema along the medial aspect of the medial femoral condyle which probably represented a contusion. (PX 3) While Dr. Rende acknowledged that there was edema, he would not concede that it could represent a contusion. While admitting that the edema could be acute, the doctor concluded that it was not in this case.

It is well settled in our law that an employer takes an employee as it finds him. On May 17, 2010, the Petitioner had substantial degenerative arthritis in his left knee but had no evidence of prior symptoms or treatment for that condition. He had an accident which produced acute symptoms as evidenced by the x-ray and MRI performed soon thereafter. His symptoms to some extent have continued without interruption to the present time. As Dr. Stachniw persuasively opined, his arthritis has significantly worsened since the accident to the point where he now needs a knee replacement. ((PX 6 at 9, 15) Dr. Rende's opinions are not persuasive. His reluctance to admit that the MRI findings referenced above show an acute injury seem to be based on his belief that the Petitioner was lying about his absence of pre-accident symptoms, a belief which has no support in the evidence. As the Supreme Court said in its decision in Sisbro, the question is whether the accident accelerated or aggravated the pre existing condition. See 207 Ill. 2d 193

(2003) The evidence here shows that it did, and the Petitioner's request for surgical authorization is granted.

STATE OF ILLINOIS)	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF COOK)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Howard Simon,
Petitioner,

vs. NO: 12 WC 17170

Ford Motor Company,
Respondent.

16IWCC0164

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident and permanent disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Having reviewed the record, the Commission changes the date of accident to November 23, 2011 to comport with the evidence contained in the record. Additionally, the Commission views the permanency issue differently than the Arbitrator and finds Petitioner is permanently disabled to the extent of 10% man as a whole under Section 8(d)2 of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the correct date of accident is November 23, 2011.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $695.78 per week for a period of 51.25 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 25% loss of use of the left hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $695.78 per week for a period of 50 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 10% loss of a man as a whole.

16IWCC0164

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $70,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 9 - 2016

MB/jm

O: 2/25/16

43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SIMON, HOWARD
Employee/Petitioner

Case# **12WC017170**

16IWCC0164

FORD MOTOR COMPANY
Employer/Respondent

On 6/5/2015, 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 0.07% 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:

0222 GOLDBERG WEISMAN & CAIRO LTD
JOEL J BLOCK
1 E WACKER DR SUITE 3900
CHICAGO, IL 60601

0560 WIEDNER & McAULIFFE LTD
RANDALL W SALDEK
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

16IWCC0164

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

- ☐ 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

Howard Simon
Employee/Petitioner

v.

Ford Motor Company
Employer/Respondent

Case # **12** WC **17170**

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 **Stephen Friedman**, Arbitrator of the Commission, in the city of **Chicago**, on **May 11, 2015**. 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 **November 24, 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 $**69,680.00**; the average weekly wage was $**1340.00**.

On the date of accident, Petitioner was **60** years of age, ***married*** with **0** dependent children.

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $695.78/week for 51.25 weeks, because the injuries sustained caused the 25% loss of the Left Hand, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $695.78/week for 75 weeks, because the injuries sustained caused the 15% loss of the person as a whole, as provided in Section 8(d)2 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.

Signature of Arbitrator

June 4, 2015
Date

ICArbDec p. 2

JUN 5 - 2015

Statement of Facts

Petitioner Howard Simon testified that on November 24, 2011 he was working for Respondent Ford Motor Company as a machinist. His duties included making repairs and machine work. He had been employed by Respondent for 34 or 35 years.

Petitioner testified that, on the date of the accident, he was using the small lathe. Petitioner identified photographs of the machine (Px 1A-1J). Petitioner described the jaws on the chuck which held the piece in place. These jaws were tightened with a T wrench used on the socket head cap screws. The cap screws are removed with an Allen wrench. The wrench is 4 or 5 inches long. The screws are under a great deal of pressure. You can use a hammer or take a pipe to loosen them.

The lathe that he was using had CNC, computer numerical control. You enter numbers into the control box and the machine is supposed to do that. Before you enter the information to program the machine, he would do the calculations on a piece of paper. You would have a list of X and Z coordinates. Petitioner did not have his program sheet with him at trial. Petitioner testified that on the date of the accident he had already written the calculations that were going to be entered on a piece of paper.

Petitioner testified that he would not create a Job ticket for tools he made. There would sometimes be tickets for things other people needed. Petitioner testified that he never made anything for his personal use or for sale.

Petitioner testified that on the date of the accident he was turning a piece on the lathe. Petitioner testified that he was turning a pipe. It was approximately 30 to 35 inches long. He used a piece of metal that was in a rack in the plant. Petitioner identified the piece he was working on in Respondent's Exhibit 4. He testified he was making a cheater bar, a pipe to put on the wrench to add leverage to loosen the cap screws. It was tapered so that he could cut it into two or three pieced. It would kind of taper, lock the Allen wrench in. There were different hole diameters to fit different size Allen wrenches.

Petitioner testified that he owns shotguns and shoots trap. He has equipment to reload shotgun ammunition. He testified to how this is performed and the dangers of putting too much powder in a shell. His hobbies are metal engraving and wood engraving of the wooden stocks for firearms. Petitioner testified that he has never manufactured any type of firearm parts. Petitioner testified that he was not making a shotgun barrel on November 24, 2011. He has never made a shotgun barrel. He did not know the strength of the particular pipe he was working on at the time of his accident. He is not a metallurgist.

Petitioner testified that he was injured when his shirt sleeve was pulled into the lathe. His left wrist was dislocated. He also injured his right bicep and right side of his pelvis.

Petitioner testified that he was taken to St. James Hospital emergency room by ambulance. The records of St. James Hospital were admitted as Petitioner's Exhibit 2. The records document that Petitioner was transported by EMS from the Ford factory after getting his clothing caught in a lathe. He was admitted at 8:38 PM on November 23, 2011. He had complaints in the left wrist, right shoulder and left leg as well as left chest pain. X-ray studies disclosed a fracture to the left distal radius with dislocation of the left wrist and a fracture of the fifth metacarpal. This was reduced. Petitioner was noted to have a fracture of the pelvis. A deformity of the right scapula was also noted. Petitioner was discharged at 1:12 AM on November 24, 2011 (Px 2).

The records of Palos Community Hospital were admitted as Petitioner's Exhibit 5. Petitioner then presented at the emergency room at Palos Community Hospital at 5:00 PM on November 24, 2011 (Px 5 p.11). Petitioner reported he could not control the pain at home and presented at the Palos Hospital emergency room. Petitioner was admitted for evaluation of his multiple injuries. The November 24, 2011 assessment by Dr. Schiappa was comminuted fracture left distal radius, strain left shoulder, strain right shoulder with nerve irritation, left sided pelvic fracture, left forehead laceration, fracture right 6th rib. Wrist x-rays confirmed the comminuted fractures of the distal radius (Px 5 p.280). A rib study disclosed a questionable non displaced fracture of the left 6th rib (Px 5 p. 288). A CT scan of the pelvis confirmed acetabular fractures (Px 5 p.291). An MRI of the right shoulder disclosed tendinosis, a suggestion of a labrum tear, suggestion of a tear of the long head of the biceps, osteoarthritis, and muscle strains (Px 5 p.296-297). On November 30, 2011, Petitioner underwent a closed reduction and insertion of pins and plaster to the left wrist and radius (Px 5 p. 245-246). On December 1, 2011, Petitioner had an EMG which noted acute severe incomplete right median neuropathy as well as carpal tunnel syndrome and mild right ulnar sensory neuropathy at the wrist (Px 5 p.312-314). On December 5, 2011, Dr. Mochizuki noted Petitioner would need continued PT and OT and this was discussed with St. Joseph's (Px 5 p.21-22). Petitioner was discharged on December 12, 2011 (Px 5 p.3)

The records of Presence St. Joseph Medical Center were admitted as Petitioner's Exhibit 6. Petitioner was admitted for inpatient rehabilitation on December 12, 2011.Petitioner was discharged to outpatient therapy on December 20, 2011.

The records of Southside Orthopedics were admitted as Petitioner's Exhibit 3. Petitioner was seen postoperatively. On January 5, 2012, the record notes that, with respect to the left wrist, Petitioner's cast was off and the pins were out. Petitioner was on partial weight bearing with his pelvis. The doctor recommended he continue with use of his walker. On January 19, 2012 the doctor notes that he has done remarkably well after the caste was removed. There is full pronation and supination, good grip strength and full range of motion of the elbow. The doctor also notes some return of function on the right and recommends additional e-stim and motion exercises. Petitioner was to be seen again if no improvement. A repeat EMG of the right arm was performed on February 7, 2012. There were continued findings consistent with the EMG performed on December 1, 2011.

Brad Beard testified for Respondent. He is the manufacturing engineering manager for Respondent. He was in that position on November 24, 2011. He was advised of the injury by a telephone call to his home. He followed company protocol by roping off the area and leave everything intact. When he arrived the following day there was a flannel shirt draped over the work piece. There was a round work piece checked up and engaged in the tailstock. Mr. Beard testified that he took the work piece. He identified Respondent's Exhibit 1 as the piece he kept. He testified that this was the piece that was taken to Mr. Gillette for identification. He could not state if Respondent's Exhibit 1 was in existence on the floor. He did not believe that the piece was a cheater bar because the outside is tapered.

Mr. Beard testified he also found a piece of paper with a job tag with a series of X and Z numbers. It was on the bench approximately 2 feet from the lathe. He identified Respondent's Exhibit 3 as the piece. It is a series of numbers used to program the CNC lathe. It is titled "Barrel Prog." He does not know how long it was at the site. He does not know who wrote it. He does not know how it wound up at the site.

Mr. Beard suspected that the piece was a shotgun barrel. He has never seen an incomplete barrel. He is a shotgun shooter. To be a shotgun barrel the inside diameter has to be a specific diameter. He did not put a

shell in the piece. He did not measure it with a caliper. His opinion is based upon collection and shooting shotguns for 35 years.

John Gillette testified for Respondent. He is the president of Classic Guns, Ltd. in Crete, Illinois. He has operated Classic Guns, Inc. since 1996 restoring and repairing older weapons. Before then he was a machinist. In the military he was an armorer doing weapons repair. He testified that a 12-guage shotgun has a bore of 729 thousandths. It would also be choked, a smaller diameter at the muzzle. He was visited on December 21, 2011 be two Ford employees. One was Mr. Beard. Mr. Gillette testified that Respondent's Exhibit 1 is a rough shotgun barrel. He testified that it was a 12-guage blank. The diameter of the bore is 729 thousandths. It was 725 the other day but there is rust, not a good measurement on the inside. Respondent's Exhibit 1 is choked. He testified that if Respondent's Exhibit 1 was cut in half or thirds it might also be used as a cheater bar. He did not test the tensile strength of the steel. He testified that in shotgun barrels the hardness is important to some extent, but the main thing is the alloy and elasticity in the metal. There is no chamber on respondent's Exhibit 1. There are no lugs or attachments. He did not measure the internal bore to make sure it was straight.

Robert Bevis testified for Petitioner as a rebuttal witness. He is a firearms dealer and manufacturer and a gunsmith. He was certified through Ashworth and Phoenix State Arizona University as a journeyman gunsmith. He is a manufacturer certified by the ATF. He testified that the components of a shotgun barrel consist of a chamber where the shell would be inserted, a throat, the barrel itself and the muzzle. The barrel needs to be a Rockwell Hardness between 40 and 50. There needs to be a way to attach the barrel to a receiver, usually a lug or hind or threading. The shell must fit snuggly into the chamber area.

Mr. Bevis examined Respondent's Exhibit 1. He testified that it did not have the internal throating. It does not have any mounting lug or extractor. It would need to be countersunk for a shell. It would need some type of extracting system. He testified form his inspection that it could not be make into a shotgun barrel. He thinks the metal is a little weak. The interior is scraped. In his opinion, it is not finishable as a barrel. The hole is too small for the 12 gauge dummy round. The witness then demonstrated several barrels and testified to the elements that were missing from Respondent's Exhibit 1 to be a barrel for each variety of shotguns available.

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident, the Arbitrator finds as follows:

It is undisputed that on November 24, 2011, Petitioner was in the course of his employment with Respondent turning a piece of pipe on a lathe when his shirt became entangled in the lathe and he was drawn into the machine sustaining injuries. Respondent has disputed that the accident "arose out of the employment," claiming Petitioner was injured while making a shotgun barrel for his personal use rather that a tool for the employer's benefit.

A claimant bears the burden of proving by a preponderance of the evidence that his or her injury arose out of and in the course of the employment. The mere fact that the claimant's duties took him to the place of injury and that, but for his employment, he would not have been there, is not sufficient, of itself, to support a finding that his injuries arose out of his employment. An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury.

Petitioner testified that at the time of his injury he was making a cheater bar to assist with leverage when tightening and loosening the cap screws on the jaws of the lathe. He testified that the piece of pipe he was using was one he found in the rack in Respondent's plant. He described his intention to cut the piece into shorter sections once it had been turned. He unequivocally denied that he was making or had ever made a shotgun barrel. If Petitioner's injury occurred while he was creating a cheater bar for use in Respondent's plant, the injury would clearly arise out of his employment.

Respondent's witness Mr. Beard identified Respondent's Exhibit 1 as the piece in question. He gave his opinion it looked like a shotgun barrel. He also questioned whether it could used as a cheater bar, stating that there is no need to taper the outside diameter of a cheater bar. He also identified Respondent's Exhibit 3 entitled "Barrel Prog." as being found near the lathe and containing the x and z coordinates used for programming the CNC lathe. Respondent also presented expert testimony from Mr. Gillette who opined that Respondent's Exhibit 1 was a rough 12 gauge shotgun barrel. He based his opinion on a caliper measurement of the inside diameter. He testified it was the proper 729 thousandths and was choked.

Petitioner presented the expert testimony of Mr. Bevis who testified that Respondent's Exhibit 1 did not have internal throating. The internal bore is too small for a 12 gauge shell. He demonstrated that a shell would not fit. He describe the hardness needed for the metal in a shotgun barrel and felt that this metal was a little weak, although he had not actually tested it. He opined that he did not believe that the piece was a finishable shotgun barrel.

Petitioner testified unequivocally that he was not making a shotgun barrel and that he had never made a shotgun barrel. He testified that he was aware of the dangers inherent in attempting to make a barrel from an unknown or inferior strength of steel. Because the accident occurred before Respondent's Exhibit 1 was completed, the final product being machined cannot be determined with certainty. Although the Arbitrator notes some inconsistencies in Petitioner's testimony, particularly with respect to tapering inside diameter as opposed to outside diameter, the Arbitrator finds that Petitioner's testimony as to his knowledge of shotguns and the dangers associated credible and supportive of his assertion that he would not make a shotgun barrel from a piece of pipe found on the rack at Respondent's plant. The Arbitrator also observed Petitioner's craftsmanship in the wood engravings that he displayed and finds it a reasonable inference that he would bring this level of craftsmanship in designing a tools such as a cheater bar and therefore find his testimony that he was tapering the outside diameter to improve the hold credible.

After reviewing the evidence, the Arbitrator finds several gaps in Respondent's defense theory. Respondent did not contradict Petitioner's testimony that the piece was from the floor or rack of Respondent's plant. Mr. Beard testified he could not state if Respondent's Exhibit 1 was in existence on the floor. The photographs offered by Respondent identify the piece as 36 inch round stock, implying that the piece was identifiable to the individual labeling the photo. Respondent further does not clearly link Respondent's Exhibit 3 to its claim that Petitioner was making a shotgun barrel. The document, while found at the accident scene, is not connected by testimony to the Petitioner. No evidence was submitted that it was prepared by Petitioner. No evidence was submitted as to how long it was there or how it got there. No evidence was submitted that the program if completed by the lathe on a piece of 36 inch round stock would in fact create a shotgun barrel or what the finished product would be.

With this evidence as background, the Arbitrator has weighed the expert opinions of Mr. Gillette and Mr. Bevis and finds the opinions of Mr. Bevis more persuasive. The Arbitrator notes the inability of Mr. Gillette to testify

to the alloy of steel used in Respondent's Exhibit 1, a critical element to determining if it is usable as a shotgun barrel despite having had the opportunity to evaluate the piece on two occasions before trial. The Arbitrator notes that Mr. Bevis has greater qualifications as an expert and his testimony displayed a more complete analysis of the requirements needed for Respondent's Exhibit 1 to be a shotgun barrel, despite his not having had an opportunity to examine Respondent's Exhibit 1 until the day of trial.

Based upon the record as a whole, including the testimony and expert opinions presented and the exhibits submitted, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that he sustained accidental injuries arising out of and in the course of his employment with Respondent on November 24, 2011.

In support of the Arbitrator's decision with respect to (L) Nature and Extent, the Arbitrator finds as follows:

Petitioner's accidental injuries occurred after September 1, 2011 and therefore permanent partial disability shall be determined based upon the criteria established in Section 8.1b of the Act.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a machinist at the time of the accident. Petitioner presented no evidence as to whether he was able to return to work in his prior capacity as a result of said injury. Because of this, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Petitioner's age, the Arbitrator notes that Petitioner was 60 years old at the time of the accident. This would make Petitioner an older worker. No evidence was presented as to Petitioners employment status or ability as of the time of trial. Because of this, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that no evidence was presented as to Petitioner's current employment or future earning capacity. The Arbitrator notes that because of Petitioner's age that his work life would be less. Because of this, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes initially that Petitioner did not testify as to any current complaints or disabilities. The medical records submitted reflect treatment only through January 19, 2012 and a repeat EMG of the right arm on February 7, 2012. Therefore, the Arbitrator must evaluate this matter on the basis of the initial medical treatment and an absence of current subjective complaints. Because of the medical evidence submitted, the Arbitrator therefore gives greater weight to this factor.

In the emergency room, Petitioner advanced complaints in the left wrist, right shoulder and left leg as well as left chest pain. X-ray studies of the left wrist disclosed a fracture to the left distal radius with dislocation and a fracture of the fifth metacarpal. Petitioner was noted to have a fracture of the pelvis. A deformity of the right scapula was also noted. Petitioner then presented at the emergency room at Palos Community Hospital at 5:00 PM on November 24, 2011. Wrist x-rays confirmed the comminuted fractures of the distal radius. A rib study disclosed a questionable non displaced fracture of the left 6th rib. A CT scan of the pelvis confirmed acetabular fractures. An MRI of the right shoulder disclosed tendinosis, a suggestion of a labrum tear, a suggestion of a tear of the long head of the biceps, osteoarthritis, and muscle strains. An EMG noted acute severe incomplete right median neuropathy as well as carpal tunnel syndrome and mild right ulnar sensory

neuropathy at the wrist. On November 30, 2011, Petitioner underwent a closed reduction and insertion of pins and plaster to the left wrist and radius.

Petitioner was admitted for inpatient rehabilitation on December 12, 2011.Petitioner was discharged to outpatient therapy on December 20, 2011. The discharge summary notes patient's strength is good. He has no pain with range of motion. Full recovery was anticipated.

On January 19, 2012 the Southside Orthopedics records notes that he has done remarkably well after the cast was removed. There is full pronation and supination, good grip strength and full range of motion of the elbow. The doctor also notes some return of function on the right. Petitioner was to be seen again if no improvement, but no further treatment records were submitted and Petitioner did not testify to any additional treatment. A repeat EMG of the right arm was performed on February 7, 2012.

The Arbitrator finds that Petitioner suffered injuries to the left wrist consisting of the fracture dislocation that required surgery on November 30, 2011. As of January 19, 2012, the records confirm remarkable progress with no need for further aggressive therapy. The Arbitrator notes that Petitioner testified without the use of an appliance to assist with walking and therefore concludes that he has recovered from the pelvic fractures and rib fracture. The medical documents that Petitioner's right shoulder injury was improving as of the last treatment. The Arbitrator did not observe any serious or permanent disfigurement as a result of the laceration to the forehead.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 25% loss of use of Left Hand pursuant to §8(e)9 of the Act as a result of the injury to the left wrist and sustained permanent partial disability of 15% loss of use of person as a whole pursuant to §8(d)2 of the Act as a result of the remaining injuries to the right shoulder, rib and pelvis.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Danny R. Burgess,
Petitioner,

vs.

NO: 12 WC 21543

16IWCC0153

Tri County Coal, LLC,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of occupational disease, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 6, 2015 is hereby affirmed and adopted.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 4 - 2016

MB/mam
o:1/7/16
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BURGESS, DANNY R
Employee/Petitioner

Case# **12WC021543**

16IWCC0153

TRI COUNTY COAL LLC
Employer/Respondent

On 7/6/2015, 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 0.11% 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:

5236 CULLEY FIEST KUPPART & TAYLOR
ROMAN P KUPPART
3 S MAIN ST SUITE 2
HARRISBURG, IL 62946

1662 CRAIG & CRAIG LLC
KENNETH F WERTS
115 N 7TH ST PO BOX 1545
MT VERNON, IL 62864

16IWCC0153

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

☐ 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

Danny R. Burgess
Employee/Petitioner

v.

Tri County Coal, LLC
Employer/Respondent

Case # 12 WC 21543

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 William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on May 21, 2015. 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 Sections 1(d)-(f) of the Occupational Diseases Act

FINDINGS

On November 26, 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 not sustain an occupational disease 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 not causally related to the alleged occupational disease.

In the year preceding the injury, Petitioner earned $55,742.02; the average weekly wage was $1,066.81.

On the date of accident, Petitioner was 56 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

Respondent has paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00.

Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

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.

William R. Gallagher, Arbitrator

June 29, 2015
Date

JUL 6 - 2015

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an occupational disease to his lungs and heart arising out of and in the course of his employment for Respondent. The Application alleged a date of last exposure of November 26, 2011, and that Petitioner sustained the occupational disease as a result of exposure to dust.

At the time of trial, Petitioner was 59 years of age. He graduated from high school. He had 35 years of coal mining employment with all of that time being underground. While working as a coal miner, he was regularly exposed to coal and rock dust. He worked at the face of the mine 33 out of the 35 years. Petitioner was also exposed to roof bolting glue which gave him headaches.

Petitioner's last day of work for Respondent was November 26, 2011, at its Crown III mine. On that date he was 56 years old. His classification was inby. He testified that the inby classification covers all of the jobs at the belt tail including loading coal, roof bolting, running a continuous miner, running a ram car, shoveling on the belt and running the scoop. On his last day of employment Petitioner was exposed to and breathed coal dust. Petitioner testified that his employment ended at that time because he had left shoulder surgery.

Petitioner has not looked for work since leaving the coal mine. He testified that he is currently on Social Security disability for both shoulders. He testified that he has had rotator cuff repair on both shoulders and surgery on his right knee. Petitioner graduated from high school in May 1974 and started working for Freeman at Orient #6 mine in July 1974. He worked there for 22 years. He was laid off for three years. He worked at Big Ridge Mine for approximately three months. He did a few odd jobs in the meantime and then worked for Frontier Kemper Mine Construction at the Big Ridge Mine for approximately six months. From Big Ridge he went to work at Kerr McGee for three months shoveling on the belt. He then worked at Coal Age Machine Shop working on mining machinery. Petitioner was eventually called back to Respondent's Crown III Mine. Petitioner testified that he attempted to go back to work after his shoulder surgery, but he had a lot of restrictions and the company would not allow him to go back to work with those restrictions.

Petitioner testified that while working in the mines all of his jobs were hard manual labor. He had to bend, stoop and squat in order to do those jobs. He testified that this would cause him to have breathing problems. He first noticed his breathing problems about three years before he retired. He was working as an inby, running a ram car and roof bolting. At times he would have to bend the bolts to get them to fit in the hole. He had to help load the bolts on the bolter. He also had to hang miner cable which is approximately

six inches in diameter. While running a bolter or hanging the cable, he would have to stop and take breaks because of his breathing problems.

Petitioner testified that as of trial he could walk a half to three quarters of a block before becoming short of breath. He testified that he was able to walk farther than that before he quit mining. He testified that his breathing problems have gotten worse since he first noticed them. Petitioner could climb a flight of steps before becoming short of breath.

Petitioner testified that he was not taking any breathing medication. He testified that his breathing problems affect his activities of daily life. If he is in the yard doing anything, he has to stop and catch his breath. If he tries to help carry in groceries, he cannot do much of that without being out of breath. He testified that these activities are affected by both his breathing and shoulder problems. Petitioner testified that he coughs daily, a lot more at night than during the day. Petitioner testified that as of trial he could not physically do any of his previous coal mine jobs because of his shoulders and his breathing.

Petitioner developed problems with his shoulders in 2011. He testified that he was working as an inby doing a lot of roof bolting at that time. He eventually had to cease working because of the problems with his shoulders. He had surgery on his left shoulder on November 29, 2011. He testified that he began collecting accident and sickness benefits at that time. He continued to receive said benefits through the time he had surgery on his right shoulder on February 10, 2012. Petitioner testified that he filed a claim against Respondent for his shoulder injuries and ultimately settled that case. On June 11, 2012, Petitioner signed a resignation of employment with Respondent. He was still under restrictions from Dr. Herrin at that time. Petitioner testified that when he signed the resignation with Respondent that severed all of his rights to be recalled by the mine. He testified that he was never going back to the mine after he signed that resignation. He applied for and received a normal retirement pension. He received a 30 and out pension which meant that since he had 30 years of union time he would not be penalized for taking early retirement. He never worked again.

Petitioner saw Dr. Houser at the request of his attorneys on September 17, 2012. Petitioner testified that with regard to the questions Dr. Houser asked about his breathing and when his breathing problems began and whether he suffered from a cough, Petitioner was honest when he gave Dr. Houser the answers to those questions. Petitioner testified that he tries to go to the gym and walk a little bit. Other than that he does not have any hobbies. When he goes to the gym two or three times a week, he does curls with each arm using 10 to 15 pound weights. Petitioner testified that while working out at the gym he becomes short of breath and has to stop and take breaks.

Petitioner was seen by Dr. William Houser on September 17, 2012 (Petitioner's Exhibit 3, p 6). Dr. Houser has been affiliated with the Deaconess Hospital Black Lung Clinic since 1979 as the Medical Director and routinely performs examinations for the Department of

Labor (Petitioner's Exhibit 3, p 4). Dr. Houser is board certified in internal medicine and pulmonary disease. He was previously board certified in critical care medicine for 20 years, but he voluntarily let that lapse in 2007 (Petitioner's Exhibit 3, p 3). Dr. Houser testified that 100% of his practice deals with the care and treatment of patients with pulmonary disease and at least 15% of his patient census deals with the care and treatment of coal miners or former coal miners (Petitioner's Exhibit 3, p 4). Over the years, Dr. Houser has conducted 5,000 or 6,000 black lung exams (Petitioner's Exhibit 3, p 5).

Petitioner reported to Dr. Houser that he had dyspnea for approximately one year. Petitioner noted that this occurred occasionally at night and with exertion or activity. Petitioner reported to Dr. Houser he was able to walk about three-fourths of a mile. He had occasional wheezing. He normally did not have cough, sputum or hemoptysis. He did report one episode of pneumonia which was treated as an outpatient (Petitioner's Exhibit 3, p 7). Dr. Houser testified that the physical examination of Petitioner's chest was within normal limits. Dr. Houser testified that there does not have to be abnormalities on physical examination of the chest in order to have coal workers' pneumoconiosis (Petitioner's Exhibit 3, pp 7-8). Petitioner's pulmonary function studies were normal. Dr. Houser testified that it is not unusual for someone with simple coal workers' pneumoconiosis to have normal pulmonary function studies. He testified that having pulmonary function studies within the range of normal does not mean that the lungs have not been damaged (Petitioner's Exhibit 3, pp 8-9).

Dr. Houser diagnosed Petitioner as having coal workers' pneumoconiosis related to each and every exposure to coal and rock dust that he experienced during his 26-year coal mine employment history (Petitioner's Exhibit 3, pp 9-10). Dr. Houser testified, at the present time, most coal miners do not develop the disease process of coal workers' pneumoconiosis (Petitioner's Exhibit 3, p 11). Dr. Houser testified that the scarring of pneumoconiosis is permanent. He testified that the scar tissue from coal workers' pneumoconiosis and the halo of focal emphysema around that scarring cannot carry on the function of normal, healthy lung tissue. By definition, if one has coal workers' pneumoconiosis, he has an impairment in the function of the lung at least at the site of the scarring and emphysema (Petitioner's Exhibit 3, pp 11-12). Dr. Houser testified that because Petitioner has coal workers' pneumoconiosis he would be precluded from safely returning to the environment of a coal mine. He testified that further exposure to coal dust would endanger Petitioner's health because additional exposure would increase the likelihood of either a progression or more rapid progression of the disease (Petitioner's Exhibit 3, pp 12-13).

Petitioner is not a patient of Dr. Houser. He saw him one time at the request of his attorney. He has seen hundreds of individuals at the request of Petitioners' attorneys (Petitioner's Exhibit 3, pp 15-16). Dr. Houser testified that dyspnea on exertion is a non-specific complaint. It does not necessarily imply a disease state and does not necessarily imply a lung problem per se (Petitioner's Exhibit 3, p 18). Petitioner denied

chronic cough or sputum. Dr. Houser testified Petitioner did not have chronic bronchitis. Petitioner did not relate to Dr. Houser taking a breathing medication and did not give any past history of ever having taken a breathing medication (Petitioner's Exhibit 3, p 19).

The spirometry performed on Petitioner revealed no evidence of obstruction or restriction. Dr. Houser testified that based upon the spirometry he performed, Petitioner would be capable of heavy manual labor from a ventilatory standpoint (Petitioner's Exhibit 3, p 20). Dr. Houser testified that the chest x-ray he reviewed was assigned the lowest profusion level it could have been assigned and still remain positive for pneumoconiosis. Absent the positive history Petitioner gave of exposure at work and his positive interpretation of the chest x-ray, Dr. Houser would not have made the diagnosis of coal workers' pneumoconiosis (Petitioner's Exhibit 3, pp 20-21). Dr. Houser testified that at one point in time he sought out the certification of a B-reader. He took the B-reader course and then took the test to be certified as a B-reader. One of his instructors was Dr. Jerome Wiot. Dr. Houser testified he did not pass the B-reader test (Petitioner's Exhibit 3, pp 23-24). Dr. Houser testified that once an individual ceases his exposure to coal dust, there is a five percent (5%) chance of progression to the next higher classification of disease. Dr. Houser could not say within a reasonable degree of medical certainty that Petitioner fell within that five percent (5%) (Petitioner's Exhibit 3, p 25).

Dr. Michael Alexander, a board certified radiologist and B-reader, interpreted a chest x-ray of June 19, 2012, as positive for pneumoconiosis, profusion 1/0 with P/P opacities in the bilateral upper and mid lung zones. Dr. Alexander interpreted a chest x-ray of October 2, 2013, as positive for pneumoconiosis, profusion 1/1 with P/P opacities in all lung zones (Petitioner's Exhibit 1, Petitioner's Exhibit 2).

Dr. Jeff Selby, a board certified pulmonologist and B-reader, interpreted the chest x-ray of October 2, 2013. Dr. Selby did not find any abnormalities consistent with pneumoconiosis (Respondent's Exhibit 7).

At the request of counsel for Respondent, Dr. Cristopher A. Meyer reviewed a chest x-ray dated June 19, 2012. Dr. Meyer testified that the film was quality I. He found no evidence of coal workers' pneumoconiosis (Respondent's Exhibit 1, p 42). Dr. Meyer has been board certified in radiology since 1992 (Respondent's Exhibit 1, p 8). Dr. Meyer has been a B-reader since 1999 (Respondent's Exhibit 1, p 21). Dr. Meyer was asked to take the B-reading exam by Dr. Jerome Wiot (Respondent's Exhibit 1, pp 21-22). Dr. Wiot was on the original committee that designed the training course which is called the B-reader program (Respondent's Exhibit 1, p 23). Dr. Meyer has recently been asked to have a more academic role with the B-reader course (Respondent's Exhibit 1, p 33). Dr. Meyer testified that the faculty is typically experienced senior level B-readers (Respondent's Exhibit 1, p 34). Dr. Meyer testified that radiologists have a 10% higher pass rate on the B-reading exam than other specialties. In Dr. Meyer's opinion

radiologists have a better sense of what the variation in normal is (Respondent's Exhibit 1, pp 35-36).

Dr. Meyer testified that the B-reader looks at the films of the lung to decide whether there are any small nodular opacities or any linear opacities and based on the size and appearance of the small opacities, they are given a letter score (Respondent's Exhibit 1, pp 23-24). Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described by small round opacities (Respondent's Exhibit 1, pp 29-30). The distribution of opacities is also described because different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper zone predominant process. The last component of the interpretation is the extent of the lung involvement, or the so-called profusion (Respondent's Exhibit 1, p 24). Dr. Meyer testified that the profusion defines the density of the small opacities in the lung (Respondent's Exhibit 1, p 31).

At the request of Respondent's counsel, Dr. James R. Castle reviewed medical records and chest x-rays regarding Petitioner (Respondent's Exhibit 2, pp 21-41). Dr. Castle is a pulmonologist and is board certified in internal medicine and the subspecialty of pulmonary disease (Respondent's Exhibit 2, p 4). Dr. Castle practiced in Roanoke, Virginia for 30 years. His practice was limited to pulmonary disease and chest disease which encompassed critical care medicine (Respondent's Exhibit 2, p 7). Dr. Castle's practice included treating patients with occupational lung disease. He had some patients in his practice that had coal workers' pneumoconiosis (Respondent's Exhibit 2, p 8). Dr. Castle has been certified as a B-reader since 1985 (Respondent's Exhibit 2, p 14). Two of Dr. Castle's instructors at West Virginia University School of Medicine were Dr. Keith Morgan and Dr. Lee Lapp. Dr. Morgan was one of the early individuals in the country who started looking at coal workers' pneumoconiosis to determine the extent of the disease and its effect on the individual (Respondent's Exhibit 2, pp 13-14).

Dr. Castle reviewed a chest x-ray from Ferrell Hospital dated October 2, 2013, on CD. Dr. Castle found no evidence of pneumoconiosis (Respondent's Exhibit 2, p 41). Dr. Castle testified that chronic bronchitis is a chronic cough productive of sputum for at least three months for two consecutive years. Dr. Castle testified that Petitioner denied any cough and sputum production when he was examined by Dr. Houser on September 17, 2012. He testified that it did not appear that Petitioner had chronic bronchitis. Dr. Castle testified based upon the testing performed by Dr. Houser, from a ventilatory standpoint, Petitioner was capable of heavy manual labor. Dr. Castle testified that Petitioner's ventilatory function was entirely normal (Respondent's Exhibit 2, pp 41-42).

Dr. Castle testified that after a thorough and extensive review of all the submitted medical data, Petitioner did not have any evidence of pulmonary disease or impairment occurring as a result of his occupational exposure (Respondent's Exhibit 3, pp 42-43). Dr. Castle testified that Petitioner did not demonstrate any physical findings indicating the presence

of an interstitial pulmonary process. The physical examination of the lungs was basically normal virtually on every examination (Respondent's Exhibit 2, pp 43-44). Dr. Castle testified that the physiologic studies obtained by Dr. Houser did not show any evidence of any respiratory impairment from any cause including coal mine dust exposure. Dr. Castle testified that Petitioner did not have any evidence of respiratory impairment occurring as a result of his occupational exposure to coal mine dust (Respondent's Exhibit 2, pp 44-45).

Dr. Castle testified that coal workers' pneumoconiosis is a type of interstitial lung disease. He testified that the scarring and fibrosis that is caused by coal workers' pneumoconiosis cannot generally participate in gas exchange or physiologic function. He testified that the scarring and fibrosis that occurs with pneumoconiosis is permanent. The scarring and fibrosis represent an alteration in the structure and function of the involved lung tissue (Respondent's Exhibit 2, pp 49-51).

Medical records of Benton Community Health Care were received into evidence at trial. Petitioner was seen on June 13, 2012, as a new patient. On that date Petitioner denied tobacco use. Review of systems respiratory was negative for cough or dyspnea. Physical examination of the chest revealed the lungs clear to auscultation (Respondent's Exhibit 3, pp 5-7).

Medical records of Carlinville Family Practice were received into evidence at trial. Petitioner was seen on January 10, 2008, complaining of cough. Symptoms included chest congestion, productive cough, runny nose, shortness of breath and sore throat. On examination he had normal respiratory effort and his lungs were clear to auscultation. He was given a prescription for antibiotic (Respondent's Exhibit 5, pp 58-59). Petitioner was seen in follow up on February 21, 2008. On that date under review of systems respiratory he had a cough and no shortness of breath. On examination he had normal respiratory effort, and the lungs were clear to auscultation. The assessment included cough (Respondent's Exhibit 5, pp 55-56). On April 18, 2008, Petitioner had no cough or shortness of breath (Respondent's Exhibit 5, pp 52-53). Petitioner was seen on January 21, 2011, with nasal congestion, runny nose, dry cough, facial pain and headache. On examination he had normal breath sounds and no adventitious sounds. The assessment was acute sinusitis (Respondent's Exhibit 5, pp 21-22).

Petitioner was seen on July 25, 2011, with hypothyroidism. Physical examination of the chest revealed normal breath sounds (Respondent's Exhibit 5, p 16). Petitioner was seen on September 26, 2011. The doctor examined Petitioner's shoulders and charted that there was no known injury. With repetitive motion Petitioner suffered shoulder pain, shoulder stiffness and decreased range of motion. Physical examination of the chest revealed normal breath sounds (Respondent's Exhibit 5, pp 14-15).

Petitioner was seen on November 23, 2011, for pre-op visit. He was scheduled for left shoulder surgery on November 29, 2011. Physical examination of the chest revealed

normal breath sounds (Respondent's Exhibit 5, pp 8-9). He was seen again on February 2, 2012, for pre-op visit for right rotator cuff repair (Respondent's Exhibit 5, p 5).

Medical records of Orthopedic Center of Illinois were received into evidence at trial. Petitioner was seen on October 6, 2011, relating problems with both shoulders (Respondent's Exhibit 4, pp 101-102). Petitioner underwent an MRI of the left shoulder on November 9, 2011. Same was interpreted as revealing a partial thickness tear of the distal anterior aspect of the supraspinatus tendon at its attachment; osteoarthritis of the glenohumeral and acromioclavicular joint with some prominent hypertrophic change at the acromioclavicular joint; and probable tear of the superior aspect of the labrum (Respondent's Exhibit 4, pp 87-88). On November 29, 2011, Petitioner underwent a left shoulder arthroscopy by Dr. Herrin (Respondent's Exhibit 4, pp 77-79). On February 10, 2012, Petitioner underwent surgery on his right shoulder (Respondent's Exhibit 4, pp 52-55).

Petitioner returned to the office on May 21, 2012, at which time he still noted discomfort in each shoulder and complained of pain in the anterior portion of his left shoulder. As far as work activities, Petitioner was advised he should do no lifting greater than 10 pounds with regard to the left shoulder. In regard to the right shoulder, he should do no lifting or overhead work at all (Respondent's Exhibit 4, pp 33-34). Petitioner was seen in the office for follow up on June 18, 2012, at which time it was charted that Petitioner recently retired from the mine. The doctor charted, "He was concerned about being able to do the work activities that would be required. I should note that we still, at this point, have him under some restrictions regarding his shoulder problems." (Respondent's Exhibit 4, p 23). On September 10, 2012, Petitioner was evaluated for his bilateral shoulder problems. He had reasonable active motion of both shoulders. The doctor opined Petitioner could continue with his bilateral upper extremities as tolerated. Further, Dr. Herrin opined that Petitioner was at MMI in regard to his surgical intervention for his shoulders (Respondent's Exhibit 4, p 4).

Medical records of SIH Medical Group at Benton Community Healthcare were received into evidence at trial. Petitioner was seen on January 2, 2013. Review of systems on that day was negative for cough and chest pain. His O2 saturation was 97%. On physical examination, the lungs were clear to auscultation (Respondent's Exhibit 6, pp 117-119). Petitioner was seen on April 23, 2013, for cold symptoms with cough that began two weeks prior. He described the cough as productive of clear sputum. On examination his lungs were clear to auscultation. The assessment was acute sinusitis (Respondent's Exhibit 6, p 100-102). Petitioner was seen on February 6, 2014, for cough, congestion and chills. He described the cough as persistent and productive and present for one week. The lungs were clear to auscultation and respiratory effort was normal. The assessment was cough and sinusitis (Respondent's Exhibit 6, pp 71-73).

Petitioner was seen at St. Joseph's Memorial on May 16, 2014, for an outpatient polysomnography interpretation. It was indicated at that time that Petitioner was found to have significant sleep apnea (Respondent's Exhibit 6, pp 55-60). Petitioner was seen on January 15, 2015, for musculoskeletal pain in the right knee and hypertension. Pertinent negatives on that visit included chest pain and dyspnea. Review of systems was negative for dyspnea. On examination the chest and lungs were normal with clear auscultation and regular effort (Respondent's Exhibit 6, pp 1-4).

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusions of law:

The Arbitrator concludes that Petitioner did not sustain an occupational disease arising out of and in the course of his employment with Respondent that manifested itself on November 26, 2011.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified that bending, stooping and squatting to perform his work in the mines caused him to have breathing problems. He testified that he first noticed his breathing problems about three years before he retired. He testified that his breathing problems had gotten worse since he first noticed them. Petitioner, however, told Dr. Houser that he had had dyspnea for one year at the time of Dr. Houser's examination. This would place the onset of the dyspnea near the end of Petitioner's last day of coal mine employment. Petitioner testified that he is on Social Security disability for both of his shoulders. Petitioner was performing his job duties in the mine up until he ceased work for surgery on both shoulders. Following those surgeries Respondent would not allow him to go back to work with his restrictions.

Dr. Houser and Dr. Castle testified that based on the spirometry performed as part of Dr. Houser's examination, Petitioner would be capable of heavy manual labor from a ventilatory standpoint. While Dr. Houser testified that Petitioner's coal workers' pneumoconiosis would preclude him from safely returning to the environment of a coal mine, it was not this admonition against further exposure but rather a disability resulting from his shoulder surgeries that caused Petitioner not to continue his work in the coal mine.

Dr. Houser further testified that his physical examination of Petitioner's chest was within normal limits. Dr. Houser also testified that Petitioner's pulmonary function studies were normal.

The Arbitrator finds the x-ray interpretations by Dr. Meyer, Dr. Selby and Dr. Castle to be more persuasive than those of Dr. Alexander and Dr. Houser (not a B-reader).

In regard to disputed issues (L) and (O) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issues (C) and (F).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Angela Young,

Petitioner,

vs. NO. 12WC024120

16IWCC0160

State of Illinois Department of Revenue,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the parties herein and proper notice given, the Commission, after considering the issues of permanent disability, causal connection, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 1, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

16IWCC0160

Pursuant to §19(f)(1) of the Act there shall be no right of appeal, as the State of Illinois is Respondent in this matter.

DATED: MAR 4 - 2016
SJM/sj
o-2/11/2016
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

YOUNG, ANGELA
Employee/Petitioner

Case# **12WC024120**

16IWCC0160

ST OF IL, DEPT OF REVENUE
Employer/Respondent

On 7/1/2015, 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 0.11% 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:

0332 LIVINGSTONE MUELLER ET AL
MARTIN J HAXEL
PO BOX 335
SPRINGFIELD, IL 62705

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

4138 ASSISTANT ATTORNEY GENERAL
WARREN A WILKE
500 S SECOND ST
SPRINGFIELD, IL 62706

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

JUL 1 = 2015

RONALD A.RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

16IWCC0160

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Angela Young
Employee/Petitioner

v.

State of Illinois, Department of Revenue
Employer/Respondent

Case # 12 WC 24120

Consolidated cases: n/a

The only disputed issue is the nature and extent of the injury. 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 William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on May 27, 2015. By stipulation, the parties agree:

On the date of accident (manifestation), October 6, 2010, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

On this date, Petitioner sustained 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 $55,217.00; the average weekly wage was $1,061.86.

At the time of injury, Petitioner was 53 years of age, married, with 0 dependent child(ren).

Necessary medical services and temporary compensation benefits have been provided by Respondent.

Respondent shall be given a credit of $3,539.61 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $3,539.61. The parties stipulated at trial that Petitioner was owed an additional three-sevenths weeks of temporary benefits and that Respondent would make immediate payment of same.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner the sum of $637.12 per week for a period of 62.375 weeks, because the injuries sustained caused the 12 ½% loss of use of the left arm; 12 ½% loss of use of the left hand; and two and one-half percent (2 ½%) loss of use of the right hand, 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.

William R. Gallagher, Arbitrator

June 22, 2015
Date

JUL 1 - 2015

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained a repetitive trauma injury arising out of and in the course of her employment for Respondent. The Application alleged a date of accident (manifestation) of October 6, 2010, and that Petitioner sustained repetitive trauma to the hands and arms (Arbitrator's Exhibit 2).

At trial, Petitioner and Respondent stipulated that Petitioner sustained a compensable repetitive trauma injury and that the only disputed issue was the nature and extent of disability. Further, the parties agreed that Petitioner was owed an additional three-sevenths weeks of temporary total disability benefits and that Respondent would make immediate payment of same.

Petitioner testified that she worked for Respondent in a clerical position which required her to spend approximately 90% of each work day keyboarding. Over time, Petitioner developed symptoms of numbness and tingling in both hands, but more so in the left than right.

Petitioner sought medical treatment from Dr. Diana Widicus, who referred her to Dr. Edward Trudeau, for nerve conduction studies. Dr. Trudeau saw Petitioner on October 8, 2010 (the date of manifestation alleged in the Application) and performed nerve conduction studies at that time. The nerve conduction studies were positive for left carpal tunnel syndrome but negative for right carpal tunnel syndrome (Petitioner's Exhibit 2).

On November 17, 2010, Petitioner was seen by Dr. Michael Neumeister, a plastic surgeon. Dr. Neumeister examined Petitioner and reviewed the nerve conduction studies that had just been performed by Dr. Trudeau. He agreed that Petitioner had left carpal tunnel syndrome. Dr. Neumeister initially recommended conservative treatment which consisted of splinting of both wrists (Petitioner's Exhibit 3).

Dr. Neumeister subsequently performed left carpal and cubital tunnel release surgeries on April 24, 2012. No surgery was either recommended or performed in regard to the right upper extremity. When Dr. Neumeister saw Petitioner on May 31, 2012, he released her from treatment (Petitioner's Exhibit 3).

At the direction of Respondent, Petitioner was examined by Dr. Ryan Calfee, an orthopedic surgeon, on July 11, 2014. Dr. Calfee agreed that Petitioner had left carpal tunnel and cubital tunnel syndromes which had been treated appropriately. Dr. Calfee also noted that Petitioner had some tingling of the thumb, index and middle fingers of the right hand but had not sought any treatment for same. He opined that Petitioner had mild right carpal tunnel syndrome and that Petitioner was at MMI (Petitioner's Exhibit 1).

At trial, Petitioner testified that her left hand and grip are both weaker, that she still has occasional tingling and that her left elbow is still tender. Petitioner further stated that she still experiences some tingling of the right hand as well. Petitioner agreed that she was able to return to work to her regular job; however, she stated that keyboarding aggravated her symptoms.

Conclusion of Law

The Arbitrator concludes that Petitioner has sustained permanent partial disability to the extent of 12 ½% loss of use of the left arm; 12 ½% loss of use of the left hand; and two and one-half percent (2 ½%) loss of use of the right hand.

In support of this conclusion the Arbitrator notes the following:

Petitioner was diagnosed with left carpal tunnel and cubital tunnel syndromes, both of which required surgery. Petitioner still has complaints consistent with those conditions.

Petitioner was diagnosed with mild right carpal tunnel syndrome and has minimal complaints. No surgical procedure was either recommended or performed.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LORRAINE ORMSBY,

Petitioner,

16IWCC0133

vs.

NO: 12 WC 29753

UNITED AIRLINES,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of permanent partial disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Based upon a review of the record as a whole, and taking into account the criteria and factors pursuant to Section 8.1b of the Act, Petitioner's age, the impact on her ability to earn wages in the future, the AMA impairment rating provided by Dr. Cohen, the occupation of Petitioner, and evidence of disability contained within the medical records, the Commission modified the Arbitrator's permanent partial disability award from 7.5% loss of use of the man as a whole to 10% loss of use of the man as a whole under Section 8(d)2.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 9, 2015, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner

16IWCC0133

the sum of $508.79 per week for a period of 44 weeks, for the period of May 23, 2013 through March 26, 2014, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is given a credit of $22,387.61 for temporary total disability benefits paid to date.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $457.91 per week for a period of 50 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent partial disability to the extent of 10% loss of use of the man as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $23,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 24 2016
KWL/kmt
02/22/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0133

ORMSBY, LORRAINE
Employee/Petitioner

Case# 12WC029753

UNITED AIRLINES INC
Employer/Respondent

On 7/9/2015, 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 0.08% 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:

0365 BRIAN J McMANUS & ASSOC, LTD
30 N LASALLE ST
SUITE 2126
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
ASALYA I AKHMEROVA
ONE N FRAKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)

)SS.

COUNTY OF COOK)

☐ 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 **16 IWCC0133**

LORRAINE ORMSBY

Employee/Petitioner

v.

Case # 12 WC 29753

Consolidated cases: N/A

UNITED AIRLINES, IN

Employer/Respondent

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 **Ketki Steffen**, Arbitrator of the Commission, in the city of **Chicago, IL** , on **April 13, 2015**. 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 **Possible nature and extent credit.**

FINDINGS

On **12/21/2011**, 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 $**39,685.36**; the average weekly wage was $**763.18**.

On the date of accident, Petitioner was **55** years of age, ***single*** with **1** dependent children.

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**22,387.64** for TTD, $**N/A** for TPD, $**N/A** for maintenance, and $**N/A** for other benefits, for a total credit of $**N/A**.

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

ORDER

Credits

Respondent shall be given a credit of $**22,387.64** for TTD, $**N/A** for TPD, and $ **N/A** for maintenance benefits, for a total credit of $**N/A**.

Medical benefits

Respondent has paid all reasonable and necessary medical services as provided in Section 8(a) of the Act.

Temporary Partial Disability

Respondent shall pay Petitioner temporary total disability benefits of **$508.79**/week for **44** weeks, commencing **5/23/2013** through **3/26/2014**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$22,387.61** for temporary total disability benefits that have been paid.

Permanency

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 7.5 % loss of use of **use of man as a** whole or 37.5 weeks pursuant to **§8(d)(2)** 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.

Ketki Stetten 7/9/15

Signature of Arbitrator Date

JUL 9 - 2015

ICArbDec p. 2

Procedural History

In 2005, Petitioner Lorraine Ormsby suffered a prior work related right shoulder injury which did not result in any surgery being undertaken. (Tr. p. 11-12). She returned to full duty capacity from 2006 until her current 12/21/2001 work related injury . (Tr p 12). Petitioner's Application for Adjustment of Claim for case 06 WC 05215 supports an April 18, 2005 date of accident involving the right arm/shoulder. (RX. 7) The Commission main frame for case 06 WC 05215 shows a settlement for 14% loss of use of the right arm. (RX. 5) The Illinois Workers' Compensation Commission Settlement Contract Lump Sum Petition and Order for case 06 WC 05215 supports injury to the right shoulder. (RX.6)

Petitioner testified that she had no difficulty with her right shoulder after the 2005 injury and prior to the December 2011 accident.

Factual History

In the case at bar, Petitioner was 55 years old at the time of her uncontested work accident of December 21, 2011 while employed by Respondent, United Arilines, Inc. She had been employed by United Airlines as a flight attendant for the last 24 years. (Tr p10-11)

On December 21, 2011 while trying to pull a stuck extended delay kit from the last row of seats, Ms. Ormsby experienced pain in her right shoulder due to the physical exertion employed trying to get this stuck kit dislodged. (Tr p12) The parties stipulated that Petitioner was involved in a work accident. Petitioner testified to experiencing pain

in her right shoulder following this incident. The parties stipulated to timely notice. The parties also stipulated to all TTD and medical being paid by Respondent.

On December 23, 2011, Petitioner sought medical care with her primary care physician, Dr. Brent Petersen. Dr. Petersen advised activity modification and anti-inflammatory medications. Dr. Petersen completed a United Airlines Workers' Compensation Employee Work Status Form releasing Petitioner to work without restrictions. (PX.1)

Petitioner came under the care of Dr. Justin Gent on June 29, 2012. Physical examination revealed near full range of motion except internal rotation that was diminished on the right when compared to the left, some mild loss of rotator cuff strength, and mild degenerative changes at the AC joint and Type II acromion and subacromial cysts in the greater tuberosity of the proximal humerus per X-rays. Dr. Gent recommended an MRI and released Petitioner to unrestricted duty work activities. (PX.2)

The right shoulder MRI, performed on July 2, 2012, revealed moderate hypertrophic degenerative changes of the distal acromioclavicular ("AC") joint; increased signal in the distal supraspinatus tendon at the point of insertion with a focal defect approximately 7 mm from the site of insertion compatible with a full-thickness tear; fluid in the subacromial/subdeltoid bursa; normal tendons of the infraspinatus and Teres minor; degenerative changes in the glenohumeral joint space with narrowing; normal subscapularis tendon; and no joint effusion. (PX. 3)

On July 9, 2012, Dr. Gent believed there was a small full-thickness tear in the supraspinatus tendon. He discussed non-operative versus operative management. Petitioner elected to undergo physical therapy. Dr. Gent released Petitioner to unrestricted duty work activities. (PX.2)

Petitioner followed up with Dr. Gent on October 5, 2012 with persistent complaints. The physical examination remained relatively unchanged. Secondary to persistent pain, Dr. Gent recommended surgical intervention. (PX.2) Dr. Gent's records contain correspondence dated October 24, 2012 requesting authorization for right shoulder arthroscopy rotator cuff repair and AC joint resection. (PX.2)

Ms. Ormsby also attended a number of section 12 exams with Dr. David Garelick. (Tr p15) Following examination and review of medical records, Dr. Garelick diagnosed right rotator cuff tendonitis with a high-grade partial-thickness (possible full-thickness) rotator cuff tear. He opined that the pathology of the right shoulder shown on MRI may have been present prior to the work accident, but that the injuries sustained while working were sufficient to cause the previously quiescent finding to become symptomatic. As such, he believed there was a causal connection between the work accident and Petitioner's present condition of ill-being. Further, he felt it was reasonable she undergo shoulder arthroscopy. (RX.1) Dr. David Garelick believed the right shoulder injury to have been severe enough that he was skeptical Ms. Ormsby would ever be able to return back to work as a flight attendant. (Tr p15)

On November 26, 2012 and February 22, 2013, Dr. Gent completed a United Airlines Workers' Compensation Employee Work Status Forms releasing Petitioner to work without restrictions. (PX.2) During the February 22, 2013 follow up, Dr. Gent discussed surgery with Petitioner. (PX.2)

On March 25, 2013, Petitioner came under the care of Dr. David Anderson. Petitioner testified that she elected to obtain a second opinion for Dr. Anderson. Dr. Anderson assessed shoulder pain with a partial-thickness rotator cuff tear and a rotator cuff sprain and strain. The doctor reviewed the MRI and opined it showed a high-grade, partial-thickness tear of the supraspinatus versus a full-thickness tear. Dr. Anderson discussed the diagnosis and treatment options with Petitioner. Petitioner was to follow up on a "prn" basis. Dr. Anderson also completed a United Airlines Workers' Compensation Employee Work Status Form releasing Petitioner to work without restrictions as of March 25, 2013. (PX. 5)

On May 23, 2013, Petitioner underwent right shoulder arthroscopy with an arthroscopic rotator cuff repair, an arthroscopic subacromial decompression, and an arthroscopic labral debridement, performed by Dr. Anderson. The post-operative diagnoses included a right shoulder rotator cuff tear and Grade 1 tearing of the superior labrum. The operative report confirms findings of a partial-thickness tear of the rotator cuff and Grade 1 fraying of the posterosuperior labrum. (PX.4) Post-operatively, Petitioner attended physical therapy at Accelerated Physical Therapy.

On August 19, 2013, Dr. Anderson recommended continued physical therapy twice a week. (PX.4) A Utilization Review ("UR") of September 3, 2013 does not support certification of physical therapy as Petitioner had exceeded the ODG-TWC

recommended therapy visits with limited evidence of exceptional factors that would support an extended course of care beyond the recommended guidelines. (RX. 4)

On October 11, 2013, Petitioner underwent a repeat IME with Dr. Garelick. At this juncture, the doctor opined that it is common for a patient to continue to have pain complaints and some stiffness four and a half months post-surgery. However, he concurred with the UR physician that additional therapy is probably not the best use of the insurer's resources at this time. Rather, Dr. Garelick recommended three to four weeks of work conditioning, four to five times per week, with concentration on strengthening and overhead lifting. Maximum medical improvement ("MMI") was anticipated in six to eight weeks. (RX.2)

Petitioner followed up with Dr. Anderson on November 11, 2013. Dr. Anderson agreed with the IME physician regarding initiation of work conditioning and instructed a follow up in four weeks. (PX.3-5) Petitioner underwent the course of work conditioning at Centegra Hospital, which was completed on January 3, 2014. (PX.7)

On February 14, 2014, Petitioner presented for a repeat IME with Dr. Garelick. She continued with occasional pain in the right shoulder and difficulty with overhead lifting. Petitioner's subjective complaints included weakness. Dr. Garelick explained that it is impossible to state whether or not the rotator cuff tear was caused by the work injury, but Petitioner did seem to become symptomatic following the work injury. At this juncture, Dr. Garelick recommended an FCE and saw no benefit in additional work conditioning. MMI was anticipated on the date of the FCE. (RX.3)

Petitioner testified that the FCE was never performed. Further, Petitioner testified that she asked Dr. Anderson to release her to full duty work as a flight attendant because she felt she was capable of fulfilling the guidelines of her job.

Petitioner submitted into evidence a United Description of Flight Attendant Job Duties. (PX.4) This document provides for physical requirements of working in aircraft aisles and galleys for periods of up to 14 hours or more, performing duties that require standing walking, climbing, stooping, crouching, squatting, kneeling, reaching, twisting and bending; pushing or pulling movable carts; frequent use of force up to 25 pounds to lift, push, or pull objects, such as beverage stowage bins; occasional use 25 to 55 pounds of force to lift, push, or pull objects; and at times use of forces greater than 55 pounds to lift, push, or pull objects. Some of these push, pull, or lifting forces must be performed with the arms at or above shoulder level, such as in the case of closing or opening overhead bins. (PX.4)

Petitioner testified that she was released to unrestricted duty work effective March 14, 2014. Petitioner testified to returning to work as a flight attendant without restrictions as of March 2014. She also testified that she had to undergo recurrent qualifications and meet the physical demands of the position as a flight attendant in order to return to unrestricted duty work. She testified that United Airlines would not allow her to return to work as a flight attendant if she had any sort of physical restrictions that did not meet the job requirements. Petitioner testified that she continues to work in her regular position as a flight attendant for United Airlines at the time of trial. This is the same position Petitioner held prior to the accident.

Further, Petitioner testified that her shoulder feels different and she has some limitations at work. She reported difficulty with work above the waist, weight-bearing activities and stowing luggage, as well as cleaning, yard work, and sleeping. She testified to experiencing aches, weakness and pain in her right shoulder. Petitioner testified she is right-hand dominant. Petitioner testified that she was not prescribed any additional formal treatment, surgery or medications by her treating physicians since completing care for the right shoulder in March of 2014.

On January 23, 2015, Petitioner underwent an impairment rating evaluation with Dr. James Cohen. Dr. Cohen diagnosed status post right rotator cuff repair. Dr. Cohen opined Petitioner is at MMI and therefore an impairment rating is appropriate. The doctor calculated an impairment rating according to the *AMA Guides to the Evaluation of Permanent Impairment*, Sixth Edition. Dr. Cohen computed 7% upper extremity impairment. This calculated to 4.2% whole person impairment, or up to 5% whole person impairment. (RX.8)

Findings/Analysis

In support of the Arbitrator's Decisions relating the issue of prior credit, the Arbitrator finds as follows:

Petitioner testified to a prior 2005 work injury involving the right shoulder. Petitioner's Application for Adjustment of Claim for case 06 WC 05215 supports an April 18, 2005 date of accident involving the right arm/shoulder. The Commission main frame for case 06 WC 05215 supports a settlement for 14% loss of use of the right arm.

The Illinois Workers' Compensation Commission Settlement Contract Lump Sum Petition and Order for case 06 WC 05215 supports injury to the right shoulder.

In the case at bar, Petitioner suffered an injury to the same right shoulder that she injured in 2005. Respondent argues that under the general rules of application of Section 8(e)17 of the Illinois Workers' Compensation Act ("Act") Respondent is entitled to a credit under section 8(e)17 which provides as follows:

> "In computing the compensation to be paid to any employee who, before the accident for which he claims compensation, had before that time sustained an injury resulting in the loss by amputation or partial loss by amputation of any member, including hand, arm, thumb or fingers, leg, foot or any toes, such loss or partial loss of any such member shall be deducted from any award made for the subsequent injury. For the permanent loss of use or the permanent partial loss of use of any such member or the partial loss of sight of an eye, for which compensation has been paid, then such loss shall be taken into consideration and deducted from any award for the subsequent injury." *820 ILCS 305.*

The Respondent further proposes that the statutory modification of the percentage awarded for an injury is not relevant in determining a credit. Respondent alleges that under the applicable rules of Section 8(e)17 Respondent is entitled to a credit of 35.42 weeks of compensation for the prior right shoulder settlement of 14% loss of use of the right arm against the PPD award in the current case.

The Arbitrator finds little disagreement with Respondent's argument that specific prior loss credit is appropriate and that the statutory modifications of the percentage award does not negate this requirement. The Arbitrator also agrees with Respondent that the calculation method should involve giving a credit for the number of weeks or PPD that was awarded and not the percentage. The Arbitrator, however, disagrees with

the position that Petitioner's permanency award should be reduced by the prior award for the arm or shoulder injury from her 2005 case as a matter of law.

In support thereof, the Arbitrator notes the holding in the case of *Will County Forest Preserve v. IWCC,* 2012 IL App 3(d) 110077WC (rehearing denied 7/5/12), the Illinois Appellate Court determined that shoulder injuries do not qualify as a specific loss under §8(e) but instead fall under the catch all provisions of §8(d)2 of the Act. Since §8(d)2 does not provide credit for prior awards, Respondent in this matter would not be entitled to a credit for a previous award under §8(e) of the Act. Based on the Court's findings, the Arbitrator finds that Petitioner's shoulder injury is not a specific loss but rather, falls under the man as a whole award and Respondent would not be entitled to credit under Sec. 8(e) of the act. Although Respondent's legal arguments regarding specific loss credit and the method of calculating this credit are correct, they are not applicable to the case at bar pursuant to the court's ruling in Will County, id.

Therefore, the Arbitrator denies the Respondent a prior credit of 35.42 weeks relating to the settlement of the April 18, 2005 work injury.

In support of the Arbitrator's Decisions relating to the nature and extent of the petitioner's injury under Section 8(d)2 of the Act, the Arbitrator finds as follows:

This case arises out of a December 21, 2011 accident, a date after the September 1, 2011 amendment of the Act. Post amendment, pursuant to Section 8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

"(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The 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. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:

(i) the reported level of impairment pursuant to subsection (a);

(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.

No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order." *820 ILCS 305.*

Upon consideration of the above factors, the Arbitrator finds the following:

(i) The level of impairment pursuant to the AMA Guidelines: Dr. Cohen examined Petitioner on January 23, 2015 and issued an impairment rating of 7% upper extremity impairment. This calculated to 4.2% whole person impairment.

(ii) Petitioner's occupation: Petitioner was employed by Respondent as a flight attendant. Petitioner submitted into evidence a United Description of Flight Attendant Job Duties. This document provides for physical requirements of working in aircraft aisles and galleys for periods of up to 14 hours or more, performing duties that require

standing walking, climbing, stooping, crouching, squatting, kneeling, reaching, twisting and bending; pushing or pulling movable carts; frequent use of force up to 25 pounds to lift, push, or pull objects, such as beverage stowage bins; occasional use 25 to 55 pounds of force to lift, push, or pull objects; and at times use of forces greater than 55 pounds to lift, push, or pull objects. Some of these push, pull, or lifting forces must be performed with the arms at or above shoulder level, such as in the case of closing or opening overhead bins.

(iii) Petitioner's age: Petitioner was 55 years of age at the time of the injury. Arbitrator gives this factor less weight as Petitioner's has limited work life left ahead of her.

(iv) The Employee's Future Earning Capacity: Petitioner testified that she was released to unrestricted duty work effective March 14, 2014. Petitioner testified that she continues to work in her regular position as a flight attendant for Respondent at the time of trial. Furthermore, Petitioner's treating physician felt Petitioner was capable of performing her full duty activities as a flight attendant without any formal restrictions and Petitioner has demonstrated a capability to work in a full duty capacity for over a year. Petitioner also testified that she had to undergo recurrent qualifications and meet the physical demands of the position as a flight attendant in order to return to unrestricted duty work. She testified that Respondent would not allow her to return to work as a flight attendant if she had any sort of physical restrictions that did not meet the job requirements. This is the same position Petitioner held prior to the accident. The Arbitrator finds this a favorable factor for the Respondent.

(v) Evidence of Disability: Petitioner sustained a partial-thickness rotator cuff tear of the right shoulder secondary to the work accident of December 21, 2011. The Arbitrator

notes Petitioner reported some residual symptoms at the time of hearing. Petitioner testified her shoulder feels different and she has some limitations at work. She reported difficulty with work above the waist, weight-bearing activities and stowing luggage, as well as cleaning, yard work, and sleeping. She testified to experiencing aches, weakness and pain in her right shoulder. Petitioner testified she is right hand dominant. Petitioner also testified she last sought medical care over a year ago, or in March 2014, as it relates to the work injury.

Dr. Garelick, United's initial section 12 examiner opined in his 2/14/2014 report that "I read the United Airlines job description and it appears that flight attendant's need to on occasion lift up to 55 pounds overhead. This is clearly outside the Petitioner's physical limitations as indicated by the IME. However, Ms. Ormsby elected to forgo a prescribed functional capacity evaluation and returned back to work full duty on 3/27/2014 albeit with physical difficulty. The Arbitrators considers this a favorable factor for the Petitioner as she has chosen to return back to gainful employment.

Lastly, the Arbitrator has given due consideration to the fact that Petitioner did suffer a prior right shoulder injury in 2005, was treated (without surgery) and returned back to full duty work without restrictions. The Arbitrator further notes that the Petitioner was able to fulfill her full duties without restrictions for over 6 years and the Respondent's own IME has found that the Petitioner suffered a new injury and has restrictions that would prevent her from fulfilling some of her duties as a flight attendant.

Therefore, upon consideration of the above factors and in accordance with the facts presented at trial, the Arbitrator concludes Petitioner sustained 7.5 % loss of

person as a whole, or 37.5 weeks of PPD at the applicable PPD rate of $457.91 under Section 8(d)2 of the Act.

Ketki Steffen 7/9/15

Signature of Arbitrator Ketki Shroff Steffen Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☒ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daniel Clemmons,
Petitioner,

vs.

NO: 12 WC 33438

First Response, EMG, Inc.,
Respondent.

16IWCC0167

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation and prospective medical and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

In his decision, the Commission finds that the Arbitrator made an error in reporting the content of Dr. Bare's reports. More specifically, the Arbitrator stated that Dr. Bare did not clearly state what clinical records he reviewed and relied on and he did not clearly note whether he was relying on clinical records or Petitioner's history at the examination when recording a fact. However, the record shows that Dr. Bare clearly set forth the medical entries and the basis for his facts in his report. The Arbitrator also indicated Dr. Bare noted that Dr. Thometz was recommending arthroscopy in July of 2013 when Dr. Thometz said during that time that observation alone was warranted. The evidence shows that what Dr. Bare actually said is that Dr. Thometz "subsequently" recommended a surgical arthroscopy. The records shows that this "subsequent" event actually took place on June 6, 2014 and not in July of 2013 as the time the Arbitrator incorrectly attributed to Dr. Bare. The Arbitrator was correct in finding that Dr. Bare, in his second report, indicated Petitioner did not undergo physical therapy when Petitioner reported that he had done so. With these observations at hand, the Commission re-assessed the

16IWCC0167

weight which it will assign to Dr. Bare's independent medical reports. Having taken into consideration the above in its review of the evidence, the Commission assigns more weight to Dr. Bare's opinions than the Arbitrator assigned. After assigning more weight to Dr. Bare's opinion, the Commission reaches the same conclusion as the Arbitrator did in light of all the evidence contained in the record and with the exception of re-weighing and re-assigning weight to Dr. Bare, the Commission affirms the Arbitrator's decision in the case at bar.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's current condition of ill-being is not causally related to the September 14, 2012 work accident. Petitioner is at maximum medical improvement and Petitioner is not entitled to any further benefits or the arthroscopic surgery proposed by Dr. Thometz.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit in the amount of $2,777.25 for all amounts paid to or on behalf of Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 9 - 2016

MB/jm

O: 2/25/16

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Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

CLEMMONS, DANIEL
Employee/Petitioner

Case# **12WC033438**

16IWCC0167

1ST RESPONSE EMS INC
Employer/Respondent

On 7/21/2015, 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 0.13% 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:

5536 DAN COLLINS LAW FIRM LLC
DANIEL L COLLINS
7548 103RD ST
BRIDGEVIEW, IL 60455

0210 GANAN & SHAPIRO PC
JOSEPH P BRANCKY
210 W ILLINOIS ST
CHICAGO, IL 60654

16IWCC0167

STATE OF ILLINOIS)
)SS.
COUNTY OF)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION §19(b) DECISION

Daniel Clemmons
Employee/Petitioner

v.

1st Response EMS, Inc.
Employer/Respondent

Case # **12 WC 33438**

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 **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **3/18/2015**. 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. [x] 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. [x] Is Petitioner entitled to any prospective medical care?
L. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other Whether Petitioner has exceed his choice of physicians under the Act.

FINDINGS

On the date of accident, **9/14/2012**, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**21,976.24**; the average weekly wage was $**422.62**

On the date of accident, Petitioner was **21** years of age, ***single*** with **0** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**2,777.25** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

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

ORDER

Respondent shall be given a credit for $2,777.25 for TTD benefits paid.

Petitioner's current claimed condition of ill-being is not causally related to the work related accident on September 14, 2012. Petitioner is at MMI and is not entitled to any further benefits or the arthroscopic surgery proposed by Dr. Thometz.

In addition, the proposed arthroscopic surgery is not reasonably necessary to cure or relieve any injury sustained by Petitioner in his work related accident on September 14, 2012.

Petitioner did not exceed the number of choices for medical or hospital services as contemplated by § 8(a) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

Signature of Arbitrator

July 20, 2015
Date

JUL 21 2015

ICArbDec19(b)

DANIEL CLEMMONS V. 1ST RESPONSE EMS
12 WC 33438

INTRODUCTION

This matter proceeded to hearing on Petitioner's § 8(a) and § 19(b) Petition on March 18, 2015, before Arbitrator Steven Fruth. The disputed issues were: ***F:*** Is Petitioner's current condition of ill-being causally connected to the accident?; ***K:*** Is Petitioner entitled to recommended prospective medical care?; ***O:*** Did Petitioner exceed the number of physician choices as provided in § 8(a) of the Act?

Petitioner testified at the hearing. Both parties submitted documents in evidence without objection. The Arbitrator took the evidence under consideration.

STATEMENT OF FACTS

Petitioner began working for 1st Response EMS, Inc. Respondent as an Emergency Medical Technician in early 2012. Petitioner testified that while at work on September 14, 2012, he was assisting in bringing a patient a flight of stairs in a "stair chair." Petitioner's foot caught on the carpeting, causing him to fall down 9 steps. Petitioner testified that he had immediate pain to his right shoulder, and also pain and swelling in his right knee.

Petitioner sought immediate treatment that same day at Advocate Lutheran General Hospital Emergency Department. (PX #3) He complained of pain in his right knee and right shoulder. Both joints were tender but neither was swollen. Both joints had full ranges of motion. An x-ray exam of his right knee was negative. He was given a dose of 325 mg hydrocodone for pain. He was diagnosed with a right knee contusion and advised to follow up with his primary care physician. He was discharged to home.

Petitioner had continued shoulder pain and sought treatment at Adventist LaGrange Memorial Hospital Emergency Department (LaGrange) on September 15, 2012. (PX #5) He reported that he tripped and fell down 3 steps the day before. Petitioner was complaining of right shoulder pain. He rated his pain 6/10. On exam he complained of tenderness and pain with motion of the right shoulder. An x-ray of his right shoulder was negative. The chart shows Petitioner was given a dose of morphine for pain but was discharged with a prescription of ibuprofen. He was diagnosed with a right shoulder contusion and advised to follow up with Dr. Mark Cavalenes and with occupational health. He was discharged to home.

At Respondent's direction, Petitioner sought treatment at MercyWorks (PX #2) on September 17, 2012 for his knee and shoulder. He had been there on August 31, 2012 for a finger laceration. On September 17 he complained of 8/10 pain. His right knee was negative for swelling or effusion. His knee range of motion was slightly reduced but he was able to squat with mild pain. He was diagnosed with contusions of his right shoulder and right knee and advised to return on September 25. He was taken off work.

On September 25 Petitioner reported that his shoulder pain was improved but that his knee pain was still 8/10. On exam he had full range of motion and a normal gait. There was no swelling or effusion. He was advised to return on October 9 to review results of MRIs that were ordered. He was released for work with a 10 pound lift restriction for his right arm.

Petitioner returned to MercyWorks on October 16, 2012. He reported his shoulder pain was 4/10 and his knee pain was 7/10. Exams of the knee and shoulder were essentially normal. It was noted that the shoulder MRI was normal. It was noted that the knee MRI showed marrow edema with a questionable micro-fracture. Petitioner was advised to follow up with his orthopod, Dr. Tometz (*sic*). He was advised to return on October 19. His work restrictions remained in place. On October 19, 2012 Petitioner still had 7/10 pain. He was referred for physical therapy. There were no changes in the exams of the shoulder or the knee, no swelling or effusion. Petitioner was advised to return on November 9 and was taken off work.

Petitioner returned on November 9, 2012, still complaining of 7/10 knee pain. He reported not much improvement with physical therapy. He had another normal exam of the right knee. There was, again, no swelling or effusion. Petitioner had an appointment scheduled with his orthropod to evaluate whether to proceed with a cortisone injection or arthroscopy. He was advised to continue with therapy and to return on November 23and was taken off work.

Petitioner did not return to MercyWorks.

On September 19, 2012, Petitioner sought treatment at Palos Community Hospital (Palos) after feeling right knee instability. (PX #4) Emergency Department physician Gregg Goldberg, M.D. noted Petitioner "... comes in because of the persistent pain and because his workers' compensation doctor will not let him get an MRI. He says he wants an MRI done..." after a fall down 4 stairs. Triage nurse Rogers noted "[F]eels he needs MRI..." An exam of the right knee revealed no bruising, swelling, abrasion, or tenderness. The right shoulder had no bruising or swelling but was slightly tender. Tests for the rotator cuff were mildly positive. He was given a dose of Norco for pain. Petitioner was diagnosed with right shoulder and right knee pain. He was advised to follow up with Dr. Hugh O'Neill, his primary care physician.

Respondent submitted records of Petitioner's emergency department visits over time (RX #3, RX #4 & RX #5):

> Palos for a left ankle injury on May 1, 2008. A left ankle x-ray was negative and revealed no injury or abnormality.
>
> Palos on January 8, 2009 for upper back and neck pain. X-rays were negative for any injury or pathology.

Palos on August 2, 2009 for neck pain. A cervical x-ray revealed no abnormality or injury.

Palos on May 28, 2010. An x-ray of his wrist revealed no abnormality or injury.

LaGrange on July 5, 2010 for back pain. X-rays of his back that revealed no abnormality or injury.

LaGrange on April 12, 2011 for ankle pain from twisting his right ankle on April 8. An x-ray was negative for fracture.

Rush-Copley on December 27, 2011for head and neck pain. A CT scan of his brain was normal. An x-ray of his neck was taken that was normal.

On October 12, 2012, Petitioner had an MRI exam of his right knee ordered by Dr. Goldberg (Palos). It showed subcortical marrow edema at the lateral aspect of the lateral femoral condyle, suggestive of a contusion. (PX #1B)

Petitioner first saw Dr. Joseph Thometz on October 18, 2012. (PX #1A) He testified that Dr. Thometz was one of several doctors recommended by his attorney. Petitioner reported improved right shoulder pain, but continued right knee pain and intermittent knee swelling. Petitioner did not report locking but did say the knee "will give out". On exam Dr. Thometz found full extension but limited flexion. There was no instability. The MRI reported noted marrow edema of the distal femur. He diagnosed a "contusion/bone bruise," and recommended physical therapy. Dr. Thometz noted Petitioner was not capable of regular work at that time.

Petitioner returned to Dr. Thometz on November 9, 2012. Petitioner had no effusion in the knee, full extension with some pain and slightly reduced flexion. Dr. Thometz diagnosed "[s]tatus post bone contusion," and recommended an additional 2 weeks of physical therapy. Dr. Thometz took him off work for 2 weeks. Petitioner testified that Dr. Thometz discussed doing an arthroscopy during this visit.

Petitioner testified that he did about 2 weeks of physical therapy but stopped because he felt his knee was not improving.

Petitioner returned to Dr. Thometz on November 19, 2012. An exam found a full range of motion and no effusion. Dr. Thometz diagnosed an improved knee contusion, requested he complete a physical therapy and strengthening program, and released him to regular work on November 23, 2012. He advised Petitioner could return to see him in 3 weeks "if having difficulty".

Petitioner testified he was offered a job with Vandenberg Ambulance Company around this time. He testified he accepted it because it offered full medical benefits, whereas his job with Respondent did not. He testified this position was as an EMT, which was the same position he held with Respondent. However, Petitioner needed a full release in order to take the new job.

Petitioner testified that he next sought treatment with Dr. Thometz on March 8, 2013 (a billing entry indicates it was actually March 7). He had no new injury. His right knee began bothering him again, as he had been walking up and down stairs more frequently than before. Petitioner said Dr. Thometz wanted a new MRI.

Petitioner had another MRI of his right knee on June 27, 2013, ordered by Dr. Thometz. (PX #1B, pp 21-22) The MRI showed "subtle bone marrow edema/bone bruise involving the lateral femoral condyle and mid part of the patella," with trace joint effusion.

On July 5, 2013, Petitioner returned to Dr. Thometz for knee pain. (PX #1B) An exam found no effusion. He found good motion. Dr. Thometz reviewed the recent MRI and found "a little bit of marrow edema involving the lateral femoral condyle and the patella." Dr. Thometz noted there was no occult chondral lesion observable in the MRI. However, he noted that if Petitioner's symptoms continued he would consider an arthroscopic evaluation to see if there was an occult lesion or some other symptomatic plica. He recommended observation unless Petitioner's symptoms warranted consideration of arthroscopy.

Petitioner testified that he had an injection in his knee, did not get any relief. He testified he did not raise the issue of further physical therapy with Dr. Thometz.

On June 6, 2014, Petitioner saw Dr. Thometz again for the knee. (PX #1C) Petitioner reported relief from a recent steroid injection for only one day. There was no note of whether Dr. Thometz had prescribed on conducted the injection. On exam Dr. Thometz noted no effusion. Dr. Thometz felt that because Petitioner had only a temporary response to the injection, it confirmed an intra-articular source of ongoing pain. He recommended a diagnostic arthroscopy to rule out symptomatic plica, occult cartilage lesion, possible Carticel biopsy, and a possible occult meniscal tear. Even so, Dr. Thometz gave a work status without restrictions.

Petitioner was examined pursuant to § 12 of the Act by Aaron Bare, M.D., an orthopedic surgeon on February 12, 2014 (RX #1) and on September 10, 2014 (RX #2). In addition to the clinical examination on February 12 Dr. Bare reviewed office notes from Palos Community Hospital, Mercy Occupational Medicine and Dr. Thometz. He also reviewed "imaging results" (reports) of the knee and shoulder and the June 27, 2013 MRI report. For the September exam Dr. Bare reviewed his report of the February 12 exam, the report of the October 11, 2012 MRI of the right knee, and "office notes from 2012 to 2014."

Petitioner testified at hearing that he was honest with Dr. Bare. Dr. Bare recounted Petitioner's history of injury and treatment at Lutheran General Hospital, LaGrange Memorial Hospital, and Palos Community Hospital in his report of the February exam. Dr. Bare noted that Petitioner reported that he had followed up with his primary physician, Dr. Hugh O'Neill, before consulting with Dr. Thometz. Dr. Thometz diagnosed a bone bruise in the knee. Petitioner began physical therapy. By November

19, 2012 Dr. Thometz released Petitioner for full duty work but also recommended that Petitioner continue physical therapy.

Dr. Bare noted 2 subsequent consultations after 3 ½ months and then another 4 months later. At that last visit Dr. Thometz was recommending a diagnostic arthroscopy.

On exam Dr. Bare observed mild crepitation but no other abnormal signs. Based on the exam and his review of radiology reports he diagnosed right knee patellofemoral pain. He found that Petitioner's objective findings could correlate with the current condition. Dr. Bare did not detect symptom magnification. Although Dr. Bare did not believe Petitioner's condition warranted surgery he did believe that Petitioner would benefit from a cortisone injection. Dr. Bare opined that Petitioner's condition then was related to his injury at work on September 14, 2012, but also, that Petitioner should achieve MMI within 4-6 weeks of the consultation after injection and physical therapy.

Petitioner testified that Dr. Thometz gave him an injection in his knee, but he did not get any relief. He testified he did not raise the issue of further physical therapy with Dr. Thometz.

At the September exam Dr. Bare Petitioner reported that Dr. Thometz had given him an injection. It was noted that Petitioner did not have subsequent physical therapy as recommended by Dr. Bare. Dr. Bare performed a more thorough clinical exam of Petitioner's right knee. He found no abnormalities at that time. He continued with his diagnosis of patellofemoral pain. Dr. Bare continued with his opinion that Petitioner's knee was nonsurgical. He stated that patellofemoral pain was typically a nonsurgical situation and generally has a poor post-operative prognosis. In addition, Dr. Bar opined that Petitioner's objective findings did not correlate to the subjective complaints. Dr. Bare stated that Petitioner had achieved MMI by the release to full duty on November 19, 2012 and was capable of full duty work without restrictions.

Petitioner testified he still has constant pain and occasional swelling in his right knee. He testified he walks around to help with swelling in his knee, and takes Ibuprofen approximately once a day. He testified he experiences swelling once every few days. Petitioner testified he has been working full duty for his new employer since being hired. He testified he has not seen Dr. Thometz since June 2014. He testified he has not sought treatment with any additional medical providers since that time for his right knee.

CONCLUSIONS OF LAW

F: Is Petitioner's current condition of ill-being causally connected to the accident?

The Arbitrator finds Petitioner suffered a right shoulder contusion and right knee contusion as a result of his work accident on September 14, 2012. The Arbitrator finds that those injuries resolved by November 23, 2012 when Petitioner returned to full duty

work according to Dr. Thometz's release on November 19, 2012. . The Arbitrator finds Petitioner's present condition of ill-being is not related to the accident.

Causal connection can be proved by circumstantial evidence from a chain of events. Here Petitioner was injured while in the course of his duties as an EMT on September 14, 2012. He fell down stairs while attempting to move a patient for transport. He sought emergency care at Lutheran General Hospital on the day he fell. He was diagnosed with a right knee contusion. On the following day Petitioner sought emergency care at LaGrange Memorial Hospital. There he was diagnosed with a right shoulder contusion. Petitioner then followed at MercyWorks and with Dr. Joseph Thometz. He was diagnosed with and treated for a right shoulder contusion and a right knee contusion. No objective abnormality was found in either the knee or the shoulder in radiological studies or on clinical exams. Petitioner's treatment included some physical therapy. On November 19, 2012 Dr. Thometz released Petitioner to return to work at full duty as an EMT, starting November 23, 2012.

The Arbitrator finds that the chain of events clearly shows that Petitioner was injured on duty on September 14, 2012 and was released for full duty on November 23, 2012. There is no dispute that Petitioner had recovered from his right shoulder injury at that time.

Petitioner returned to Dr. Thometz almost 4 months later, on March 8, 2013, with right knee complaints. Apparently Dr. Thometz injected Petitioner's knee but there were no clinical records of this procedure in evidence. Petitioner followed with Dr. Thometz through July 5, at which time Dr. Thometz recommended observation of the knee before evaluating for arthroscopy.

Petitioner returned to Dr. Thometz again on June 6, 2014. At that time Dr. Thometz was then recommending a diagnostic arthroscopy of the right knee.

Petitioner was examined twice by Dr. Aaron bare pursuant to § 12 of the Act. Dr. Bare's reports on those exams were admitted in evidence. Dr. Bare opine various things at various times. In the end Dr. Bare opined that the diagnostic arthroscopy recommended by Dr. Thometz is not medically reasonable or necessary to cure or relieve an injury sustained to the right knee on September 14, 2012.

~~Due to inaccuracies and inconsistencies the Arbitrator does not find Dr. Bare's~~ opinions to be persuasive. Dr. Bare had noted that Dr. Thometz was recommending arthroscopy in July 2013 when Dr. Thometz noted that observation was warranted. In his second report Dr. Bare suggested that Petitioner had not had physical therapy when Petitioner indeed did have several sessions of therapy. In neither report did Dr. Bare clearly state what clinical records he reviewed and relied on. Also, he did not clearly note whether he was relying on clinical records or Petitioner's history at exam when recording a "fact".

However, the Arbitrator does not find Dr. Thometz's opinions that diagnostic arthroscopy is medically reasonable and necessary to cure or relieve an injury sustained on September 14, 2012. Dr. Thometz never found any instability when examining

Petitioner's right knee. He did not find effusion or swelling on exams. This is despite Petitioner's testimony that he continues to have swelling in his knee. There were no significant abnormalities on radiological studies. In short, Dr. Thometz's clinical records do not sufficiently explain the medical necessity for a diagnostic arthroscopy.

In addition, the Arbitrator finds that the chain of events circumstantial evidence failed to establish a causal link to Petitioner's current complaints. Petitioner returned to full unrestricted duty as an EMT at his own request in November 2012. In March 2013 he had complaints with his right knee but no significant objective clinical findings. A year passed to June 2014 before he sought out Dr. Thometz again with knee complaints. Again, his clinical presentation was essentially normal. The circumstantial chain of events was broken when Petitioner was released for full duty by Dr. Thometz in November 2012.

Based on the above, the Arbitrator finds Petitioner sustained a right shoulder contusion and a right knee contusion as a result of a September 14, 2012 work accident. Petitioner underwent no therapeutic care for his right shoulder and only conservative treatment for his right knee. After a few months Petitioner was released to full duty. He has worked in a full duty capacity as an EMT ever since. Based on the evidence Petitioner failed to prove that he suffers from an ongoing condition with his right that was caused by the September 14, 2012 accident.

The Arbitrator therefore finds Petitioner reached MMI in November of 2012 and that his present condition of ill-being is not related to his work accident.

K: Is Petitioner entitled to recommended prospective medical care?

For reasons stated above the Arbitrator finds Petitioner is not entitled to the prospective care recommended by Dr. Thometz. Due to the lack of significant objective clinical findings, the lack of explanation why the recommended procedure is necessary, and the extended breaks in time from one consultation to another Petitioner has failed to prove that he is entitled to the recommended prospective medical care.

O: Did Petitioner exceed the number of physician choices as provided in § 8(a) of the Act?

The Arbitrator finds that Petitioner did not exceed his choice of physicians under § 8(a) of the Act. Petitioner sought and received emergency care as contemplated under the Act for his injuries on the day of his injury and also on the following day. Emergency care does not qualify as a provider choice under § 8(a). Thereafter Petitioner exercised his choices for medical care provided by a hospital or physician when he sought care at Palos Community Hospital and from Dr. Thometz.

Petitioner first sought care on the day of his accident at the Emergency Department of Lutheran General Hospital. He complained of both right knee and right

shoulder pain. Both his knee and shoulder were examined. However, only the right knee was x-rayed. Petitioner was discharged with a diagnosis of knee contusion. There was no discharge diagnosis regarding the shoulder. Clearly, the condition of Petitioner's shoulder did not warrant meaningful medical assessment at that time.

On the following day, September 15, Petitioner's shoulder complaints worsened to the point where he sought emergency care at LaGrange Memorial Hospital. There his shoulder was the focus of his complaints and the medical assessment of those complaints. His shoulder was x-rayed and he was referred to an orthopedic surgeon for further evaluation of his shoulder injury. The Arbitrator takes note that injuries to one part of the body may be masked by a more painful injury to another part of the body for a period of time. The Arbitrator also takes note that on occasion injuries may become more painful over a period of 1 to 2 days and still be related to the original trauma. Note is taken that Petitioner was given an injection of a narcotic analgesic for his shoulder pain at LaGrange.

The Arbitrator finds that Petitioner's encounter in the Emergency Department of Palos Community Hospital was a choice of medical providers as contemplated by § 8(a) of the Act. Petitioner clearly went to Palos because he wanted an MRI. Up to that point no physician had recommended or ordered an MRI. Petitioner was seeking to control and manage his own health care rather than rely on the judgment of licensed medical professionals.

The report of the right knee MRI done October 12, 2012 recorded Gregg Goldberg (Palos) as the ordering physician and as Doctor 1 and Petitioner's primary care physician, Hugh O'Neill, M.D., as Doctor 3. There was no direct evidence that Petitioner consulted with Dr. O'Neill regarding his accident injuries. The only evidence of a consultation with Dr. O'Neill is in Dr. Bare's report date February 14, 2014. Evidence of Dr.O'Neill's intervention is circumstantial only and the Arbitrator finds it is not sufficient to establish that Petitioner exercised a choice with Dr. O'Neill.

Petitioner's care and treatment at MercyWorks was at the direction of Respondent and therefore was not a choice of medical care exercised by Petitioner.

Petitioner testified that he consulted with Dr. Thometz at the recommendation of his attorney. Dr. Thometz represents Petitioner's 2nd choice.

Respondent submitted evidence of Petitioner's medical history of some 7 incidents prior to his work accident where Petitioner sought diagnostic imaging for complained of injuries that revealed no objective findings. The Arbitrator does not find this evidence relevant to the material issues of this case. Therefore the Arbitrator did not consider that history in judging the merits of this case.

Petitioner sought emergency treatment at Lutheran General Hospital and at LaGrange Memorial Hospital in compliance with § 8(a) of the Act. Thereafter he exercised his 1st choice of medical care providers when he sought care at Palos Community Hospital. Thus, Petitioner's consultation with Dr. Thometz constituted his 2nd choice and, correspondingly, Respondent is obligated to pay for that medical car.

Jul 20, 2015

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Yvonne Bell,
Petitioner,

vs. NO: 12WC 35484

City of Chicago,
Respondent,

16IWCC0150

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of nature and extent and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 2, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 3 - 2016
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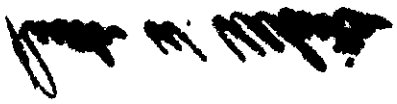
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White



ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BELL, YVONNE
Employee/Petitioner

Case# **12WC035484**

12WC004199

CITY OF CHICAGO
Employer/Respondent

16IWCC0150

On 9/2/2015, 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 0.27% 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:

0494 JOSEPH SPINGOLA
1314 KESSINGTON
SUITE 3843
OAK BROOK, IL 60522

0766 HENNESSY & ROACH PC
DANIEL WELLNER
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

☐ 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

Yvonne Bell
Employee/Petitioner

v.

City of Chicago,
Employer/Respondent

Case # 12 WC 35484

Consolidated cases: 12 WC 4199

16IWCC0150

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 **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **July 31, 2015**. 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 **9-21-12**, 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 $**70,411.38**; the average weekly wage was $**1,354.07**.

On the date of accident, Petitioner was **53** years of age, ***single*** with **0** 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 $**51,841.34** for TTD, $**28,294.41** for TPD, $**19,343.79** for maintenance, and $**0** for other benefits, for a total credit of $**99,479.54**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $902.71 per week for 55 5/7 weeks commencing 9-22-12 through 9-20-13 and commencing 11-25-13 through 12-27-13 as provided in Section 8(b) of the Act. Respondent shall pay Petitioner maintenance benefits of $902.71 per week for 21 2/7 weeks commencing 12-28-13 through 5-26-14 as provided in Section 8(a) of the Act. Respondent shall pay Petitioner temporary partial disability benefits of $314.18 per week for 61 4/7 weeks, commencing 5-27-14 through July 31, 2015 as provided in Section 8(a) of the Act. Respondent shall be given a credit of $51,841.34 for TTD, $28,294.41 for TPD, and $19,343.79 for maintenance benefits for a total credit of $99,479.54.

Respondent shall pay any outstanding medical expenses to University of Illinois Anesthesiology and hold Petitioner harmless from any claims arising therefrom.

Respondent shall pay Petitioner permanent partial disability benefits, commencing August 1, 2015, of $602.13 per week until Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in Section 8(d) 1 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.

Molly C Mason
Signature of Arbitrator

9/2/15
Date

SEP 2 - 2015

Yvonne Bell v. City of Chicago
12 WC 4199 and 12 WC 35484 (consolidated)

Arbitrator's Findings of Fact Relative to Both Cases

Petitioner testified she worked as a motor truck driver for Respondent for 23 years. She worked out of Local 700. Typically, her duties consisted of pre-checking her assigned garbage truck, picking up laborers and driving the truck through alleys in a designated area. In the winter, she sometimes operated a salt spreader rather than a garbage truck.

Petitioner testified she previously pursued a workers' compensation claim against Respondent for injuries involving her right wrist and right shoulder. That claim was resolved.

The parties agree Petitioner sustained an accident on January 13, 2012 while working for Respondent. This accident is the subject of 12 WC 4199. Arb Exh 1.

Petitioner testified she was climbing back into a salt spreader truck near the end of her shift on January 13, 2012, after re-fueling, when she heard a pop in her left shoulder. She finished parking the truck, reported the accident to an acting supervisor and went home.

On January 16, 2012, Petitioner sought Emergency Room treatment at UIC. The records reflect Petitioner complained of left shoulder pain of three days' duration which she attributed to "going up and down the truck that she drives." PX 6, p. 31. The Emergency Room physician ordered left shoulder X-rays, which were negative for fracture. He diagnosed a left shoulder sprain. He prescribed anti-inflammatories and recommended Petitioner avoid heavy lifting and seek follow-up care. PX 6, p. 43.

Petitioner testified she returned to work thereafter and completed an accident report. Respondent then directed her to MercyWorks on Ashland.

On January 17, 2012, Petitioner saw Dr. Diadula at MercyWorks. The doctor recorded a consistent history of the January 13, 2012 accident and previous right wrist and shoulder surgeries. He noted that Petitioner complained of 6/10 left shoulder pain, radiating to the left side of her neck, as well as difficulty lifting her left arm above shoulder level. On left shoulder examination, he noted abduction to 40 degrees, forward elevation to 90 degrees and tenderness in the subacromial area, acromioclavicular joint and bicipital groove. He obtained left shoulder X-rays which showed no fracture on preliminary reading. He diagnosed a left shoulder strain. He took Petitioner off work and prescribed Ibuprofen. PX 1, pp. 1-2.

Petitioner returned to MercyWorks on January 24, 2012 and again saw Dr. Diadula. He recommended a left shoulder MRI and kept Petitioner off work. The MRI, performed without contrast on February 2, 2012, showed moderate to severe tendinopathy of the supraspinatus tendon, with a 5 mm partial-thickness, partial width tear, an 8 mm partial-thickness, partial width undersurface tear of the anterior half of the supraspinatus tendon at its humeral

insertion, moderate degenerative changes of the acromioclavicular joint and biceps tendon tenosynovitis. PX 3, p. 4.

On February 8, 2012, Dr. Ali of MercyWorks reviewed the MRI, referred Petitioner to Dr. Heller and instructed Petitioner to remain off work. PX 3, p. 2.

Petitioner testified she chose to see Dr. Benjamin Goldberg at UIC rather than Dr. Heller because Dr. Goldberg had treated her right shoulder in the past.

On February 17, 2012, Petitioner saw Dr. Goldberg and his surgical resident. Petitioner testified she brought her MRI film to the appointment. The resident noted a history of prior right shoulder surgery. He also noted that Petitioner was now complaining of left shoulder pain secondary to a work injury of January 13, 2012. He described Petitioner as right-handed.

On examination, the resident noted demonstrable weakness in both shoulders with resisted movements, left greater than right, along with exquisite tenderness in both acromioclavicular joints. After he and Dr. Goldberg reviewed the MRI, they recommended a left shoulder arthroscopy. PX 6.

On March 26, 2012, Dr. Goldberg performed a left shoulder arthroscopy, subacromial decompression, biceps tenotomy and distal clavicle excision. PX 6, pp. 66-68.

On March 30, 2012, Dr. Goldberg noted that Petitioner's surgical incisions were clean and dry. He directed Petitioner to stay off work, start physical therapy and return in three weeks. PX 6, pp. 80-81.

Petitioner underwent an initial physical therapy evaluation at UIC on April 2, 2012. On examination, the therapist noted swelling and warmth throughout the left shoulder. He also noted a reduced range of left shoulder motion. PX 6, pp. 98-99.

Petitioner continued attending therapy thereafter.

Petitioner next saw Dr. Goldberg on April 16, 2012. The doctor noted no evidence of infection and "poor flexion actively to about 110 degrees." He recommended that Petitioner continue physical therapy. He released Petitioner to right-handed work. PX 6, pp. 75-76.

Petitioner testified she underwent physical therapy for about eight weeks.

On July 26, 2012, Petitioner's physical therapist recommended work conditioning. PX 6, p. 376.

Petitioner testified that Dr. Goldberg released her to return to work as of August 31, 2012. On that date, the doctor noted that Petitioner had participated in work hardening and was still experiencing mild left shoulder pain but felt "ready to go back to work." He released

Petitioner to 8-hour shifts as of September 4, 2012, with the 8-hour restriction to last one week. PX 6, pp. 332-333.

Petitioner testified she resumed her normal motor truck driver duties on September 12, 2012. Her left arm was still sore at that point and she had difficulty pulling herself up into the truck.

The parties agree Petitioner sustained another work accident on September 21, 2012. This accident is the subject of 12 WC 35484. Arb Exh 2.

Petitioner testified that, after driving a garbage truck on September 21, 2012, she was swiping out in the office when she slipped and fell, landing on her left side. As she went down, she struck her left knee and then struck her left elbow and shoulder. She was in a lot of pain afterward and could not get up. A supervisor came to the scene, asked her some questions and called an ambulance. She was then transported to the Emergency Room at Holy Cross Hospital.

The Emergency Room records (PX 4) reflect that Petitioner reported falling and injuring her left knee as well as her recently operated left shoulder. The Emergency Room physician examined Petitioner and obtained X-rays. He diagnosed a left ankle sprain and strains of the left knee, left shoulder and upper back. He applied a knee immobilizer and prescribed Hydrocodone and Ibuprofen. He recommended that Petitioner seek orthopedic follow-up. PX 4, pp. 5-8.

On September 24, 2012, Petitioner returned to MercyWorks on Ashland and saw Dr. Diadula. The doctor recorded a consistent history of the September 21, 2012 work fall and subsequent Emergency Room care. He noted that Petitioner complained of 6-7/10 pain in her left knee, left ankle, left shoulder, left neck, left upper back and right upper arm. After examining Petitioner, he diagnosed left knee and left shoulder contusions, a left ankle sprain and strains of the left side of the neck, mid back, left upper back and right upper arm. He prescribed Vicodin, Ibuprofen and warm soaks. He provided Petitioner with crutches and directed her to stay off work and follow up on October 2, 2012. PX 5, p. 4.

Petitioner returned to MercyWorks on October 2, 2012, as directed, and complained of significant left shoulder and left knee pain along with mild left neck and left ankle pain. After re-examining Petitioner, Dr. Diadula prescribed a left shoulder MRI and directed Petitioner to remain off work. The MRI, performed without contrast on October 10, 2012, showed a large partial-thickness undersurface tear of the supraspinatus, a Type III acromion and inferior offset of the distal clavicular head, "together causing prominent mass effect on the supraspinatus just proximal to the musculature junction." PX 5, pp. 4-5.

Petitioner returned to MercyWorks on October 19, 2012 and again saw Dr. Diadula. The doctor reviewed the MRI and again noted complaints of significant pain in both the left shoulder and the left knee, along with mild pain in the left ankle. He recommended a left knee MRI and indicated Petitioner planned to see an orthopedic surgeon of her choice. The left knee

MRI, performed on October 29, 2012, showed tricompartmental degenerative changes, worse at the patellofemoral compartment, a small joint effusion and no sign of a meniscal tear. RX 1. On November 8, 2012, Dr. Diadula reviewed the left knee MRI, noted ongoing complaints and referred Petitioner to Dr. Maday for the left knee and to Dr. Perns for the left ankle. PX 5, p. 5.

Petitioner testified she never saw Dr. Maday or Dr. Perns. Instead, she elected to return to Dr. Goldberg.

Records in PX 6 reflect Petitioner saw Dr. Goldberg and a surgical resident on November 9, 2012. The resident recorded a history of the work fall. He noted that Petitioner complained of left knee pain and weakness and increased left shoulder pain secondary to the fall. On left knee examination, he noted a full range of motion, medial and lateral joint line tenderness and a positive reverse McMurray. He described Petitioner's gait as antalgic. On left shoulder examination, he noted a decreased range of motion, significant pain with resisted abduction and forward flexion and a positive Hawkins sign. He reviewed both MRIs, noting that the left shoulder MRI showed a significantly larger supraspinatus tear than the previous MRI performed in January.

On November 9, 2012, Dr. Goldberg recommended both left knee and left shoulder surgery. He indicated that the knee should be addressed first to avoid Petitioner having to use crutches following a rotator cuff repair. He indicated he did not believe Petitioner would be able to resume her former job since it required her to pull herself up into a truck. PX 6, pp. 329-331.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Tonino on December 6, 2012. The doctor's letterhead reflects he is chief of sports medicine at Loyola University Medical Center.

In his report of December 6, 2012, Dr. Tonino noted he had previously examined Petitioner in February 2010 in connection with her right shoulder injury. He indicated that Petitioner was no longer voicing any complaints relative to her right shoulder.

Dr. Tonino recorded consistent histories of the January 2012 and September 2012 work accidents. He indicated he lacked any records concerning the treatment and surgery Petitioner underwent after the January 2012 accident.

On bilateral shoulder examination, Dr. Tonino noted elevation to 120 degrees on the left versus 140 on the right, external rotation to 30 degrees on the left versus 45 on the right, internal rotation to L5 on the left versus T12 on the right and mild pain with rotator cuff testing of the left shoulder.

On left knee examination, Dr. Tonino noted no effusion, a full range of motion, tenderness over the medial and lateral borders of the patella and some mild patellofemoral crepitus.

Dr. Tonino's impression was "partial thickness rotator cuff tear, left shoulder" and "left knee chondromalacia." With respect to treatment, Dr. Tonino found Petitioner to be a candidate for left knee and left shoulder injections as well as therapy for four to six weeks. He did not view Petitioner as a surgical candidate for either the shoulder or knee. He indicated he could not address causation since he lacked the records concerning the treatment Petitioner underwent between January and September 2012.

With respect to the left shoulder, Dr. Tonino found Petitioner capable of working "only with restrictions of ten pounds lifting and no overhead or repetitive use of the left upper extremity." With respect to the left knee, Dr. Tonino found Petitioner capable of working with "no squatting, twisting, climbing or lifting more than 20 pounds." RX 1.

On December 11, 2012, Dr. Goldberg performed a left knee arthroscopy, partial medial meniscectomy and chondroplasty. PX 6, pp. 312-313.

On December 14, 2012, Petitioner followed up with Dr. Goldberg. The doctor described Petitioner as walking and doing well overall. He recommended that Petitioner stay off work, start therapy and return in four weeks. PX 6, p. 318.

The parties agree that Dr. Goldberg performed another left shoulder surgery on March 18, 2013. They also agree that the records concerning this surgery do not appear in the large volume of records received from UIC pursuant to subpoena. One of Respondent's exhibits (RX 3) reflects that the surgery consisted of a left shoulder arthroscopy, subacromial decompression, extensive debridement of the glenohumeral joint, labral debridement and mini open rotator cuff repair.

On March 20, 2013, Dr. Tonino issued a supplemental report after reviewing additional 2012 records from UIC, Dr. Goldberg, MercyWorks, Respondent and Holy Cross Hospital. Dr. Tonino expressed no awareness of the second left shoulder surgery performed on March 18, 2013. Based on his records review, Dr. Tonino found a causal connection between Petitioner's present condition and the September 21, 2012 accident. He noted that Petitioner complained of both her left knee and her left shoulder when she went to the Emergency Room on that date. He recommended that Petitioner undergo a left knee injection and a subacromial left shoulder injection, followed by therapy and a functional capacity evaluation. RX 2.

Dr. Tonino re-examined Petitioner on September 5, 2013, now noting the left shoulder surgery of March 18, 2013 and Dr. Goldberg's August 2, 2013 permanent restriction of "no climbing into the truck." Dr. Tonino noted that Petitioner complained of mild left shoulder discomfort but described her left knee and right shoulder as "feeling good." On left knee examination, the doctor noted a full range of motion, no effusion and no signs of ligamentous or meniscal pathology. On bilateral shoulder examination, the doctor noted elevation of 160 degrees on the left, compared with 180 on the right, external rotation of 45 degrees bilaterally

and internal rotation to L5 bilaterally. He also noted good strength with rotator cuff testing of both shoulders.

Dr. Tonino found Petitioner to be at maximum medical improvement. He did not see the need for any work restrictions but recommended that Petitioner be re-examined by her treating doctor after performing full duty for six weeks to determine how she was doing. He indicated that a functional capacity evaluation could be considered if Petitioner experienced difficulty after returning to work. RX 3.

On November 4, 2013, Petitioner returned to Dr. Goldberg. In his lengthy note of that date, the doctor outlined the injuries sustained and surgeries performed to date. He noted that Petitioner experienced a "long recovery with lots of therapy" following her most recent left shoulder surgery and required permanent work restrictions of "no climbing up into trucks or vehicles that are 2 feet or greater off the ground." He indicated it "would be dangerous" for Petitioner to have to use her arms to pull the weight of her body up into a truck. He also noted that Petitioner was able to drive vehicles that were lower to the ground, such as passenger cars or low vans. He indicated he reviewed photographs taken by Petitioner of a work truck which showed that the distance between the ground and the step appeared to exceed two feet. [See photographs marked as PX 1A-1D and PX 2A-2B.] He completed paperwork relating to the permanent restrictions, noting that he had completed the same paperwork at previous visits. He directed Petitioner to follow up with him as needed. PX 6, pp. 588-589.

Petitioner testified she has not seen Dr. Goldberg since November 4, 2013. As of that date, she was still having difficulty with prolonged standing and stair usage. Her knee would "crack" when she stood up. She was also experiencing aching in her left shoulder.

Petitioner testified she returned to work for Respondent. When she first resumed working, she drove a van for a couple of days. The driver's door of the van was low enough to the ground that the assignment was within her restrictions. She asked Respondent to permanently assign her to van driving but Respondent refused to do this. Petitioner offered into evidence a group of documents (PX 12) reflecting she completed a "City of Chicago Reasonable Accommodation Request Form" on November 4, 2013 citing Dr. Goldberg's permanent restriction and asking to be assigned to drive a pick-up truck or van in Respondent's rodent control division. Included in PX 12 are forms completed by Dr. Goldberg outlining the surgeries he performed as well as the permanent restriction.

On December 17, 2013, Petitioner underwent a functional capacity evaluation at UIC. The evaluator noted a history of the left knee and left shoulder surgeries. He also documented Dr. Goldberg's permanent restriction of no operation of vehicles that are 2 feet or higher off the ground. He indicated that Petitioner reported having been off work since October 25, 2013.

The evaluator described Petitioner as putting forth full and consistent effort. He also described Petitioner's pain ratings as reliable 100% of the time, "suggesting that pain could have been a limiting factor during testing." He indicated he relied on a job description provided

by Respondent. He noted that, while this description indicated Petitioner was not required to perform overhead reaching, Petitioner told him she did indeed have to reach up to grab a hand rail in order to pull herself into a truck.

The evaluator found Petitioner capable of working within a sedentary physical demand level. PX 7.

On March 5, 2014, Jacqueline R. Bethell, M.S., CRC, [hereafter "Bethell"], a rehabilitation consultant affiliated with MedVoc Rehabilitation, Inc., met with Petitioner and her counsel to obtain information concerning Petitioner's education, employment background and medical history.

In her report of March 14, 2014 (Joint Exh 1), Bethell indicated that Petitioner was born on August 15, 1959 and reported obtaining a high school diploma from Richard T. Crane High School in 1978. According to Bethell, Petitioner described herself as an above average student. Bethell further indicated that, following high school, Petitioner studied electronics at DeVry University for about eight months, without obtaining any certificate and took various computer-related classes at two colleges, without obtaining any certificates. She also indicated that Petitioner reported obtaining a certificate in tax preparation from H & R Block in approximately 2000. She further noted that Petitioner holds a valid CDL B license, denied being convicted of any felonies or misdemeanors, is legally authorized to work in the United States, is very familiar with computers and can type about 25 to 30 words per minute. With respect to the latter, Bethell stated that Petitioner felt she needed some "brushing up" on her keyboarding skills. Bethell indicated she asked Petitioner's counsel to provide her with Petitioner's transcripts so that she could determine whether Petitioner could benefit from additional schooling or retraining.

Bethell indicated that Petitioner reported she was still undergoing left knee therapy "as her left knee has continued to bother her." [The Arbitrator notes that no therapy records from early 2014 are in evidence.] Bethell also indicated that Petitioner reported having Type II diabetes but described her diabetes as "under control."

With respect to daily activities, Bethell indicated that Petitioner reported driving to her disabled daughter's house in order to take her granddaughter to school, performing grocery shopping for her daughter, taking care of her two dogs and performing routine household tasks such as cooking, laundry and cleaning.

With respect to Petitioner's work history, Bethell indicated that Petitioner reported working for Respondent between 1990 and 2013, primarily driving a garbage truck but sometimes driving dump trucks and salt spreaders. She stated that Petitioner reported training a couple of co-workers but denied any supervisory experience.

Bethell noted that Petitioner's current restrictions prevented her from driving any vehicle with a door higher than two feet off the ground but that Petitioner was not restricted

from driving lower vehicles such as passenger cars or vans. Bethell indicated that, at the request of Petitioner's attorney, she contacted Latricia Glover of Respondent to pursue reassignment of Petitioner to a position within her restrictions but that Glover merely directed her to Respondent's counsel.

Bethell opined that, based on Petitioner's functional capacity evaluation and permanent restrictions, as well as the interview, Petitioner could return to work as a dispatcher, customer service representative or front desk clerk. In reliance on the Bureau of Labor Statistics, Bethell indicated that the median hourly wage for these three jobs is $19.03, $16.80 and $9.46, respectively. Joint Exh 1.

On May 27, 2014, Bethell issued a progress report indicating she had met with Petitioner on three occasions since the initial meeting and had forwarded job leads to Petitioner on May 5, 16 and 21, 2014. Bethell also indicated that, on April 9, 2014, she spoke with "John" of Respondent's Streets and Sanitation Human Resources Department and learned that Petitioner would not be able to resume working for Respondent with her restrictions, as Petitioner was "expected" to be able to operate "all trucks" used by Respondent. Bethell further stated she confirmed this with Angie Matos of Respondent on April 14, 2014, with Matos reporting that Respondent would not accommodate restrictions and that Petitioner would have to be released to full duty in order to return to her job.

Bethell stated that, at her May 9, 2014 meeting with Petitioner, Petitioner reported having contacted six prospective employers, with three of those contacts having been made in person, and also reported having been approved by the State of Illinois to work as a personal assistant for her daughter. Bethell indicated that, on May 16, 2014, MedVoc applied online on Petitioner's behalf for a customer service position, a traffic supervisor position and three dispatcher positions. Bethell further indicated that Petitioner arrived 25 minutes late for the May 20, 2014 meeting and advised she expected to hear from the State of Illinois that day. Petitioner reported she would be working 24 to 25 hours per week as a personal assistant. Petitioner also reported having applied in person to Answer Net on May 13, 2014 and having subsequently completed a computer examination at Answer Net's direction. Petitioner indicated she had heard from no other employers at that point. With the assistance of a MedVoc employee, Petitioner completed two additional online applications. Bethell further noted that, between May 12 and 16, 2014, Petitioner contacted eleven prospective employers, with three of those contacts in person. According to Bethell, Petitioner had targeted school bus driver, cashier and security guard positions rather than the three positions (dispatcher, etc.) previously identified by MedVoc.

In an addendum, Bethell noted that, on May 28, 2014, Petitioner reported having been hired by the State and having started working as her daughter's personal assistant on May 27, 2014. Petitioner indicated she would be working Monday through Friday from 9 AM to 2 PM each day. Bethell further indicated that on May 30, 2014, MedVoc was asked to place vocational rehabilitation on hold. Joint Exh 1.

At her attorney's request, Petitioner underwent an examination by Dr. Chmell, an orthopedic surgeon, on June 21, 2014. In his report of the same date, Dr. Chmell recorded consistent histories of both work accidents. He noted that Petitioner had last worked in October 2013 and complained of left shoulder pain with diminished motion and strength as well as left knee pain and swelling with intermittent locking and giving way. He also noted a complaint of low back pain which Petitioner attributed to her altered gait. He further noted that Petitioner denied having any left shoulder problems before the January 13, 2012 accident and denied having any left knee problems before the September 21, 2012 accident.

Dr. Chmell described Petitioner as 5 feet, 7 inches tall and weighing 311 pounds. He noted that Petitioner's gait was normal when she walked slowly but that she limped on the left side when she increased her pace.

On bilateral leg examination, Dr. Chmell noted a moderate effusion in the left knee only, with the left knee circumference 3.5 centimeters greater than the right knee circumference. He also noted relative atrophy of the left quadriceps muscle, a diminished range of motion in the left knee only, mild medial joint line tenderness in the left knee only, marked lateral joint line tenderness in the left knee only, crepitus in all three compartments of the left knee, Grade 5 strength throughout both legs except at the left knee, where the strength was Grade 4, and healed arthroscopy scars at the left knee.

On bilateral arm and shoulder examination, Dr. Chmell noted healed surgical scars about both shoulders, a diminished range of motion in both shoulders, moderate subacromial crepitus and tenderness in the left shoulder and negative provocative tests in the left shoulder.

Based on his examination and records review, Dr. Chmell opined that the left shoulder surgeries were reasonable, necessary and attributable to the work accidents, that the left knee arthroscopy was reasonable, necessary and attributable to the September 21, 2012 accident, that Petitioner had achieved maximal medical improvement, that the accidents left Petitioner with significant permanent impairment and disability to her left shoulder and left knee and that, as a result of the accidents, Petitioner required permanent restrictions and would never be able to resume working as a motor truck driver. Dr. Chmell further indicated he agreed with the restrictions described in Petitioner's medical records. PX 8, pp. 1-5.

On November 14, 2014, Bethell issued a "Vocational Rehabilitation Opinion Report and Labor Market Survey." In this report, Bethell indicated she had reviewed Petitioner's pay stubs from the State of Illinois for the period May 2014 through August 15, 2014 and that it appeared Petitioner was averaging $628 every two weeks. Bethell opined that Petitioner could anticipate earning a higher wage than this and could return to full-time employment based on her work history, current physical capabilities and age.

Bethell indicated she conducted a labor market survey in October and November 2014, targeting dispatcher, customer service representative and front desk positions. Bethell stated

that, "through this Labor Market Survey, it was found that [Petitioner] can anticipate earning a mean entry-level wage of $12.45 per hour." Joint Exh 1.

Petitioner testified that, while she was undergoing vocational rehabilitation with MedVoc, she found a job on her own with the State of Illinois. She is still performing this job. The job involves assisting her adult daughter, who is disabled. Respondent is paying her a differential.

Petitioner testified she can no longer walk as far as she could before the September 2012 accident. She has to take breaks and apply ice to her left knee at the end of the day. Her left arm "doesn't work like it did before." She finds it difficult to use her left arm to reach overhead.

Petitioner identified a Local 700 document reflecting current hourly wages based on different truck categories. PX 10. Petitioner testified her former job fell within the two to three truck axle category. If she were still able to perform her motor truck driver job, she would currently be earning $35.03 per hour.

Under cross-examination, Petitioner testified her current State of Illinois job involves helping her daughter with daily activities and errands. She does not lift her daughter. Her daughter is able to dress herself. Her daughter has a wheelchair and leg braces. She has good and bad days.

Petitioner testified she has had no employment other than her current State of Illinois employment since she left Respondent. She is looking for other employment. She has not placed any limit on the hours she can work. She works part-time in her current job, about 26 hours per week, because that is the schedule the job affords, per the State of Illinois. She found this job on her own. She had to complete an application but did not have to meet any specific requirements concerning education or experience. She does not know whether her current job will last.

Petitioner testified she currently owns a 2014 GMC Terrain sports utility vehicle. This vehicle is "not that high" off the ground.

Petitioner testified that, following her second left shoulder surgery, she resumed working for Respondent on September 21, 2013. She worked until the end of October 2013 and then went off work per Dr. Goldberg.

On redirect, Petitioner testified that Respondent denied her the opportunity of continuing to work driving smaller vehicles such as vans. Bethel was instructed to look into this but nothing came of it. At the advice of her union, she requested a "reasonable accommodation" from Respondent. She considers an assignment to drive smaller vehicles to be a "reasonable accommodation." Respondent denied her request.

In addition to the exhibits previously discussed, Petitioner offered into evidence a written description of a motor truck driver job. This description lists a number of "minimum qualifications," including the "ability to enter and exit vehicles and automotive equipment safely." The description also reflects that motor truck drivers may be exposed to severe weather conditions and "must be able to lift and carry up to 35 pounds occasionally." Attached to the job description is a form signed by Dr. Goldberg on November 4, 2013 indicating, with reference to Petitioner, that the physical requirements of the job "are not consistent with the worker's physical capabilities." PX 6, pp. 590-591.

No witnesses testified on behalf of Respondent. In addition to the exhibits previously described, Respondent offered into evidence various print-outs of medical and indemnity payments. RX 4-5.

[CONT'D]

Arbitrator's Credibility Assessment

Petitioner's lengthy tenure with Respondent weighs in her favor, credibility-wise. None of the physicians who treated or examined Petitioner noted any symptom magnification or inconsistencies.

Petitioner came across as a hard-working, straightforward individual who was ready and willing to resume driving for Respondent so long as she did not have to violate Dr. Goldberg's permanent restriction. It is unfortunate that Respondent declined to accommodate her, as confirmed by Bethell, the MedVoc vocational rehabilitation counselor.

The Arbitrator found Petitioner very credible.

Arbitrator's Conclusions of Law Relative to 12 WC 35484

The sole disputed issue in this case, as in the companion claim, is nature and extent. The Arbitrator has elected to award permanency only in this case, for the reasons outlined in the decision in the companion claim.

Petitioner seeks an award of wage differential benefits pursuant to Section 8(d)1 of the Act.

As a preliminary matter, the Arbitrator finds Dr. Goldberg's permanent restriction of no operation of vehicles with doors two feet or more above ground level to be reasonable and appropriate, given the nature of Petitioner's injuries, Petitioner's surgical history, Petitioner's age, the formal job description and the results of the valid functional capacity evaluation. [With respect to the latter, the Arbitrator notes the evaluator's concession that he did not test Petitioner's ability to perform overhead work, based strictly on the job description, despite Petitioner's accurate reporting that she was required to use grab bars to pull herself up into her assigned vehicles.] Dr. Goldberg has treated Petitioner over a period of years. During that period, he has operated on Petitioner's right shoulder (secondary to a previous work accident) as well as her left shoulder and left knee. In contrast, Respondent's examiner, Dr. Tonino, saw Petitioner twice, once in connection with the right shoulder and once in connection with the left shoulder and left knee. Dr. Goldberg had an opportunity to view the photographs that Petitioner took in order to document the type and configuration of her assigned work vehicles. Dr. Goldberg also had an opportunity to review the formal description of Petitioner's motor vehicle driver position. There is no evidence indicating that Dr. Tonino was afforded access to the photographs, the job description or the functional capacity evaluation. The Arbitrator assigns very little weight to Dr. Tonino's ultimate opinion that Petitioner could resume full duty,

at least on a six-week trial basis, since he lacked this vital information and since that opinion is in direct conflict with the multiple shoulder- and knee-related restrictions he enumerated in his original report (RX 1).

The Arbitrator is also struck by Dr. Goldberg's statement that it would in fact be "dangerous" for Petitioner to have to use her upper extremities to pull her not insubstantial body weight up into higher vehicles. The Arbitrator gives deference to this statement, noting that motor truck drivers are required to work in all kinds of weather conditions and to be able to "safely" enter their vehicles.

The Arbitrator notes that, while Dr. Goldberg's 2013 restriction appears to be shoulder-related, there is more current evidence of left knee disability. When Dr. Chmell examined Petitioner in June 2014, he noted atrophy of the left quadriceps as well as a moderate left knee effusion, medial and lateral joint line tenderness of the left knee and a diminished range of motion. He also noted that, following an initial period of post-operative improvement, Petitioner had experienced a recurrence of left knee pain that had gradually worsened. Several months earlier, Bethell had noted that Petitioner was still engaged in therapy for her left knee. The evidence suggests that Petitioner's left knee condition has deteriorated since Dr. Goldberg addressed the need for work restrictions.

Having considered the entire record, the Arbitrator finds that the work accident of September 21, 2012, in combination with the previous work accident of January 13, 2012, rendered Petitioner "partially incapacitated from pursuing her usual and customary line of employment" as a motor truck driver.

The Arbitrator further finds that Petitioner's current personal assistant job for the State of Illinois is appropriate, at least in terms of its physical requirements. The job is part-time but there is no evidence Petitioner is self-limiting. She credibly testified that her part-time status is set by the State and not by her. She also credibly testified she is continuing to look for work. While Respondent argues that Petitioner stopped participating in vocational rehabilitation when she accepted the job, Bethell's report of May 27, 2014 does not support that argument. In that report, Bethell noted that Petitioner continued to participate in the job search process even after she learned, in early May 2014, that she had been approved by the State. In an addendum, Bethell indicated she was asked to place vocational rehabilitation efforts "on hold" on May 30, 2014, three days after Petitioner began working for the State. There is no evidence indicating that Petitioner refused to continue the job search process after being hired by the State. Nor is there evidence indicating that Bethell viewed the State job (setting aside its part-time classification) as inherently inappropriate. In her subsequent and final report, dated November 18, 2014, Bethell opined that Petitioner could likely earn more than $9 per hour but simultaneously targeted three potential employers (with one of those employers indicating it was not currently hiring) offering an entry level wage of $8.25 to $10.25 per hour. Bethell also targeted other potential employers offering higher hourly wages, ranging from $10.25 to $18.25 per hour, but five of these employers indicated they were not currently hiring. Joint Exh

1.

The Arbitrator is not persuaded by Bethell's opinion that Petitioner should focus on dispatcher, customer service representative and front desk positions. Petitioner's work history is long but shallow. Throughout her many years at Respondent, she spent her time operating various kinds of heavy vehicles. There is no evidence indicating she ever worked as a dispatcher or interacted with the public in a customer service capacity.

Petitioner maintains she is entitled to a wage differential award based on an hourly rate of $12.45 per hour multiplied by forty hours, or $498.00 per week, citing Bethell's November 18, 2014 report. Petitioner's paycheck stubs from the State reflect, on average, part-time earnings of $333.60 per week between May 2014 and June 2015. PX 11. Petitioner readily concedes she is capable of full-time employment. Respondent maintains that, if the Arbitrator awards wage differential benefits, those benefits should be calculated based on Bethell's uppermost projected hourly wage of $18.25, citing two prospective dispatcher jobs outlined in the labor market survey. The parties essentially agree that Petitioner would now be earning $35.03 per hour, or $1,401.20 per week, if she could still physically perform the duties of a motor truck driver within her specific axle-related classification. PX 10.

The Arbitrator, having considered all of the foregoing, finds that Petitioner is entitled to wage differential benefits and that the calculation of such benefits should be based, in part, on "suitable employment" earnings of $12.45 per hour or $498.00 per week. The Arbitrator awards wage differential benefits at the rate of $602.13 per week, with this figure representing 2/3 of the difference between the $1,401.20 ($35.03/hour x 40 hours) per week Petitioner would now be earning as a motor truck driver and $498.00, or 2/3 of $903.20.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Accident/causation	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify:	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRANDI BROOKS,

Petitioner,

16IWCC0152

vs.

NO: 12 WC 40495

ILLINOIS-AMERICAN WATER,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, and medical expenses both current and prospective, and being advised of the facts and law, reverses the Decision of the Arbitrator, finds that Petitioner did not sustain her burden of proving accident or causation to a current condition of ill being, and denies compensation.

Findings of Fact and Conclusions of Law

1. Petitioner testified she was a customer service representative for Respondent "going on" 14 years. Her "typical workday consists of taking incoming calls eight hours a day. Constant typing, typing and talking, and operating the mouse on her computer." She is left handed but operates her mouse with her right hand. The mouse has a roller. She wears a headset. She uses a pen, but "not a whole lot." Her chair has arms but if she rests her arms on them too long, they get numb.

2. Petitioner also testified she started having problems with her hands sometime in 2012. She did not seek medical attention at that time. Eventually, she reported her condition to Respondent which sent her to Dr. Dirkers. She eventually saw Dr. Beatty in November of 2012. He diagnosed left carpal tunnel syndrome ("CTS") and recommended surgery. She has not seen Dr. Beatty or any other doctor since February of 2013. Petitioner was now experiencing problems with her right hand as well

3. When asked about hobbies outside work Petitioner answered, "pretty much just work, home, church, and cooking." She does not have diabetes, high blood pressure, or a thyroid condition. Thus far Dr. Beatty has only recommended surgery for her left wrist.

4. On cross examination, Petitioner testified she has a computer at home which she has occasion to use, "but it rarely works." She texts on her phone every so often, but not much because she has "a Walmart phone." She notices the symptoms mostly when she wakes up and sometimes it awakens her. She does "not really" notice symptoms with her activities outside work. There was no specific incident involving her accident date. She did not think she filled out an accident report on that date. Initially, she was provided splints, but could only use them for a couple of days because she could not sleep in them.

5. Petitioner was present when pictures of her work station were taken pursuant to an ergonomic job analysis. The pictures accurately reflect her job station. Petitioner has not missed any time from work due to the current symptoms in her hands. She has not requested any modification of her job duties.

6. On redirect examination, Petitioner testified they change shifts in which they shift locations and work stations. She basically changes work stations every six months. Sometimes when she comes to work after a weekend she has to readjust her chair because somebody else had used it.

7. Cynthia Billings was called by Respondent and testified she is group supervisor for Respondent. Currently, she basically supervises supervisors but in August of 2012 she supervised Petitioner. Petitioner used a computer and phone. The ergonomic analysis accurately described Petitioner's work station.

8. The ergonomic analysis performed on October 17, 2012 noted Petitioner's job involved "continuous computer work all day at the desk. She worked 95% of the work day operating a keyboard and mouse and 80% of the time using the computer and phone with a headset simultaneously. Hand writing was performed less than 5% of the time. Petitioner was observed with a neutral wrist posture with no awkward or sustained wrist deviations. The chair was fully adjustable and the keyboard was at or slightly below the elbows. The only "no" boxes checked were that the documents were not "off the flat surface and at the same distance as the monitor screen," and the writing surface was not on the dominant hand side.

9. The medical records indicate that on September 11, 2012, Petitioner presented to Dr. Dirkers' nurse practitioner, Ms. Brown, with complaints of bilateral wrist symptoms she believed related to CTS. She reported pain and numbness at times. The symptoms began about two years previously and she used wrists supports provided to her by her father for about six to seven months. Petitioner indicated her symptoms were worsening. She was given wrist supports to use when sleeping and working and told to take over-the-counter Ibuprofen.

10. On September 19, 2012, Petitioner presented to Dr. Dirkers reporting she still had symptoms. She found it difficult to work with the condition. Dr. Dirkers ordered a bilateral EMG/NCV.

11. An EMG/NCV taken on October 25, 2012, showed mild left median sensory distal neuropathy at the wrist which could represent CTS and findings consistent with a mild demyelinating process with no evidence of axopathy. The right NCV was normal as was the EMG bilaterally.

12. On November 5, 2012, Dr. Dirkers noted the NCV showed mild sensory delay on the left side only. The EMG was also normal. With the latency at 3.8, Dr. Dirkers did not believe referral for a surgical consultation was appropriate. He offered her a trial of Mobic.

13. On November 26, 2012, Petitioner presented to Dr. Beatty. Her description of her job indicates she was "sitting at desk typing all day. Answering phone. Every part of [her] job requires" the use of her hands. When she was not typing she was "clicking" her mouse. She was referred to Dr. Beatty by her lawyer. She complained of numbness and tingling in her left hand. She used a night splint since October. The treatment note indicated that an NCV/EMG showed mild left CTS.

14. On February 3, 2013, Dr. Beatty, recommended surgery to manage Petitioner's persistent complaints.

15. Dr. Beatty testified by deposition that he is a plastic, reconstructive, and hand surgeon and is board certified. He first saw Petitioner on November 26, 2012. She complained of numbness and tingling in her left hand and fingers which persisted over several years. The symptoms increased over the past year. An EMG showed mild left CTS. Petitioner reported wearing a splint since October and anti-inflammatories did not help. Initially, Dr. Beatty thought conservative treatment should continue.

16. Dr. Beatty also testified that Petitioner related her condition to her work activities "according to her perception of what she does. For instance, when she's doing a lot of typing all day, she identifies the symptomology that is occurring, answering phones, but the typing activity in particular is the problem that she perceives or acknowledges is causing her difficulties." Dr. Beatty noted that Petitioner did not have contributory hobbies or medical condition. He opined that obesity was not "a major contributory factor in the industrial work environment." "We don't see a patient that weighs 400 pounds or something like that." In a previous recorded statement, Petitioner stated she was 5'7" and weighed 210 pounds.

17. Dr. Beatty thought an idiopathic cause meant "that you just haven't figured it out yet." It was hard for him to accept that the condition "just happens out of the blue." He also has a problem with statistics that show CTS is more common in women. He believes it is related to the professions women likely have. He opined that Petitioner's job was "the causative basis or exacerbation or worsening of a preexisting carpal tunnel diagnosis."

18. Dr. Beatty was shown Dr. Goldfarb's reports issued pursuant to a Section 12 examination. He appeared to have criticized them, but it is not exactly clear on what basis. He seems to indicate that Dr. Goldfarb did not adequately explain the bases of his conclusions; "he needs to let us know what are you thinking as an IME doctor."

19. On cross examination, Dr. Beatty testified he did not review the records of previous providers. He agreed that degenerative arthritis can lead to nerve irritation, neuritis, and compression. Petitioner's lawyer referred her to him as well as about eight other patients annually. He thought he could relate a cause for all of his patients' CTS. He had not seen an ergonomic study or picture of Petitioner's work station. He thought the typing was probably the work activity most contributory to CTS. He did not know how much Petitioner used a computer outside of work. He agreed that his notes do not include Petitioner's statement that her symptoms worsened by the end of her workday, but he could "make a phone call and we can add that in any time." Dr. Beatty testified he never administers injections for CTS because that does not take care of the problem. He did not see evidence of right CTS or cubital tunnel syndrome ("CUTS").

20. On redirect examination, Dr. Beatty agreed that Dr. Goldfarb did not see Petitioner until December 2, 2013. Dr. Goldfarb diagnosed mild bilateral CUTS, right worse than left and possible mild CTS. It was possible that Petitioner developed CUTS after Dr. Beatty last saw her. Dr. Beatty also testified that even if a work station was ergonomic, it may have not been properly set up for Petitioner.

21. Dr. Goldfarb testified by deposition that he is board certified in orthopedic surgery and specializes in hand and arm surgery. He sees about 400 to 450 patients a month and performs about 15 to 20 surgeries a week. Dr. Goldfarb conducted an examination of Petitioner on December 2, 2013 pursuant to Section 12 of the Act.

22. Petitioner presented with right worse than left hand numbness and tingling which was worse at night and early morning. She had symptoms for about five years but it was worsening recently. It did not bother her as much during the day but she can get symptoms while talking on the phone. Petitioner indicated she had nerve studies but he did not know the results.

23. After his examination, Dr. Goldfarb concluded Petitioner might have mild CUTS and potentially mild CTS. He would need a repeat nerve study for a more detailed assessment. She was ergonomically assessed and found to be in a correct position. His examination of Petitioner showed "mild suggestion" of CUTS or CTS. He would recommend a repeat NCV and possible a diagnostic cortisone injection. In his experience such an injection rarely cures the condition.

24. Dr. Goldfarb was provided medical records, job description, ergonomic analysis, and Petitioner's statement after his examination. The NCV showed the nerve compression was "really mild" which did not mean that it was not painful or irritating.

16IWCC0152

25. Dr. Goldfarb did not find any evidence that Petitioner's work activities put her at increased risk for CTS or CUTS. He cited literature that suggest there is no relationship between the type of work activities Petitioner performed and CTS and one that actually indicated that typing can be protective against CTS.

26. On cross examination, Dr. Goldfarb agreed that Petitioner could have bilateral CTS and CUTS. He has opined that a patient's CTS was caused by work activities in the past. He believed that very high force and repetitive and extended wrist flexion-extension can be risk factors for developing CTS. Working in cold temperatures can also be related to CTS. The use of the mouse can possibly be a risk factor depending on the position of the wrist. He was not aware of any literature in which the association of use of a mouse and CTS was studied. 90% of CTS cases are idiopathic.

The Arbitrator found Petitioner proved accident/causation because he found the opinion of Dr. Beatty more persuasive than that of Dr. Goldfarb. He noted that Dr. Goldfarb saw her only once, while Dr. Beatty was her treater and a "thorough understanding" of Petitioner's work activities. The Arbitrator awarded Petitioner current medical expenses and ordered Respondent to authorize and pay for surgery recommended by Dr. Beatty.

Unlike the Arbitrator, the Commission does not find the causation opinion testimony of Dr. Beatty more persuasive than that of Dr. Goldfarb. The Arbitrator stressed that Dr. Goldfarb saw Petitioner only once. However, Dr. Beatty apparently only saw her only twice. In addition, by asserting that CTS can never be idiopathic, he likely assumes that if CTS cannot be explained by other preexisting risk factors, the condition is necessarily work related, a conclusion with which the Commission does not agree. The Commission is not persuaded that work activities comprised only of substantial typing, using a computer mouse, and using a telephone with a headset significantly contributes to the development or aggravation of CTS. The Commission also notes that Petitioner operated the mouse with her right hand while her CTS was on the left. Petitioner's work activities do not include any forceful gripping/grasping and/or significant vibratory impact which are now considered the greatest risk factors associated with occupational CTS.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated May 28, 2015 is hereby reversed and compensation is denied.

The party commencing the proceeding for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: MAR 3 - 2016

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-2/10/16
46

STATE OF ILLINOIS	)	☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF COOK	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lacresha Taylor,

Petitioner,

16IWCC0170

vs.

NO: 13 WC 14986

Alpha,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of medical, temporary total disabilty, penalties, two doctors rule and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 29, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 1 1 2016
KWL/vf
O-3/7/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

16IWCC0170

TAYLOR, LACRESHA
Employee/Petitioner

Case# 13WC014986

ALPHA
Employer/Respondent

On 4/29/2015, 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 0.09% 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:

1315 DWORKIN AND MACIARIELLO
JULIO COSTA
134 N LASALLE ST SUITE 1515
CHICAGO, IL 60602

0208 GALLIANNI DOELL & COZZI LTD
ROBERT J COZZI
20 N CLARK ST SUITE 1800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

16IWCC0170

Lacresha Taylor
Employee/Petitioner

v.

Alpha
Employer/Respondent

Case # 13 WC 14986

Consolidated cases: _____

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 **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **1/22/15**. 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. [x] 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. [x] 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. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

16IWCC0170

FINDINGS

On the date of accident, **2/22/13**, 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 $**17,680.00**; the average weekly wage was $**340.00**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $**N/A** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits in the amount of $22,603.23 representing 99-5/7 weeks of unpaid benefits from February 23, 2013 through January 22, 2015.

Respondent shall pay all outstanding reasonable and medical services in the amount of $70,180.21 pursuant to the IL fee schedule rate.

No penalties are awarded in this matter.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

Signature of Arbitrator

04-29-15
Date

ICArbDec19(b)

APR 29 2015

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION 19(b)/8(a) DECISION

Lacresha Taylor Petitioner, v. Alpha, Respondent.	)	**16IWCC0170** Case No. 13 WC 014986 Arbitrator Kurt Carlson

FINDINGS OF FACT

On February 22, 2013, Petitioner, Lacresha Taylor, who was 46 years old, was in the employ of Alpha Bus Company (Respondent). Petitioner testified she was hired as a part time bus driver and had worked for approximately three weeks before she was injured. She further testified that at the time of her injury, she was in training and her duties and responsibilities consisted of riding with the bus drivers and assisting with handicap passengers.

Petitioner testified that on February 22, 2013, she was in "good" overall health. She testified that on that date, she slipped on water near the restroom on the work premises, causing her to fall completely onto the floor with her right knee bent behind her leg. She testified that the injury occurred indoors and that coworkers witnessed the incident. She further testified that it had been snowing on the day of her injury. Petitioner testified she reported the injury on the same day and was provided a copy of the incident report. (PX1).

Petitioner testified that after the accident, she felt excruciating pain in her right knee and right ankle. She testified that she did not feel any pain in her right knee or right ankle prior to her accident and that all of her pain started immediately following her accident. Petitioner did, however, testify that she had sustained a minor injury to her right knee in 1980 when she was

involved in a car accident. Petitioner testified she received treatment for a month and was eventually released without any issues for that injury. Petitioner further testified that she also sustained an injury in 2009 but that the injury was related to her left leg and back, not her right knee. Petitioner testified that she did not sustain any injuries or have any right knee symptoms between 2009 and her injury on February 22nd, 2013.

At the request of her employer, Petitioner presented to Palos Heights Medical Center (PHMC) on the date of her injury, February 22, 2013. (PX2). Petitioner testified that she left work that day due to the pain she was in. Petitioner presented to PHMC with complaints of pain to her right knee and right ankle. (*Id.*). Petitioner testified that she provided PHMC with a history of her accident. The initial report from PHMC shows that Petitioner was injured when she "turned corner slipped and fell onto right leg and twisted knee and ankle." (*Id.*). X-rays of the right ankle and right knee were taken, both of which revealed no evidence of fractures or dislocations. (*Id.*). Petitioner was diagnosed with mild sprains of the right knee and right ankle and was kept off work through February 25, 2013. (*Id.*). Petitioner returned on February 25 and February 26, 2013, with continued complaints of right knee and right ankle pain. (*Id.*). The records note that there were minimal to no objective findings or subjective complaints and recommended that Petitioner return to work on February 28, 2013. (*Id.*). Petitioner attempted to return to work on February 28, 2013 but was unable to do so due to persisting pain. (PX3). Petitioner returned once more to PHMC on March 4, 2013 and was discharged. (*Id.*). The notes from that visit also reveal that Petitioner was seen elsewhere for treatment. (*Id.*).

On, February 28, 2013, Petitioner presented to her primary care physician Dr. Emerito Natanawan complaining of right knee, leg, and ankle pain. (PX3). Dr. Natanawan's physical examination revealed tenderness on palpation in the right knee, lower leg, and right ankle; all

other body parts examined were normal. (*Id.*). Dr. Natanawan diagnosed Petitioner with a right ankle sprain, right leg strain, and contusion of the right knee. (*Id.*). He prescribed her medication and discharged her to return on an as needed basis. (*Id.*).

On March 5, 2013, Petitioner presented to Dr. James T. Elias with persisting complaints of right knee and right ankle pain. Petitioner testified that she provided Dr. Elias with a history of her work accident. Dr. Elias took Petitioner off work and recommended additional physical therapy. (PX4).

On April 24, 2013, Petitioner presented for an independent medical examination (IME) at the request of Respondent and pursuant to Section 12 of the Act. (RX1, pg. 24). At that time, Dr. Wardell opined that based on the nature of her injury and her physical examination, Petitioner could have underlying previous degenerative pathology that could have been aggravated or accelerated by her reported fall at work on February 22, 2013. (RX1, pg. 26). Accordingly, Dr. Wardell recommended an MRI of the right knee and opined that any further recommendations would hinge upon Petitioner's MRI findings. (*Id.*).

Petitioner underwent an MRI of the right knee on May 13, 2013 at the request of Dr. Elias. (PX4). The MRI results revealed a flap tear in the articular cartilage overlying the medial patellar facet which, based on the radiologist's interpretation, can be a source of pain. (*Id.*). The results further revealed mild nonspecific prepatellar edema which the radiologist opined may be posttraumatic in nature given the history of Petitioner's fall. (*Id.*). Petitioner testified that given the MRI results, Dr. Elias referred Petitioner to see an orthopedic surgeon for further evaluation.

Petitioner presented to Dr. Ronald Silver on May 22, 2013 with complaints of ongoing pain, swelling and stiffness in the right knee. (PX5). Petitioner testified that she provided Dr. Silver with a history of her accident on February 22, 2013. Dr. Silver's physical examination

revealed patellofemoral crepitation, peripatellar tenderness and a mild effusion. (*Id.*). Dr. Silver further opined that the MRI results demonstrated an acute FLAP tear of the articular cartilage on the medial patellar facet as well as prepatellar edema consistent with her fall and trauma to her prepatellar and patellar area. (*Id.*). Given these findings, Dr. Silver kept Petitioner off work and recommended arthroscopic surgery of the right knee. (*Id.*). Petitioner regularly saw Dr. Silver throughout the course of the ensuing year and continued physical therapy with Dr. Elias while awaiting approval of her knee surgery. (PX5), (PX4). During this time, Dr. Silver prescribed Petitioner with prescription medication to aid in managing her pain. (PX5).

On April 18, 2014, approximately one year after his initial report, Dr. Wardell generated an addendum after reviewing additional medical records provided by Respondent. (RX1, pg. 17-19). These records included an interrogatory referencing an accident in which Petitioner was struck by a car in 1986 and a subsequent car accident on April 16, 1994 that appear to have aggravated existing injuries; one note from Advocate Health Centers dated December 7, 2007 which document an incident in which Petitioner slipped at work and fell onto both of her knees; an Illinois Workman's Compensation Commission Application for adjustment of claim dated March 31, 2008 which corresponded with the December 7, 2007 work injury; and a physical therapy record dated November 23, 2009 which documented right lower extremity weakness following an unrelated stroke. (*Id.*). Given these documented issues that predated her February 22, 2013 work injury, Dr. Wardell opined that Petitioner demonstrated pre-existing symptomatic complaints to her right knee that were not causally related to her workers' compensation claim from her February 22, 2013 injury. (RX1, pg. 21). Dr. Wardell further opined that such a determination was consistent with the findings of the report of the right knee MRI dated May 13,

2013, which given the documented past medical history, were most likely pre-existing to her work related claim of February 22, 2013. (RX1, pg. 28).

Following the addendum report, Petitioner returned to Dr. Silver on April 23, 2014. (PX5). Dr. Silver continued Petitioner off work and reiterated the need for arthroscopic knee surgery. (*Id.*). He further prescribed Petitioner with medications as a matter of medical necessity, physical therapy, and a new knee brace. (*Id.*).

Petitioner presented to Athletico on May 3, 2014 to start outpatient physical therapy three times a week for twelve weeks. (PX6). Office visit notes document an overall improvement in Petitioner's gait/transfer and a slow progress toward functional goals. (*Id.*). Petitioner completed the prescribed course of physical therapy and was clinically seen at Athletico through August 8, 2014. (*Id.*).

Despite completing physical therapy, Petitioner's right knee pain persisted and she continued to treat with Dr. Silver while awaiting surgical approval. (PX5). As of trial, Dr. Silver continues to recommend arthroscopic knee surgery and prescribes Petitioner with medications to maintain her pain while awaiting surgery approval. (*Id.*).

The evidence deposition of Dr. Silver was taken on August 4, 2014. Dr. Silver acknowledged that Petitioner did have prior knee injuries in the past but that they were minor and resolved spontaneously. (RX7, pg. 12). He testified that Petitioner had no significant medical treatment for her pre-existing medical issues, no symptoms for three and a half years prior to her February 22, 2013 work injury, and that she was working full-time without any restrictions prior to her accident. (*Id.*). Furthermore, Dr. Silver testified that the MRI films demonstrated a FLAP tear and some degree of edema at the time it was done, both of which were indicative of an acute process. (*Id.*at 13). Dr. Silver testified that given these findings, it was his opinion to a

reasonable degree of medical and surgical certainly that Petitioner's right knee condition and the need for surgery were causally related to her February 22, 2013 work accident. (*Id.*).

The evidence deposition of Dr. Wardell was taken on August 25, 2014. Dr. Wardell maintained by his addendum opinion and testified Petitioner's subjective complaints were secondary to pre-existing issues relative to her right knee. (RX1, pg. 21). Dr. Wardell once again based his opinion on the presentation of additional medical records that were provided to him subsequent to his April 24, 2013 IME which, according to him, demonstrated a long history of issues concerning her right knee. (*Id.*). According to Dr. Wardell, this history included being struck by a car in 1986, a subsequent car accident in 1994, a workers' compensation case filed in March, 2008 for a December 5, 2007 accident, and a November 24, 2009 physical therapy note. (*Id.* at 17-19). On cross-examination, Dr. Wardell testified that he never reviewed the actual MRI films and that he did not recall whether the findings on the MRI were acute or degenerative. (*Id.*at 25,29). Dr. Wardell further testified that he did not review any medical records pertaining to the right knee for Petitioner's injury in 1986 and subsequent car accident in 1994, merely relying on an "interrogatory of some sort" dated February 7th, 1996 as the basis for his opinion relative to those incidents. (*Id.*at 32). Regarding the March 2008 workers' compensation case, Dr. Wardell testified that he only reviewed one chart note dated December 7, 2007 which documented a diagnosis of contusion to the knees, thighs, and hands. (*Id.*at 36). Similarly, Dr. Wardell testified that the only records to support right knee symptomology following her 2009 stroke was a November 23, 2009 outpatient physical therapy note which documented a subjective complaint relating to pain or popping in the right knee. (*Id.*at 37).

On cross-examination, Petitioner testified that when she presented to PHMC, she stated that she had no prior injuries. She testified that she was originally recommended to return to

work on February 28, 2013 but instead, she went to see Dr. Natanawan who was her primary care physician. She testified when she presented to Dr. Wardell for the IME, she stated to him that she had no prior injuries to her right knee. Regarding her employment with Alpha Bus Company, she testified that she was not sure as to her exact starting date and that she was still in training when she injured herself. She testified that her training duties included riding on the buses with drivers and assisting passengers, particularly those that were handicapped. She testified that she has not personally received any outstanding medical bills. When asked about her accident in the 1980s, Petitioner testified that she did not recall who she treated with. She further testified that she did not recall specifics of her injury in 2007 when she worked for Continental Express. When asked about her injury in 2009, Petitioner testified that she did sustain an injury but to her left leg. When Respondent's counsel asked whether she was ever sent by Dr. Natanawan for physical therapy, Petitioner responded that she was but it was for therapy following an unrelated stroke.

On re-direct examination, Petitioner testified that none of the doctors that she saw prior to Dr. Silver were orthopedic specialists. She testified that she initially presented to Dr. Elias because she was still in pain and she was not receiving proper care at PHMC. Regarding the incident in 1986, Petitioner testified that this was a minor injury and treated for approximately one month. She testified that she was still in college when this happened and she went on to play volleyball at the collegiate level. When asked about her IME evaluation with Dr. Wardell, Petitioner testified the evaluation lasted about 10-15 minutes and that only the knee was evaluated. She further testified that she still had pain when she presented to Dr. Wardell on April 24, 2013, approximately eight weeks after her injury. When asked about her stroke in 2009, Petitioner testified that she treated for about a year and a half but that the treatment

consisted of speech therapy and physical therapy for overall right sided weakness. She testified that the treatment following her stroke was unrelated to the right knee and ankle symptoms she exhibited following her February 22, 2013 injury.

Petitioner testified that as a result of her work injuries, she has experienced significant difficulties that have affected both personal and daily aspects of her life. She testified that she needs the surgery due to the pain she is in.

CONCLUSIONS OF LAW

(F) Is Petitioner's current condition of ill-being causally related to the injury?

The Arbitrator finds Petitioner's right knee and right ankle conditions to be causally related to the February 22, 2013 work injury.

The Arbitrator finds Dr. Silver's opinion regarding the causality of Petitioner's injury more credible and consistent with Petitioner's testimony and the medical records than that of Respondent's IME expert Dr. Wardell. In so finding, the Arbitrator relies on several factors. First, Petitioner's testimony is in line with the contemporaneous medical records. Petitioner testified she was in good health, working full duty for Respondent, and required no treatment at all for over three years leading up to her work injury on February 22, 2013. After the injury, Petitioner testified that she complained of immediate pain, received treatment, underwent MRI testing, and received a recommendation for surgery. (PX1) (PX2) (PX3), (PX4), (PX5). The right knee MRI findings were indicative of a post-traumatic and acute process; a finding that both the radiologist and Dr. Silver agreed on given the history of Petitioner's fall.

Second, the Arbitrator is not persuaded by the opinion of Respondent's IME expert Dr. Wardell that Petitioner's right knee condition is pre-existing. The Arbitrator finds that Petitioner's past medical history relative to her right knee is inconsequential. There were no significant or relevant findings in Petitioner's medical history that would lend credence to the (second) opinion offered by Dr. Wardell as to causality. In his opinion, Dr. Wardell points to interrogatories that document an incident in which Petitioner injured her knee after being struck by a car in 1986 and then a motor vehicle accident in 1994 which aggravated existing injuries. (RX1). The Arbitrator notes that no medical records were submitted into evidence to corroborate

the medical treatment sought or the extent of care received for either of these incidents. However, at trial, Petitioner testified that she only treated for one month following her 1986 injury and returned to college and went on to play volleyball at the collegiate level. Next, Dr. Wardell points to a progress report dated December 7, 2007, that documents a work injury where Petitioner fell and was diagnosed with a contusion to the knee, thigh, and hands. A workers' compensation claim was filed for this injury on March 31, 2008 and Dr. Wardell was provided with the application for adjustment of claim. Petitioner testified that she did not recall specific details of this incident but later maintained she did not sustain an injury to her right knee. Finally, Dr. Wardell points to one outpatient physical therapy note dated November 23, 2009, which demonstrates right lower extremity weakness and subjective complaints of right knee popping. Petitioner testified at trial that this treatment was for right-sided weakness following a stroke and wholly unrelated to her right knee condition. Contrary to Petitioner's sporadic and isolated incidents of medical treatment over the past three decades prior to her February 22, 2013, work injury, Petitioner's right knee and ankle complaints have been consistent, ongoing, and unabated since her work injury.

Finally, the Arbitrator finds that Dr. Wardell is not a credible expert and therefore places greater weight on the opinion of Dr. Silver regarding the issue of causality. The Arbitrator notes that Dr. Wardell opines in his April 18, 2014, addendum that Petitioner may have sustained a knee strain which he would have expected to resolve within three or four weeks of the injury. This strikes at the very heart of his previous April 24, 2013, opinion, done approximately eight weeks after Petitioner's injury, in which Dr. Wardell felt compelled enough to recommend an MRI based on Petitioner's ongoing right knee complaints and physical exam findings. Of note, even after Petitioner underwent an MRI, Dr. Wardell never reviewed the MRI films yet went on

to opine that the findings were indicative of a degenerative injury; this finding is discordant with both the radiologist's interpretation and Dr. Silver's review of the MRI films. Dr. Wardell further supported his opinion by citing "pre-existing well documented issues with her right knee" while acknowledging that Petitioner was working full-duty prior to her injury and that there were no records of ongoing right knee complaints for a period of three years and three months leading up to her injury. (RX1, pg.21), (RX1, pg. 38). In doing so, Dr. Wardell's opinion seemingly rejects the possibility that Petitioner's injury could have aggravated and/or accelerated any pre-existing issues. Rather, he chooses to support his opinion by relying on four sporadic and isolated instances throughout the past three decades where her right knee is mentioned without the complete set of supporting medical records; the most recent reference being over three years prior to her February 22, 2013, injury.

Reviewing the evidence in its entirety, it is clear that Petitioner had a work injury followed by a condition of ill-being that has not abated with conservative means. To say that Petitioner may have sustained a knee strain as a result of the work accident which should have resolved three to four weeks after the accident and that Petitioner's present condition of ill-being is due solely to a pre-existing condition disregards the "chain of events" analysis cited frequently by the Commission and the reviewing courts in findings a causal relationship. *Martin Young Enterprises, Inc. v. Industrial Com.* 51 Ill.2d 149 (1972). It is for the reasons above, the Arbitrator finds that Petitioner's present condition of ill-being is causally related to the injury of February 22, 2013.

(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?

At trial, Petitioner introduced the following unpaid medical bills:

1.	Dr. Shakir Moiduddin/Palos Heights Medical Center	$907.00
2.	Dr. James T. Elias	$8.720.00
3.	Advanced Medical Imaging Center	$1,502.00
4.	Dr. Ronald Silver/Orthopedics of the North Shore	$2,620.00
5.	Prescription Partners	$5,897.02
6.	Rx Development	$41,062.24
7.	Infinite Strategic Solutions	$586.95
8.	Athletico	$8,885.02
	TOTAL:	$70,180.21

Respondent denied liability for these expenses based on causal connection and Petitioner exceeding his choice of two physicians.

The Arbitrator finds the medical treatment ordered and rendered by PHMC, Dr. Elias, and Dr. Silver to be both reasonable and necessary, and that Respondent has not paid all appropriate charges for the reasonable and necessary medical services. Section 8(a) of the Act limits an employer's liability to pay for medical services to (1) first aid and emergency services and (2) two additional doctors chosen by an employee and any additional providers and services recommended by those two doctors. (820 ILCS 305/8(a)). Moreover, under Section 8(a) of the Act, the claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of claimant's injury. *University of Illinois v. Industrial Comm'n*, 232 Ill. App.3d 154, 164 (1992). Claimant has the burden of proving that the medical services were necessary and the expenses were reasonable. See *Gallentine v. Industrial Comm'n*, 201 Ill. App. 3d 880, 888 (1990). Thus, under the plain language of Section 8(a), an employer is liable to pay for two chains of medical

services selected by the employee. Conversely, doctors chosen by the employer as well as first aid and emergency treatment do not count as an employee's physician choice.

In this case, the claimant sustained an injury to her right knee and right ankle as a result of her accident on February 22, 2013. Petitioner testified she was instructed by her employer to go to PHMC for medical treatment. The Arbitrator finds that Petitioner's unrebutted testimony establishes that PHMC was a facility designated by the employer and that Petitioner did not elect to treat there on her own. Petitioner had two follow up appointments at PHMC before she sought treatment with her primary care physician, Dr. Natanawan. (PX2), (PX3). Since the two-physician choice limitation rule does not apply to medical treatment chosen by the employer, the Arbitrator finds that PHMC does not constitute one of Petitioner's physician choices.

Petitioner then presented to Dr. Natanawan on February 28, 2013. Although this was the only appointment Petitioner had with Dr. Natanawan for symptoms related to her work injury, it nevertheless constitutes her first choice within the meaning of Section 8(a) of the Act. Subsequently, Petitioner presented to Dr. Elias who recommended physical therapy and an MRI of the right knee at AMIC. (PX4). This constituted her second choice and Respondent is liable for any reasonable and necessary medical services recommended by Dr. Elias. Petitioner testified that given the MRI results, which revealed a cartilage tear, Dr. Elias referred Petitioner for an orthopedic evaluation with Dr. Silver. Dr. Silver recommended additional physical therapy with Dr. Elias and Athetico and prescribed medications through Prescription Partners, Rx Development, and Infinite Strategic Solutions. (PX5), (PX6). Because Section 8(a) makes an employer liable for reasonable medical services referred by the second service provider, all of the treatment and medical services prescribed by Dr. Silver fall within the chain of referrals of the second provider, Dr. Elias.

As all the treatment and services rendered to Petitioner fall within the two chains of physicians as provided for in Section 8(a), the burden next falls on Petitioner to prove that the medical services were reasonable and necessary. The Arbitrator finds there is nothing in the record to show that the physical therapy with Dr. Elias was unreasonable. In fact, Petitioner testified that the physical therapy helped at the time she was doing it. Further, the MRI was reasonable in light of Petitioner's lack of improvement, a finding that Respondent's expert Dr. Wardell seemingly agreed with in his initial report. (RX1). Moreover, Respondent's IME expert, Dr. Wardell, failed to provide persuasive testimony refuting the reasonableness and medical necessity of the treatment recommended by Dr. Elias.

The Arbitrator further finds that Respondent is liable to pay for treatment and medications prescribed by Dr. Silver and dispensed through Prescription Partners, Rx Development, and Infinite Strategic Solutions. At all times, Petitioner only did therapy with one provider, either with Dr. Elias or at Athletico. (PX4), (PX5). Records from both facilities document improvement and slow progress. (*Id.*) Additionally, there is nothing in the record to suggest that the care provided at both facilities at separate times throughout the course of Petitioner's treatment was duplicative in nature or not necessary. In fact, Petitioner testified that the therapy helped her while she was doing it. Regarding the medications, the records from Dr. Silver are replete with notations documenting the medical necessity for prescription medication due to Petitioner's work injury. Dr. Silver prescribed the following medications: Meloxican for soft tissue swelling and inflammation; Protonix for gastrointestinal protection as Petitioner demonstrated gastrointestinal sensitivity to other nonsteroidal anti-inflammatory medication; Hydrocodone for pain; Ultram for lower levels of discomfort; and Terocin cream and patches to provide topical analgesia – pain relief to minimize use of narcotic analgesics. Once again,

Respondent's expert witness Dr. Wardell did not provide any testimony refuting the reasonableness of the prescription medication nor did Respondent exercise its right under Section 8.7 of the Act to obtain Utilization Review and challenge their medical necessity. At trial, Petitioner testified that the medications helped her at the time she was taking them. Therefore, the Arbitrator concludes that Petitioner has met her burden in proving that the treatment and therapy recommended by Dr. Elias and Dr. Silver, as well as the medications, were reasonable and necessary to aid in alleviating the symptomatic effects of Petitioner's work injury.

In light of the above findings, the Arbitrator finds that Petitioner did not exceed the two-physician choice limitation set for in Section 8(a) of the Act. Petitioner's treatment with PHMC did not constitute a choice of physician as she was referred to that facility by her employer. Accordingly, the treatment rendered by PHMC, Dr. Natanawan, Dr. Elias, and Dr. Silver were all within the allowable chain of referrals. As such, and because the treatment rendered was both reasonable and necessary, the Arbitrator finds Respondent liable for medical expenses billed by these providers at the fee schedule rate.

(K) Is Petitioner entitled to any prospective medical care?

The Arbitrator finds that Petitioner is entitled to prospective medical care. Petitioner is not at MMI as Dr. Silver has prescribed medical treatment that has not yet been provided to Petitioner.

As of the trial date, Petitioner has undergone extensive conservative treatment that has failed to alleviate her symptomatic pain. Despite slow progress, Petitioner testified that she is in excruciating pain and needs the surgery. As Petitioner suffered a compensable work accident

and her present condition is causally related to her work accident, the Arbitrator finds that Petitioner is entitled and Respondent liable to approve and pay for the knee surgery and any post-operative treatment prescribed by Dr. Silver.

(L) Is Petitioner entitled to TTD benefits from February 23, 2013 through January 22, 2015?

The Arbitrator finds Petitioner to have been temporarily totally disabled from February 23, 2013 through the date of hearing on January 22, 2015, a period of 99-5/7 weeks. An employee is temporarily totally disabled from the time an injury capacitates him until such time as he is as far recovered as the permanent character of the injury will permit. *Archer Daniels Midland Co. v. Industrial Comm'n*, 138 Ill. 2d 107, 118 (1990). An employee seeking TTD benefits must prove not only that he or she did not work, but also that he or she is unable to work. *Pietrzak v. Industrial Comm'n*, 329 Ill. App. 3d 828, 832 (2002).

The record shows that after seeking treatment at PHMC on February 22, 2013 through February 25, 2013, claimant was authorized to return to work to regular duty. Petitioner attempted to return to work on February 28, 2013, but simply could not continue due to persisting pain. (PX3). Petitioner testified that due to her displeasure with the medical treatment she was receiving at PHMC, she went to see her primary care physician, Dr. Natanawan. (PX3). Subsequently, On March 5, 2013, Petitioner presented to Dr. Elias who took Petitioner off work and recommended physical therapy. (PX4). Petitioner was kept off work, underwent an MRI, and referred to Dr. Silver for orthopedic evaluation. (*Id.*). On May 22, 2013, Petitioner presented to Dr. Silver who recommended right knee surgery and has kept Petitioner off work pending surgery approval. (PX5).

The Arbitrator finds the opinions of Petitioner's treating physicians and the testimony of Petitioner to be more credible than Respondent's IME expert Dr. Wardell. Dr. Silver kept Petitioner off work while waiting almost a year for Respondent to provide Dr. Wardell with additional medical records to generate an addendum to his initial IME report. Respondent did not present any expert opinion or evidence that Petitioner was capable of working full duty until Dr. Wardell's deposition on August 25, 2014. At the deposition, Dr. Wardell testified that Petitioner was capable of returning to work full duty three to four weeks after sustaining what he thought was a knee strain. The Arbitrator is not persuaded by Dr. Wardell's testimony regarding Petitioner's ability to work full duty three to four weeks after her injury given that on his first evaluation on April 24, 2013, he felt compelled enough to recommend an MRI to ascertain the pathology responsibly for her continued symptoms. (RX1, pg. 25). As such, the Arbitrator gives more weight to the opinions of Petitioner's treating physicians finding Petitioner temporarily totally disabled beginning on February 23, 2013, and continuing through January 22, 2015, and the Arbitrator finds Petitioner is entitled to TTD benefits for that 99-5/7 week period. As of trial, Respondent has not paid Petitioner any TTD benefits through the date of the hearing.

(M) Should penalties or fees be imposed upon Respondent?

No penalties are awarded in this matter.

Date and Entered:

ARBITRATOR Kurt Carlson

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☒ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Stephanie Mabry,
Petitioner,

vs. NO: 13 WC 16133

Marshall Browning Hospital,
Respondent.

16IWCC0130

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issue(s) of causal connection, medical expenses and prospective medical treatment, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, with corrections, said decision attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission hereby corrects clerical errors in the Arbitrator's decision to show that Petitioner was temporarily totally disabled from 1/23/13 through 1/29/13, from 1/31/13 through 8/31/14 and from 12/12/14 through 2/4/15, for a period of 91-3/7 weeks.

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $500.72 per week for a period of 91-3/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

16IWCC0130

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical expenses in the amount of $21,363.89 pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay for prospective medical treatment in the form of fusion surgery as recommended by Dr. Kube, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $54,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 2 3 2016

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-02/09/16
jdl/pmo
68

[illegible]

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

MABRY, STEPHANIE
Employee/Petitioner

Case# **13WC016133**

MARSHALL BROWNING HOSPITAL
Employer/Respondent

16IWCC0130

On 4/3/2015, 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 0.13% 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:

0536 RON D COFFEL & ASSOC
502 W PUBLIC SQUARE
PO BOX 366
BENTON, IL 62812

1109 GAROFALO SCHREIBER HART ETAL
JAMES R CLUNE
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

☐ 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
19(b)

Stephanie Mabry
Employee/Petitioner

v.

Marshall Browning Hospital
Employer/Respondent

Case # **13** WC **016133**

Consolidated cases: **N/A**

16IWCC0130

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 **Mt. Vernon**, on **February 4, 2015**. 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **01/19/13**, 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 $**39,056.16**; the average weekly wage was $**751.08**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of $**13,407.90** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**13,407.90**.

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 **$500.72/week** for **91** weeks, commencing **01/23/13** through **01/29/13**; **01/31/14** through **08/31/14**; and **12/12/14** through **02/05/15**.

Respondent shall be given a credit of **$13,407.90** for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of **$21,363.89**, as provided in Section 8(a) of the Act subject to the Medical Fee Schedule.

Respondent shall authorize and pay for prospective medical care in the form of fusion surgery as recommended by Dr. Kube.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

Signature of Arbitrator

March 31, 2015
Date

ICArbDec19(b)

APR 3 - 2015

STEPHANIE MABRY V. MARSHALL BROWNING HOSPITAL,
13 WC 016133 (19(b))

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner was involved in an undisputed accident on January 19, 2013. At the time of arbitration, the disputed issues included: causal connection; medical bills; temporary total disability benefits; and prospective medical care. Petitioner was the sole witness testifying at the hearing.

The Arbitrator finds:

Petitioner, age 39, was employed by Respondent as an emergency room registered trauma nurse. On January 19, 2013, she was walking in the hospital hallway in route to the laboratory to deliver blood vials, when she slipped on a wet floor. Petitioner testified she was coming around a corner and slipped in water. She attempted to catch herself to keep from falling all the way down. In doing so, Petitioner twisted her low back and inverted her left ankle. An accident report was completed. The accident report stated that Petitioner injured her left ankle and twisted her low back when she slipped on the wet floor. The injury occurred at approximately 4:30 p.m. (PX 1) Petitioner completed her shift, which ended at 11:00 p.m., and then went home. Upon arriving back to work the next day (January 20, 2013), Petitioner noticed she was in a lot of pain with respect to her left ankle. As a result she was seen in the emergency room. (PX 4)

On January 20, 2013 the emergency room doctor noted Petitioner's history of twisting her low back and left ankle. At that time, her chief complaint was left ankle pain. On physical examination, she had slight edema noted and there was bruising on the outer aspect of her left ankle. An x-ray of the left ankle was negative for fracture. She was given a differential diagnosis of fracture dislocation of the left ankle versus left ankle strain or sprain. She returned back to work and continued to have difficulty with her left ankle particularly swelling and pain. She was sent home and told to ice and elevate her left ankle. (PX 4)

Petitioner testified that she returned to work on January 23, 2013. In the interim she had remained at home as instructed and sat in a recliner with her ankle wrapped up and iced. When she returned to work on the 23rd Petitioner was again seen in the emergency room. Petitioner testified she was told she had a fracture. At that time, continued left ankle swelling and bruising was noted. Petitioner had no obvious deformity on examination. She complained of a pain level of 5/5 and constant throbbing of the left ankle. A stirrup splint was applied. She was given crutches and medications and taken off work until January 30, 2013. (PX 2; PX 4)

On January 28, 2013 Petitioner came under the care of her family doctor, Dr. Soheil Khan. Dr. Khan treated her conservatively with medications. Dr. Khan diagnosed her with a navicular left ankle bone fracture. He ordered a left ankle x-ray, but it was never done. He gave her a lidoderm patch for her left ankle pain and pain medication. (PX 5)

In a slip dated January 30, 2013 Petitioner was taken off work per Dr. Khan for another two weeks due to her foot fracture. (PX 2)

On February 12, 2013, Petitioner again complained of left ankle pain and back pain which Dr. Khan noted were both secondary to acute trauma. Petitioner was taken off work for two weeks. (PX 2; PX 5) On February 26, 2013, Dr. Khan examined Petitioner's low back and noted reduced range of motion, but no evidence of radiculitis. Dr. Khan also prescribed walking boots. He took her off work completely for another

two weeks. (PX 2; PX 5) She continued to treat with Dr. Khan for back pain, left ankle pain and was maintained on Norco and Flexeril for pain management.

Dr. Khan kept Petitioner off work as of March 19, 2013 due to her left foot being swollen secondary to her fracture. (PX 2; PX 5)

As of April 8, 2013, Dr. Khan kept Petitioner off work. (PX 2; PX 5)

On April 19, 2013, Petitioner was discharged from her employment with Respondent.

At the request of Respondent, Petitioner was examined by Dr. Petkovich on April 30, 2013, concerning her mid and lower back pain and right gluteal pain. Petitioner also had some left hindfoot pain. Petitioner was wearing a walking boot for her foot and was not working. Petitioner denied any prior back or left foot problems. In his written report dated May 2, 2013, Dr. Petkovich commented upon his physical examination, noting some tenderness upon palpation from L1 to L5 and mild restricted range of motion. X-ray reports were reviewed and new films taken. He noted sacralization of Petitioner's fifth lumbar vertebra, a normal variant in the general population. Dr. Petkovich also reviewed Dr. Khan's records and the Hospital radiology and emergency room records. His diagnoses included a muscular lumbar strain and left foot ligament strain (dorsal and lateral aspect) and he believed that both conditions were causally related to Petitioner's work accident. He felt her foot treatment had been excessive as he did not believe she had sustained a fracture. He did not feel Petitioner was at maximum medical improvement yet as she would benefit from four weeks of aggressive physical therapy. Dr. Petkovich also believed Petitioner needed lighter duty activities and he recommended that she not lift more than 20 pounds and that she should be allowed to sit down every hour for approximately ten minutes. She could work up to 6 hours a day. Dr. Petkovich "anticipated" that she would reach maximum medical improvement (MMI) for her spine after the physical therapy and that she could then resume full duty work. He did feel she was at MMI with respect to her left foot and ankle. (RX 1- Res. Ex. 2)

Dr. Khan issued a script for back physical therapy on May 8, 2013. (PX 5)

Petitioner signed her Application for Adjustment of Claim in this matter on May 8, 2013. (AX 2)

On May 13, 2013, Petitioner returned to see Dr. Khan requesting that she be referred to a back specialist as her back was hurting all the time. (PX 5)

Petitioner then underwent a lumbar spine MRI on May 30, 2013 at Advance Diagnostic Imaging. (PX 5) According to the radiologist's report, the MRI showed mild bilateral facet osteoarthritis at L3-4, mild degenerative disc disease at L4-5 along with slight retrolisthesis. The radiologist also thought there was a peripheral annular tear centrally with co-existent small, broad based central disc protrusion but no L5 nerve root displacement or compression. Mild bilateral facet osteoarthritis was also noted. L5-S1 was normal except for a congenital variation as further discussed in the report. (PX 5)

Dr. Khan re-examined Petitioner on June 5, 2013 noting they reviewed the MRI. Petitioner was not having any leg pain at that time. (PX 5) He again wrote a script for physical therapy. (PX 5)

On June 26, 2013, orthopedic spine surgeon, Dr. Richard Kube of Prairie Spine and Pain Institute, examined Petitioner in regard to her low back and left knee complaints. A "Work Flow Checklist" completed at the time of the appointment indicated "thoracic right side pain." Petitioner presented with a work injury history that she slipped on a wet floor and twisted her low back left ankle and left knee. Dr. Kube noted she was in a

left ankle boot and twisted her back while trying to catch herself from falling. Petitioner denied any numbness or tingling in her legs but did note pain in her left thigh, foot, and leg along with weakness in her left ankle, foot, and knee. According to her pain diagram, Petitioner's back pain was located in the center of her spine in the mid area (belt line) and also to the upper right. Petitioner indicated that her problem had worsened in the previous two weeks. On physical examination, Dr. Kube noted point tenderness of the SI joint on the right, positive right Fabers test and positive pelvic compression test. Dr. Kube charted Petitioner's back and left knee pain as at a medium level, and he noted she had problems with balance and tripping frequently due to imbalance dysfunction. Dr. Kube further noted that her back pain was localized in the mid back and right side. Dr. Kube reviewed the ADI L/S MRI of May 30, 2013 and noted that Petitioner had a grade 3 disc at L5, S1, a possible annular tear at this level, but noted no significant lesion on the MRI film.[1] (PX 6)

On July 2, 2013, L/S x-rays ordered by Dr. Kube at Franklin Hospital showed mild right convex mid lumbar curvature, with no acute bone abnormality. (PX 6)

Based upon his physical examination, Petitioner's complaints, and the persistent symptoms, Dr. Kube recommended more aggressive treatment. On July 3, 2013, Dr. Kube performed at SI Joint injection at Surgery Center for Southern Illinois. He gave her a light duty slip. (PX 6)

On July 24, 2013 Dr. Kube completed a "Patient Information" sheet in which he indicated Petitioner could perform light activity as of June 26, 2013. He noted that light duty included frequent lifting up to 10 lbs, no overhead work or floor to waist, rare bending and twisting, and no prolonged sitting or standing position. (PX 2; PX 6)

Dr. Kube re-examined Petitioner on July 29, 2013. Petitioner reported that the injection initially increased her pain but then it diminished the next day. Dr. Kube believed Petitioner's leg pain was more radicular than related to the sacroiliac joint. Given that, along with the L5-S1 annular tear, he recommended an epidural injection on the right at L5-S1. Dr. Kube further noted that Petitioner had been reaching out to her employer about returning to work because she had been eligible for re-hiring when she had been let go. She had tried on multiple occasions to contact Respondent but no one would respond to her and she was increasingly frustrated. Petitioner indicated she was going to look into trying to get her nurse practitioner's degree. (PX 6)

In an Intake Form dated August 21, 2013 Petitioner reported left leg pain. (PX 6)

On July 31, 2013, Dr. Kube performed a lumbar epidural steroid injection on the right at L5, S1 at Surgery Center for Southern Illinois. Injections were unsuccessful in achieving any significant relief of her back and right leg pain. Dr. Kube then charted "given the duration of the symptoms and failure of conservative measures, my recommendation is for a provocative discogram to determine if the L5, S1 disc is the pain generator." (PX 6)

Barbette Manna, "Territory Representative" for Illinois Risk Management Services (Respondent's workers' compensation claim administrator) wrote a letter to Petitioner's attorney on August 8, 2013. In it she wrote,

> Please be advised that your client's ttd benefits are suspended based on the opinion of our IME physician. The additional rec-

[1] Green highlighting in PX 6 was not done by the Arbitrator.

ommended treatment was for physical therapy. (PX 3)

Dr. Kube re-examined Petitioner on August 27, 2013. Petitioner stated the injection had done nothing for her. He recommended a provocative discogram to determine if the L5-S1 disk was the pain generator. (PX 6)

On August 28, 2013, Dr. Kube performed a provocative discogram at L4-5 and L5-S1 at the Surgery Center for Southern Illinois. Kube reported the L4-5 disc was normal. He further reported that the L5-S1 disc was positive with highly concordant pain in the annular tear rated as 9-10/10. He noted that Petitioner demonstrated concordant pain at low pressure starting at 12 or 13 and in the low 20s. He also noted that contrast material leaked out from the annular tear. Dr. Kube concluded that the results of the discogram were consistent with a very chemically irritated region from the disc annular tear and injury. (PX 6) Later that same day, Petitioner followed up with Dr. Kube regarding the discogram results. According to the doctor's notes, her discogram was "very positive" at L5-S1 and "very concordant at one of the lowest pressures I have every [sic] obtained a positive discorgram with." He further noted that the discogram showed contrast material leakage from the annular tear and chemical irritation from the disc at L5- S1 consistent with a very chemically irritated region from the disc tear and injury. Dr. Kube recommended surgical intervention consisting of a right side decompression and minimally invasive interbody fusion. In the interim he was going to try and get her a brace. (PX 6)

Petitioner was again examined by Dr. Petkovich on October 22, 2013 and a written report issued three days later. Dr. Petkovich stated in his written report that Petitioner updated him on events since their first visit with Petitioner reporting that she had returned to see Dr. Khan who did not believe that she needed any physical therapy and, therefore, she did not receive it. Dr. Petkovich also reviewed Petitioner's MRI report noting the findings were all consistent with a degenerative condition. He also commented that Petitioner's L5-S1 disc space was sacralized so there was no specific disc space. Petitioner also reported no relief with the injections given by Dr. Kube. Dr. Petkovich also reviewed the August 28, 2013 discogram. Dr. Petkovich noted Petitioner's primary complaint was persistent pain across her lower back starting at the midline and going slightly to the right. She denied any radicular symptoms throughout her left lower extremity, including numbness or tingling, and she reported no longer having any left foot or ankle pain. As a result of his examination and review of Petitioner's records, Dr. Petkovich diagnosed Petitioner with a muscular lumbar strain and degenerative disc disease at L4-5. He felt her lumbar stain was causally related to the accident at work but her degenerative lumbar disc disease was pre-existing. He wrote, "The degenerative lumbar disc condition may have been exacerbated by the [work accident]. However, I do not believe that the degenerative lumbar disc condition was aggravated or accelerated by [her work accident.]" (RX 1 - Resp. Ex. 3, p. 6) He still felt she should have a course of "intense physical therapy" and that if she had previously undergone the therapy with no relief, the injections would have been necessary. He did not feel the sacroiliac joint injections were necessary because she never had any tenderness in the sacroiliac joint area or signs of pathology in that area. Dr. Petkovich was very adamant that Petitioiner's therapy should be aggressive in nature (2 to 3 times a week for up to six weeks) and at a facility experienced in dealing with injured workers' lumbar spine conditions. He disagreed with the need for surgery at the present as she needs therapy first. He wrote, "If she would, in fact, have persistent pain following an intense physical therapy program, she may ultimately benefit from surgery on her lumbar spine for the degenerative condition in the L4-5 disc space." (RX 1 - Resp. Ex. 3, p. 7) He found her objective findings consistent with her subjective complaints. He did not feel she was yet at MMI. He felt she could continue working (although he noted she wasn't) at a light duty level. (RX 1 - Resp. Ex. 3)

Petitioner was re-examined by Dr. Kube on November 25, 2013. According to his office note, they were still trying to obtain surgical authorization. He noted Petitioner had undergone a "classic discogram" with results consistent with a disc problem. He further noted, "With the provocative discogram and with her symptom onset

and fact that she has a degenerative disk and annular tear is not relevant; however, the fact that she had no pain prior to this work injury suggests that it is likely that the injury occurred at that time. She had very minimal aggravation to the disk and quite possibly injured the disk specifically at that time. Either way, there is a causal relationship between the work injury and her current condition of wellbeing." (PX 2) Dr. Kube still felt a minimally invasive decompression fusion was appropriate. He noted her leg pain was intensifying. "In fact, her left leg is bothering her now quite a bit more so than the right side." He hoped approval would be forthcoming so that he could get her back to work soon. (PX 2; PX 6)

Petitioner returned to see Dr. Kube on April 16, 2014. According to the doctor's notes, surgical authorization was still pending and it appeared there might be some confusion regarding his thought process on the need for surgery. Dr. Kube noted he had expressed a causation opinion back in November and he still believed Petitioner had, at a minimum, an aggravation of her degenerative disc disease and "quite possibly cause of a disk injury at the time of the injury she described." While Petitioner's degenerative disc disease "in and of itself" would not explain her pain, her work accident would -- given the contemporaneous onset of her symptoms. Dr. Kube further noted he did not understand Respondent's continued delay and denial of patient care given Petitioner's desire to return to work and motivation. He wrote, "She has now lost her house as a result of this, and, of course, I grow concerned more and more all the time that the continued irritation she has in this are and the continued nerve compression can and will ultimately lead to chronic nerve damage, thereby creating a much higher level of permanence in this situation." (PX 6)

On June 11, 2014 Dr. Petkovich authored a letter to Ms. Jennifer Kaelin at Illinois Risk Management Services addressing additional questions she had posed to him regarding Petitioner. He did not examine Petitioner. It does not appear that he reviewed any further records subsequent to October 25, 2013. He believed that Petitioner sustained a muscular lumbar strain as a result of her work accident and that it should have resolved by this time. While Petitioner also has degenerative lumbar disc disease and it could have been exacerbated by the work accident it did not cause any aggravation or acceleration of the pre-existing disease as an "exacerbation" is by definition a "temporary phenomenon" as defined by the Sixth Edition AMA Guides. Thus, he felt any exacerbation Petitioner might have sustained should have resolved by this time also. Dr. Petkovich still believed Petitioner might need surgery but it would not be the result of her work accident. Finally, Dr. Petkovich stated, "I believe that [Petitioner] should have reached maximum medical improvement as a result of her work injury by this time.' (RX 1 - Resp. Ex. 4)

The evidence deposition of Dr. Richard Kube was taken on September 24, 2014. Dr. Kube, an orthopedic surgeon with the Prairie Spine and Pain Institute, testified that Petitioner's injury of January 19, 2013 aggravated, exacerbated and made worse Petitioner's degenerative disc at L5-S1 to the extent that fusion surgery was medically necessary. The recommendation for fusion was made to deal with Petitioner's low back complaints from the annular tear. Dr. Kube explained the medical necessity in his deposition was based upon the correlation of failed conservative care, the L/S MRI of Advanced Diagnostic Imaging, the failure of Petitioner to receive relief from the SI joint injection and the LESI at L5-S1, together with the very positive provocative discogram showing very highly concordant pain at the L5-S1 disc. Dr. Kube noted that Petitioner had remained symptomatic for nearly two years after the injury and that "far exceeds the time frame that most people consider adequate prior to entertaining surgical intervention." "We are dealing with someone that has low back pain which is resultant from an aggravated L5-S1 degenerative disc. And she does have some of these intermittent other leg symptoms and pains and things like that, but the predominant feature that we're dealing with is that low back pain coming from what I believe now our diagnostic imaging clearly demonstrates an L5-S1 disc condition." Dr. Kube explained that the contrast leakage from the annular tear showed extravazation at low pressure levels, and suggested a chemical irritation of the L5-S1 disc in general. In the discogram procedure, Dr. Kube observed contrast streaking up through the annular tear at the low pressure of 10 PSI.

Dr. Kube further testified the lower the pressure on discography the more significant that tends to be on determining a symptomatic disc. "It would suggest not only just a pressure component, but also suggest a chemical irritation of the disc in general." Dr. Kube explained that he observed the dye contrast streaking out during the fluoroscopic guided procedure of the discography at a low pressure of 10 psi with very severe concordant pain which was 9 out of 10 on a 1 to 10 point measure scale. (PX 7)

Dr. Kube also testified that the discogram was, in his opinion, objective. He visually observed the contrast leakage. We actually see the contrast material went from inside the disc to now flowing out of the annular tear. The leakage was visually confirmed by fluoroscopic images on the discogram. (PX 7)

The evidence deposition of Dr. Frank Petkovich was taken on October 30, 2014. (RX 1) Respondent had Petitioner examined by orthopedic surgeon Dr. Petkovich, of St. Louis, Missouri, on April 30, 2013 and October 25, 2013. Respondent also sought a clarification opinion on June 11, 2014.

Dr. Frank Petkovich testified that he has not performed spinal surgery in the past three (3) years due to a medical condition. He described his practice as clinical and after he stopped performing surgery he does routine orthopedic services and refers patients requiring surgery to other spine surgeons. In 2011, Dr. Petkovich sought and obtained credentials from the Academy of Independent Medical Examiners and is currently performing IMEs and has a clinical practice.

Dr. Petkovich testified that Petitioner as not at maximum medical improvement as of the dates of his two IME reports from the IME exams of 4/30/13 and 10/25/13 because she needed aggressive physical therapy. As of the date of his deposition he did not believe that physical therapy would be beneficial as he believed she should be "fully recovered." (PX 1, p. 49) Dr. Petkovich was unaware that Petitioner had been terminated from her employment with Respondent on 4/19/13, and was perplexed that her physical therapy recommendation had not been completed. Dr. Petkovich testified that Petitioner needed no further treatment for her back or her ankle as a result of her work accident. (RX 1)

Dr. Petkovich testified that Petitioner's left ankle ligament strain was causally related to her January 19, 2013 accident.

Dr. Petkovich further testified that the twisting mechanism of injury as described by Petitioner could have exacerbated Petitioner's low back degenerative condition. Upon examination in April of 2013, Dr. Petkovich found Petitioner had mildly reduced range of motion in her lumbar spine, forward flexion was reduced by 20 degrees, and extension was mildly decreased. He also found tenderness to palpation at L4-5.

Dr. Petkovich opined that with Petitioner's lack of any history of pre-existing problems, he felt her accident of January 19, 2013 caused an aggravation of her lumbar condition. Dr. Petkovich acknowledged that he did not review the L/S MRI film from Advanced Diagnostic Imaging and that he had no independent review of the actual film. On cross-examination he indicated that he felt the MRI annular tear was described in his interpretation of the radiologist's report as degenerative. He also did not report the radiologist's interpretation of the L/S MRI film stating that Petitioner had a co-existent small broad based central disc herniation because he interpreted that to be a degenerative finding. He said the discogram performed by Dr. Kube showing Petitioner had highly concordant pain with an annular tear could be consistent with the radiologist's interpretation of the L/S MRI dated May 30, 2013.

Dr. Petkovich agreed with Dr. Kube that Petitioner's lumbar disc condition may have been exacerbated by Petitioner's work accident. He also agreed with Dr. Kube that Petitioner may be a surgical candidate and might benefit from definitive surgery of her lumbar spine, if she failed physical therapy. He explained that in his opinion there is a difference of interpretation as to whether the disc was exacerbated, as opposed to aggravated, by the work injury. Dr. Petkovich also testified that in his clarification letter report of June 11, 2014, he clarified that, by definition, the word "exacerbation" implied a temporary phenomena. Upon further examination, he explained that in his opinion a temporary exacerbation would last for six (6) to eight (8) weeks. (RX 1)

Dr. Petkovich testified that Petitioner's annular tear could be an acute finding, but Petitioner's type of annular tear was degenerative. Dr. Petkovich testified there is "no such thing as a permanent exacerbation and that this injury she may have sustained on January 19, 2013 should have resolved, within six to eight weeks." However, he could not state the date the disc was torn.

Dr. Petkovich further testified he is performing 150 independent medical examinations a year. He is on an approved list of independent medical examining physicians and obtains referrals from various companies for second opinions and independent medical examinations. (RX 1)

Respondent requested an URL report regarding the medical necessity for the fusion surgery at L5-S1 as recommended by Dr. Richard Kube. A report by Dr. Aimee Hachigan Gould (hereinafter Dr. Gould) of Physician's Review Network was submitted on November 25, 2014. (RX 2, dep. ex. 2) Dr. Gould was of the opinion that the recommended surgery was not reasonable, necessary, or appropriate. In so concluding Dr. Gould relied upon the Official Disability Guidelines that do not recommend lumbar fusion surgery except in the case of demonstrated dynamic instability due to fracture, dislocation, infection, tumor, spondylolisthesis, anticipated iatrogenic instability as a result of a wide decompression, such as might occur with decompression of an area of lumbar stenosis, scoliosis greater than 50 degrees or spondylolisthesis with either lumbar stenosis or dynamic instability. Dr. Gould believed Petitioner had none of those diagnoses. (RX 2, dep. ex. 2)

As of December 3, 2014 Dr. Kube noted a significant change in Petitioner's left leg pain as it had recently gone numb. Pending surgery Petitioner was being managed on medication. She was being seen about every month and was still experiencing quite a bit of pain. She had recently had an event that kind of "set off her pain, specifically going down the left lower extremity." Petitioner reported lying in bed and feeling something pop and pull in her back and shoot down her left leg, resulting in a feeling of numbness. The numbness had stayed consistent since it occurred a week or two earlier. Meloxicam was added to her list of medications. and she was kept on light duty. (PX 2; PX 6)

On December 12, 2014 the deposition of Dr. Aimee Hachigian-Gould was taken. Dr. Gould, of Physicians Network, is a non- practicing orthopedic doctor from Great Falls Montana. She described herself as an independent contractor for Physicians Network, Inc which is a company located in Phoenix Arizona. She testified she does utilization reviews upon referral from Physicians Review Network. She also fills in on occasion as an administrator for Dr. Zipser, the medical director of Physicians Review Network. (RX 2)

Dr. Gould testified she does URL reviews for various companies but the majority of reviews she performs are in association with Physicians Network, Inc. She estimated that she is preparing about 200 URL reports every month, or about 2,400 URL reports per year on the high end. Her current practice is writing URL reports. She said she is home schooling her twin boys and "I'm not just seeing patients anymore." She does not perform spinal fusion surgeries, which is the procedure that is the subject at issue.

Dr. Gould explained that in the URL she performed, she used the *Official Disability Guidelines* published by the Work Loss Data Institute. She relied on the 18th edition of the *Official Disability Guidelines* in reaching her opinions. She admitted, on cross-examination, that the Work Loss Safety Data Institute Guidelines are not adopted by the state of Illinois Workers' Compensation Commission. Dr. Gould admitted that other guidelines are published including Intracorp, McKesson, American College of Occupational and Environmental Medicine, American Academy of Orthopedic Surgeons. Dr. Gould was unaware of how these guidelines compared to the *Official Disability Guidelines* she employed from the Work Loss Safety Data Institute. She chose to utilize the Work Loss Data Institute guidelines in her URL review concerning the medical necessity for the fusion surgery. (RX 2)

In relying on the Official Disability Guidelines, Dr. Gould was of the opinion that the spinal fusion recommended by Dr. Richard Kube was not medically necessary because the "*Official Disability Guidelines* do not recommend lumbar fusion except in the case of demonstrated dynamic instability due to fracture, dislocation, infection, tumor, spondylolisthesis, anticipated iatrogenic instability as a result of wide compression." She explained, "that is what the guidelines require in order for a lumbar fusion surgery to be medically reasonable and necessary or appropriate." Dr. Gould also states that the guidelines do not recommend minimally invasive fusion surgery for any reason. (RX 2)

Dr. Gould admitted that she was aware that both Dr. Kube, the treating orthopedic surgeon, and IME Dr. Frank Petkovich, opined that fusion surgery may be medically necessary or possibly indicated consisting of a lumbar spine fusion. She was unaware of whether either Dr. Kube or Dr. Petkovich relied on any of the various disability guidelines or the *Official Disability Guidelines* of the 18th Edition published by the Work Loss Data Institute. (RX 2)

Petitioner's Petition for Immediate Hearing was filed with the Commission on January 9, 2015. (PX 9)

In a "Patient Information" sheet dated January 14, 2015 Dr. Kube limited Petitioner to sedentary activity (limited lifting up to ten lbs., no overhead work or floor to waist, rare bending and twisting, no prolonged sitting or standing position). (PX 2)

Petitioner was last seen by Dr. Kube on January 20, 2015. Petitioner reported being "off" for the past couple of weeks but now having increased pain, especially into the low back and central lumbar areas. She also noted radicular-type pain but felt the back pain was more severe. Petitioner had remained on light duty with Petitioner reporting that placing patients in rooms and giving them shots was almost too much for her. On exam Dr. Kube noted central lumbar tenderness on palpation. He modified her work status to sedentary work only.

At arbitration, Petitioner testified that the injections provided by Dr. Kube provided no permanent relief. She further confirmed that Dr. Kube performed a discogram after which he recommended surgery (a fusion) which Petitioner would like to proceed with. Petitioner testified that she remains symptomatic regarding her low back. She said the nature of her pain is stabbing and constant burning. She explained the location of pain as being primarily low back but intermittent down both legs, with left worse than right.

Petitioner testified she was in a generally good state of health prior to the accident at Marshall Browning Hospital on January 19, 2013; that she worked out in the gym 3 to 4 days a week and ran 2 to 3 miles on the average day. Petitioner testified that she is unable to stand or sit for long periods and she has difficulty lifting. Before the accident, she was gainfully employed as a full time emergency room trauma nurse, and was able to work on her feet all day. She never had any prior injuries to her back, never required any medical treatment, never took any medications for back pain, and has no prior history of any work injuries or car wrecks to explain

a pre-existing symptomatic degenerative condition. Petitioner testified that she was very active. Now she requires pain medication and takes Vicodin and Flexeril.

Petitioner further testified that she was examined by Dr. Petkovich on April 30, 2013 and that the doctor recommended additional physical therapy at that time. Petitioner explained that she then returned to see Dr. Khan on May 8, 2013 and he issued a slip for physical therapy. He issued a second slip on June 5, 2013. Petitioner testified that therapy was never approved. Petitioner further recalled returning to see Dr. Petkovich on October 22, 2013 and that he only spent about five minutes with her and was very argumentative regarding why she was even there. Petitioner testified that when she was seen by Dr. Petkovich in October of 2013 she did not deny any radicular pain complaints; rather, she testified that she told him of pain pattern. She said the pain is constant. She further testified that activities of daily living are a problem for her. She cannot perform her usual household chores, and must get help with dishes and laundry.

Petitioner testified that she was terminated from her employment with Respondent when her FMLA expired. Petitioner testified she has looked for work in nursing since her termination, including doctors' offices, Respondent, and Carbondale Memorial Hospital. She acknowledged that she filled out job applications, informed prospective employer she had been injuries, and advised them she had limitations.

Petitioner acknowledged receiving temporary total disability benefits from January 25, 2013 through August 4, 2013. Petitioner testified that her temporary total disability benefits were terminated on August 8, 2013.

Petitioner testified that on September 1, 2014, Petitioner began working light duty work as a nurse for Dr. Lee Peterbee. She explained that the work was within her restrictions. She was working from 4 to 10 hours per day for 1 to 2 days a week. She said although her light duty involved greeting patients and taking them to the examination room, sitting and limited lifting, she was unable to continue working due to her back pain. She was continuing to take pain medication Vicodin and Flexeril prescribed by Dr. Kube. She was unable to work light duty after December 11, 2014.

Petitioner's outstanding medical bills are found in PX 8.

The Arbitrator concludes:

1. Issue (F) - Is Petitioner's current condition of ill-being causally related to the injury?

   Petitioner's current condition of ill-being in her left ankle and low back is causally related to her January 19, 2013 accident. This conclusion is based upon a chain of events, Petitioner's credible testimony, the treating medical records, and the more persuasive opinion of Dr. Kube over that of Dr. Petkovich or Dr. Gould.

   Petitioner denied any prior low back problems, accidents, injuries, or treatment. While Petitioner's initial treating records with Marshall Browning Hospital do not discuss Petitioner's low back pain, her accident report clearly indicates she complained of twisting her low back at the time of the accident. Understandably, the focus of attention at the emergency room on January 20 and 23, 2013 was on the then-more significant left ankle injury. No physician, including Dr. Petkovich, has ever questioned Petitioner's motivation, sincerity, or credibility. Petitioner's testimony was unrebutted.

With regard to the opinions of Dr. Kube and Dr. Petkovich, the Arbitrator finds the opinions of Dr. Kube more persuasive. Dr. Petkovich was not correct in his understanding of all the facts. As Petitioner credibly testified to, she told him she was having radiating leg pain when examined the second time. Dr. Petkovich stated otherwise. Dr. Petkovich also incorrectly summarized what Dr. Khan had done in terms of Dr. Petkovich's earlier recommendation for physical therapy. He wrote that Petitioner told him Dr. Khan wouldn't authorize physical therapy because he didn't believe in it. However, if Dr. Petkovich was provided with all of Dr. Khan's records, he would have clearly seen that Dr. Khan had issued two scripts for physical therapy. Therapy was not initiated because Dr. Khan didn't believe in it. For whatever reason, it appears Respondent did not authorize the therapy[2]. There is also no evidence that Dr. Petkovich reviewed any additional records from Dr. Kube after his October of 2013 examination. His June of 2014 letter seems to be nothing more than a reiteration of his October 2013 letter/report. Dr. Petkovich also failed to mention (or possibly perform) tests that Dr. Kube had performed during his office visits (ex. a positive Faber and positive pelvic compression sign) so that a comparison could be made. Dr. Petkovich's explanation of the difference between an "exacerbation" and an "aggravation" was unpersuasive in this instance. He believed her condition was an exacerbation because it should have only been temporary. In citing to the Sixth Edition of the *Guides*, he failed to fully set forth the definition. It reads, "The terms 'exacerbation,' 'recurrence,' or 'flare-up' generally imply worsening of a condition temporarily, which subsequently returned to baseline." (*Guides to the Evaluation of Permanent Impairment*, Sixth Edition, p. 25) Petitioner has never returned to her baseline, asymptomatic condition. Hence, she did not sustain just an exacerbation. Had Dr. Petkovich reviewed all of Dr. Kube's records he would have seen that her complaints and symptoms have continued and worsened. It does not appear that he did. Additionally, much of Dr. Petkovich's conclusions were very speculative as he "believed" or "anticipated" Petitioner would be at maximum medical improvement after physical therapy. However, he did not re-examine Petitioner after October of 2013 nor was he provided with any more of her treatment records thereafter. Thus, his opinions as of the date of his June 2014 report and deposition in 2014 were not well informed.

2. Issue (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?

   Petitioner incurred treatment expenses in the sum of $21,363.89, as follows: (1) Prairie Spine and Pain Institute - Dr. Kube - $11,783.22; (2) Cape Radiology - $56.00; (3) Surgery Center of Southern Illinois - $1,609.00; (4) Surgery Center of Southern Illinois - $1,609.00; (5) Surgery Center of Southern Illinois - $3,218.00; and (6) Metro Cardiovascular - Dr. Khan $3,088.67. (PX 8)

   Consistent with her causation determination as set forth above, the Arbitrator concludes that the foregoing medical bills are reasonable and customary and medically necessary and orders Respondent to pay them directly to the medical providers and pursuant to the Fee Schedule.

3. Issue (K) - Is Petitioner entitled to any prospective medical care?

   Consistent with her causation determination as set forth above, Petitioner is awarded prospective medical care as recommended by Dr. Kube. Dr. Kube testified within a reasonable degree of medical

[2] Apparently Respondent knew of the request for physical therapy in August of 2013 as it was referenced in Ms. Manna's letter of August 8, 2013; however, the letter did not address it further.

certainty, that a fusion is medically necessary to cure or correct Petitioner's lumbar spinal condition or to relieve the symptoms of the discogenic low back pain and chemical irritation from the annular tear, as a result of Petitioner's work accident of January 19, 2013. Even Respondent's examining physician, Dr. Petkovich, agreed that Petitioner might be a surgical fusion candidate. The opinion of Dr. Gould is not persuasive considering the opinions of the two orthopedic surgeons.

4. Issue (L) - What temporary benefits are in dispute (TTD)?

Petitioner was employed by Respondent as an ER trauma nurse. After her injury, she was terminated. At the time of the termination, it is undisputed that Petitioner's primary care physician, Dr. Khan, had her off work as of the April 8, 2013 slip.

Respondent continued paying temporary total disability benefits until August 8, 2013, at which time Petitioner's TTD benefits were terminated. By letter that same date to Petitioner's counsel, Respondent stated that Petitioner's TTD benefits were being suspended based on the opinion of Dr. Petkovich. Interestingly, Dr. Petkovich's opinion was rendered back in April of 2013 and he stated at that time that Petitioner was not at maximum medical improvement and needed physical therapy for her work-related lumbar spine condition. He felt she could work light duty. Respondent did not offer Petitioner light duty at that time but continued paying TTD benefits until August 8, 2013 when it unilaterally cut them off relying upon Dr. Petkovich's earlier report. As of August 8, 2013 Petitioner remained under light duty restrictions. No doctor had fully released her.

On her own, Petitioner found employment on a light duty basis as a nurse beginning on September 1, 2014. She remained in that job through December 11, 2014 when she was unable to continue due to pain complaints. As of January 14, 2015, Dr. Kube imposed even greater restrictions -- ie., sedentary duty only.

Respondent has not offered Petitioner restricted work at any point in time. Respondent's own examining physician had also recommended treatment which was not provided by Respondent. Petitioner's testimony regarding her efforts to find work was credible and unrebutted. Petitioner has yet to be released to full duty by her treating physician. She is not at maximum medical improvement. She is in need of further treatment.

Consistent with her causation determination above and the Arbitrator's finding that Dr. Petkovich's opinion regarding Petitioner's current ability to resume full duty is not persuasive, Petitioner is awarded temporary total disability benefits for the following periods of time: (1) 1/23/13 to 1/29/13; (2) 1/31/13 to 8/31/14; and, (3) 12/12/14 to 2/4/15, a period of 91 weeks. Respondent is given credit for TTD benefits paid from 1/25/12 to 8/4/13, a period of 27-2/7ths weeks. Petitioner is not awarded temporary total disability benefits for the date of September 1, 2014 as she testified that was her first day of work for Dr. Peterbee. The Arbitrator also notes that Respondent stipulated to the TTD period of January 23, 2013 through August 4, 2013. (See AX 1)

****

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daniel Colon,

Petitioner,

vs. NO. 13WC019743

16IWCC0175

International Fire Equipment Co.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection and permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 3, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

16IWCC0175

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $36,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 1 1 2016

SJM/sj
o-2/25/16
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

COLON, DANIEL
Employee/Petitioner

Case# **13WC019743**

INTERNATIONAL FIRE EQUIPMENT CO
Employer/Respondent

16IWCC0175

On 6/3/2015, 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 0.07% 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:

0013 DUDLEY & LAKE LLC
PETER M SCHLAX
325 N MILWAUKEE AVE SUITE 202
LIBERTYVILLE, IL 60048

0445 RODDY LAW LTD
PAUL W SCHUMACHER
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

16IWCC0175

☐ 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

Daniel Colon
Employee/Petitioner

v.

International Fire Equipment Co.
Employer/Respondent

Case # **13** WC **19743**

Consolidated cases: _____

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 **Robert Falcioni**, Arbitrator of the Commission, in the city of **Waukegan**, on **04/21, 24/2015**. 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 **05/17/2013**, 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 $**41,494.44**; the average weekly wage was $**797.97**.

On the date of accident, Petitioner was **26** years of age, ***single*** with **0** dependent children.

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**8,024.01** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**8,024.01**.

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $531.98/week for 14 6/7 weeks, commencing 05/18/2013 through 08/30/2013, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $8,024.01 for temporary total disability benefits that have been paid.

The Arbitrator further finds that Petitioner has sustained a loss of use of the right leg of 35% or 75.25 weeks thereof pursuant to Section 8(e) and 8(b).1 of the Act, as set forth more fully herein.

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.

Signature of Arbitrator

May 7, 2015
Date

JUN 3 - 2015

16IWCC0175

ILLINOIS WORKERS' COMPENSATION COMMISSION

DANIEL COLON, Petitioner, v. INTERNATIONAL FIRE EQUIPMENT CO., Respondent.	)	Case Number: 13 WC 19743

ARBITRATOR'S FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. FINDINGS OF FACT

Petitioner was employed as a fire alarm technician with Respondent when, on May 17, 2013, he slipped off of a rung of a ladder and experienced an immediate onset of pain to his right knee. He was taken by ambulance to Condell Emergency Room where x-rays confirmed a rupture of his patella tendon. (Pet. Group Ex. 1, p. 61). He was admitted for surgery under general anesthesia by Dr. Mayer who performed a repair of the right patella tendon rupture. (Pet. Group Ex. 1, pp. 231-232). Petitioner underwent a course of post-surgical therapy before returning to work on September 1, 2013. (Pet. Group Ex. 4; Arb. Ex. 1).

He returned to see Dr. Mayer on October 18, 2013 complaining of occasional aching, feelings of weakness, occasional insecurity and swelling in his knee by the middle to the end of the day. Dr. Mayer warned that although he could expect to experience some gradual improvement, he may never fully be completely asymptomatic. (Pet. Group Ex. 5, p. 47). Dr. Mayer prescribed additional therapy on December 17, 2013. (Pet. Group Ex. 6, p. 5) and again on February 11, 2014. (Id. at p. 8).

The patient underwent a functional capacity evaluation which, although placing his functional capabilities at the medium to heavy physical demand level with respect to lifting, did document only an occasional ability to crouch, kneel and squat. (Pet. Group Ex. 8, p. 1).

The Petitioner was evaluated at the request of the Respondent by Dr. Brian Cole on May 29, 2013. On physical exam, Dr. Cole noted quad atrophy, reduced range of motion and a 50%, 35 millimeter difference, in tendon length between his left and right knees, "indicating significant patella alta." (Resp. Group Ex. 1a, p. 2). Dr. Cole's impression was "right knee sub-optimal outcome after appreciable intact tendon repair from work related May 17, 2013 traumatic injury." Dr. Cole also confirmed that Petitioner's "quad deficiency leaves him unstable on uneven walking surfaces, stairs, etc." and predicted that, "from a job standpoint he is going to have a hard time with any squatting, kneeling, climbing and should likely be restricted from these permanently. He will need light duty, no lifting, pushing, pulling over (an estimated 25-30 pounds) and limitations on squatting, kneeling, climbing and uneven terrain." (Resp. Group Ex. 1a, p. 3). After reviewing a subsequent MRI, Dr. Cole recommended against reconstruction but otherwise persisted in the guided prognosis set forth in his previous report. (Pet. Group Ex. 2).

At the arbitration hearing, Petitioner testified that he continues to experience discomfort in his knee and his sense of instability on a daily basis. He is fatigued by the end of the work day, and although working currently in a similar capacity for a new employer, he is unable to work at a full pace. He does continue to play occasional recreational basketball and admits to light running.

II. IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "F" (CAUSAL CONNECTION), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Petitioner's medical records fully confirm that Petitioner's patella tendon rupture and his resulting symptoms and limitations were caused by the injury incident of May 17, 2013. Respondent's examining physician, Dr. Cole, explicitly records as his "impression" after his evaluation of the Petitioner as well as his review of treatment records: "right knee suboptimal outcome after appreciable intact patella tendon repair *from work related May 17, 2013 traumatic injury.*" (Emphasis added). The Arbitrator therefore finds that Petitioner's current condition of ill being is indeed causally related to the May 17, 2013 injury.

III. IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "L" (NATURE AND EXTENT OF THE INJURY), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

The Arbitrator finds Petitioner to be a credible witness on his own behalf. He returned to work and has continued to work notwithstanding ongoing subjective complaints of discomfort, instability and fatigue. With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of 13% of a lower extremity as determined by Dr. Cole, pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. (Exhibit #). The Arbitrator notes that this level of impairment does not necessarily equate to permanent partial disability under the Workers' Compensation Act, but instead is a factor to be considered in making such a disability evaluation. The doctor noted atrophy, range of motion deficit, consistently documented moderate palpatory findings and radiographic confirmation of severe findings of significant patella alta consistent with prior tendon rupture. Because of these findings, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a fire alarm technician at the time of the accident and that he *is* able to return to work in his prior capacity as a result of said injury. The Arbitrator notes he is now doing similar work for a different company. Because of his ability to return to similar work, albeit with some difficulty, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 26 years old at the time of the accident. Because of his long life expectancy and permanent injury, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes he has returned to work without evidence of a reduction in his wage earning capacity. Because of his lack of proven wage loss, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the findings described above by the IME physician, Dr. Cole, are indeed corroborated in the treatment records of Petitioner's treating physicians. Because of this corroboration, the Arbitrator therefore gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 35% loss of use of right leg pursuant to §8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Trevor McLaughlin,

Petitioner,

vs.

NO: 13 WC 22758
consol. 14 WC 24172
14 WC 24173

TJ's Maintenance and Remodeling, LLC,

Respondent.

16IWCC0179

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of the accident, causal connection, medical expenses, prospective medical care, and temporary total disability benefits and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission notes that on July 25, 2014, Dr. Bare, from whom Petitioner sought a second opinion, found that Petitioner should not undergo any additional surgery, which had been recommended by Petitioner's treating physician, Dr. Chhadia. He further opined that Petitioner had reached maximum medical improvement regarding his left shoulder condition. The Commission finds that the findings and opinions of Dr. Bare are persuasive and supported by the surveillance video taken of Petitioner.

Surveillance video taken of Petitioner in February 2014, March 2014, April 2014, May 2014, July 2014 and October 2014, demonstrated that Petitioner moved about without any left shoulder problems or restrictions. In fact, the Commission notes that the April 28, 2014 and April 29, 2014 videos show Petitioner carrying, loading and unloading large bags at a home improvement store and at home, as well as gardening and moving about large bags of dirt/fertilizer without any problem or limitation. (RX13) Furthermore, the July 11, 2014 surveillance video shows Petitioner unloading a bicycle, riding the bicycle, and then loading it back onto a van, again without any problem or limitation. (RX13)

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The Commission finds that based upon all of the medical evidence, Dr. Bare's findings and opinions, and the surveillance videos, Dr. Bare's finding on July 25, 2014 that Petitioner had reached maximum medical improvement is well supported by the record. Furthermore, the Commission finds that the functional capacity examination recommended by Dr. Bare is unnecessary in light of the surveillance videos.

Based upon Dr. Bare's finding that Petitioner reached maximum medical improvement on July 25, 2014, the Commission modifies the award of temporary total disability benefits to run from June 28, 2013 through July 25, 2014, and otherwise affirms and adopts the Arbitrator's Decision.

Finally, the Commission notes that under the Order Section of the Arbitrator's Decision, the Arbitrator lists the date of accident as June 3, 2014 under the award for medical expenses. The actual date of accident is June 3, 2013. Therefore, the Commission hereby corrects the Arbitrator's Decision to reflect the date of accident as June 3, 2013.

So that the record is clear, and there is no mistake as to the intentions or actions of this Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical / legal perspective. Furthermore, we have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent. Finally, one should not and cannot presume that we have failed to review any of the record made below. Though our view of the record may or may not be different than the arbitrator's, it should not be presumed that we have failed to consider any evidence taken below. Our review of this material is statutorily mandated and we assert that this has been completed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on May 7, 2015 is modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $661.33 per week for a period of 56-1/7 weeks, from June 28, 2013 through July 25, 2014, that being the period of temporary total incapacity for work under Section 8(b), and that as provided in Section 19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses causally related to the treatment of Petitioner's left shoulder condition from June 3, 2013 through July 25, 2014 under Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $1,553.90 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the

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Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under Section 19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $11,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 14 2016
MJB/ell
o-01/12/16
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

McLAUGHLIN, TREVOR
Employee/Petitioner

Case# 13WC022758

14WC024172
14WC024173

TJ'S MAINTENANCE AND REMODELING LLC
Employer/Respondent

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On 5/7/2015, 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 0.07% 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:

4392 LAW OFFICES OF HELEN BLOCH
33 N LASALLE ST
SUITE 3200
CHICAGO, IL 60602

0210 GANAN & SHAPIRO PC
MELISSA McENDRE
210 W ILLINOIS ST
CHICAGO, IL 60654

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

☐ 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
19(b)

Trevor McLaughlin
Employee/Petitioner

v.

T.J.'s Maintenance and Remodeling, LLC
Employer/Respondent

Case # **13WC 22758**

Consolidated cases: **14WC 24172 and 14 WC 24173**

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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 **Gerald Granada**, Arbitrator of the Commission, in the city of **New Lenox**, on **April 7, 2015**. 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

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On the date of accident, **6/3/2013**, 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 regarding his left shoulder ***is*** causally related to the accident.

Petitioner's current condition of ill-being regarding his hands, feet and back ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**51,584.00**; the average weekly wage was $**992.00**

On the date of accident, Petitioner was **46** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of $**24,139.86** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**24,139.86**.

Respondent is entitled to a credit of $**1,553.90** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of causally related to Petitioner's left shoulder treatment from **June 3, 2014** through **July 25, 2014** per the medical fee schedule as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $**661.33**/week for **43 5/7** weeks, commencing **June 28, 2013** through **April 29, 2014**, as provided in Section 8(b) of the Act. Respondent shall receive a credit for any TTD it has already paid.

Respondent shall be given a credit of $**1,553.90** for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

Signature of Arbitrator

5/5/15
Date

MAY 7 - 2015

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FINDINGS OF FACT

At the time of the arbitration hearing, Petitioner presented three consolidated claims. Each claim will be addressed in separate decisions. This decision relates to Petitioner's claim stemming from an alleged work injury on June 3, 2013 due to a traumatic incident. In this case, the issues in dispute are as follows: 1) accident; 2) causation; 3) medical expenses; 4) TTD; and 5) prospective medical care.

On June 3, 2013, Petitioner was 46 years old and employed as a working supervisor for Respondent, which was a company owned by Petitioner's brother Tim McLaughlin. Petitioner's sister Tammy worked in the Respondent's office and assigned work orders. Neither Tim nor Tammy testified at the arbitration hearing.

Petitioner's job duties consisted of monitoring projects, making bids to potential clients, performing constructions jobs and working on maintenance projections for regular customers. He also performed tasks of a carpenter and was required to lift product, climb ladders and used tools of the trade including hammers. Petitioner also testified that he used vibratory tools. In 2013 he was assigned to resurfacing the pavement and replacing steel doors at a trucking company. He also worked in an attic removing mold and installing new vents to prevent mold in the future.

On the date of accident, Petitioner and his crew of two employees, Raul and Fernando Sanchez, were replacing a roof on a one story building. Petitioner testified that while carrying a bundle of shingles down an extension ladder he missed a rung.. The shingles weighed approximately 60 pounds each. He had the bundle over his right shoulder and held on with his left arm and swung around to prevent a fall. His arm was above his head and he rotated around the ladder. He felt pain in his left shoulder and back. He testified on cross examination that he was only a couple of feet off the ground and could have jumped. He testified both employees were working on the roof and did not see him fall.

One of the two co-workers, Raul Sanchez, testified at the hearing. He did not see or hear the incident. Petitioner did not tell him about the incident. But, he did notice that Petitioner was favoring his left arm while the two were in the van driving home from the job site. He asked if he was okay and Petitioner stated his shoulder bothered him. He also noticed Petitioner was moving slower at work.

Petitioner testified that his other co-worker, Fernando had to hand him the shingles and he would hammer them as he could not use his left arm. Fernando did not testify.

Petitioner testified that he reported the accident to his sister, Tammy, when she called during the day for business reasons. He told his sister that his shoulder hurt and described the incident. He did not tell his brother Tim because Tim was recovering from a heart attack and was not in the office during the month of June, 2013. Petitioner also testified he could not speak to Tim as he refused to call him back. He testified that he requested a report to make a claim and that he spoke directly with the workers' compensation insurance agent.

Petitioner provided a written statement to his employer dated June 28, 2013. (RX 9) The statement documents Petitioner's understanding of the chronology of events between June 2, 2013 and June 28, 2013. Petitioner further testified that he prepared the written statement as he needed to be covered for the shoulder as he had a tear. Petitioner submitted his carpal tunnel treatment through his group carrier.

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He testified he requested a form from Respondent but they gave him the wrong form, so he wrote the statement. The statement does not indicate he advised anyone at Respondent of the accident. The statement indicates he told the office he had a doctor's appointment on June 6, 2013. According to the statement Petitioner did not have an off work note until June 28, 2013. The statement documents Petitioner worked June 3, 2013 through June 19, 2013. He went on vacation from June 20, 2013 through June 24, 2013. He then returned to work for June 25, 2013 through June 28, 2013. The statement documents his insurance would not authorize the MRI until June 16, 2013. . He does not distinguish whether the MRI is for the back or the shoulder.

Petitioner testified he had a doctor's appointment on June 6, 2013 with Dr. McNally for numbness to his hand and feet that was prescheduled. Dr. McNally's office notes document the history of the arm and feet numbness. Regarding the left shoulder, the records only state that something happened on Monday, and do not provide a history of accident. Petitioner testified he explained the entire incident to Dr. McNally at the exam. Dr. McNally's record states "last Monday, he did something to his left shoulder. " (PX A) He also states that he had a previous rotator cuff tear and biceps tear and the left shoulder "feels different." The note states his primary doctor told him to wait and see if it clears up. The only notes from his primary doctor is from January and February 2013. (RX 6) Petitioner advised Dr. Bare that his bicep was "black and blue" after the accident. (RX 5, p.1) Dr. McNally made no note of any bruising during his examination.

Petitioner had presented to his family doctor, Dr. Bailey, in January and February 2013. On January 23, 2013 he described left shoulder discomfort for the past two weeks. (RX 6) He also complained of a stiff neck. Dr. Bailey recommended medication, range of motion exercises and to have an MRI if no improvement. Petitioner returned to Dr. Bailey on February 1, 2013. He describes his left shoulder pain as feeling like someone hit him with a sledgehammer and the Hydrocodone seems to help. The doctor recommended Alleve and potentially Meloxicam, and indicated Petitioner will be seeing an orthopedic soon.

Dr. McNally's June 6, 2013 examination for the left shoulder notes a positive impingement sign. (PX A) There is no indication Petitioner has any bruising on his bicep. The diagnosis is low back pain, radiulopathy, rotator cuff syndrome, and carpal tunnel syndrome. The recommendations are closed MRI of the lumbar spine, EMG of the lower extremities, night splints for CTS, physical therapy for the left shoulder, Meloxicam, and follow up after tests and response to PT. The assessment also does not mention the accident and states the shoulder is not related to the carpal tunnel syndrome. It diagnoses the shoulder as a strain. He makes no recommendation for a shoulder MRI and no recommendation for a shoulder specialist.

Petitioner filed out a "Patient Registration" Form on June 6, 2013. (RX 10) Petitioner left blank the question regarding whether the visit is related to a work incident or a accident and notes "not sure." (RX 10, p.2) He notes he has aches and pain and left shoulder stiffness. He also filled out a "Patient Medical History" Form on June 6, 2013 wherein he notes stiffness in left shoulder, June 2, 2013; and mentions "shoulder at work," but, does not indicate how the accident occurred. The only check is for gradual onset. (RX 11, p.1)

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The phone records from Suburban Orthopedics document Petitioner called them on June 18, 2013 asking if he can have a shoulder MRI. (RX 7) The notes state it was not a problem. Petitioner also called on June 19, 2013. He advised he did not think he needed pain medication at his June 6, 2013 examination but having lots of pain in shoulders and needs pain medication. The phone records from Suburban Orthopedics document Petitioner called on June 27, 2013 and left a message indicating he has increasing pain to his shoulder and went to work and could not do his normal work. At that point, according to the note, they "developed a plan where he will see Dr. Chhadia on Monday. Prior to this phone call, Petitioner did not have an appointment with a shoulder specialist..Also on June 27, 2014, Petitioner requested an off work note from Dr. McNally via a phone call without an examination, which he did not receive.

Following the June 6, 2013 appointment, Petitioner testified he continued to work full duty. He then took a pre planned vacation to Door County on June 20, 2013 through June 24, 2013. He testified he did not treat with a doctor or hospital while on vacation.

He noted the work incident when he presented for the MRI on June 25, 2013. (RX 7, p. 41) The notes states "left shoulder pain, caught himself with left arm falling off extension ladder." (RX 7, p. 41) This is the first documentation of the specific work accident.

Following the MRI, Petitioner had a follow up appointment with Dr. Chhadia, a shoulder specialist at the same facility as Dr. McNally on June 28, 2013. His records include the history of an accident on June 3, 2013. Dr. Chhadia placed Petitioner off work. Petitioner advised Dr. Chhadia he had no prior complaints or treatment to his left shoulder. (PX A) However, Petitioner treated with Dr. Bailey, his primary care doctor, for shoulder pain on January 23, 2013 and February 1, 2013, approximately five months before the alleged accident. (RX 6, p.11).

The phone records document Petitioner attempted to direct his care and the work history. On August 15, 2013 and August 16, 2014, the notes documents that Dr. McNally only indicated his left shoulder was hurt at work, and that the Petitioner was concerned that the back needs to be documented. (RX 7, p.16) Following the June 28, 2014 examination with Dr. Chhadia, Petitioner saw Dr. McNally again on July 11, 2013. The work accident was not mentioned in this record either. Dr. McNally referred Petitioner to Dr. Novoselstsky, a pain doctor in their office. Dr. McNally did not see him again until March 25, 2014. He recommended Petitioner continue with his treatment with Dr. Novoselstsky and did not recommend any treatment for the neck or the back.

Petitioner continued to treat with Dr. Chhadia for the left shoulder and bilateral carpal tunnel conditions. He treated conservatively with physical therapy. When Petitioner did not improve with conservative care, Dr. Chhadia recommended surgery. Petitioner had surgery for a torn rotator cuff on October 3, 2013. He also had left shoulder carpal tunnel release during that surgery.

He continued to have complaints to his left shoulder and hands. Dr. Chhadia performed a right carpal tunnel release on December 19, 2013. Petitioner returned to physical therapy. He began work conditioning on May 13, 2014. His release from work conditioning on June 12, 2014 indicated he could work at the medium to heavy demand level. The records indicated his job as a working construction supervisor called for the heavy demand level. Even though Petitioner could work at the medium to heavy demand level, Dr. Chhadia placed him off work rather than provide light duty restrictions. (PX A)

Petitioner first presented to Dr. Novoselstsky in July 2013. He treated for his neck. Petitioner had a cervical spine MRI on July 25, 2015 that showed degenerative disc disease. The diagnosis was degenerative disc disease and spondolysis. Petitioner had median blocks and a radiofrequency abalation. The records do not reflect the treatment was related to a work injury or aggravated by the work accident.

Respondent scheduled an IME with Dr. Nicolson for September 25 2013. He was deposed on November 5, 2014. (RX 1) Although he found no tear, he still opined that if the surgery occurred, then it would have been related to the work accident, and he provided deference to the surgeon. (RX 1, p.37-38) He then testified that the MRI may not show all tears (RX 1, p.38). Dr. Nicholson then reviewed the October 3, 2013 surgical report. He choose not make an opinion based on the surgical report since he did not have the arthoscopic pictures. (RX 1, p.39). Dr. Nicolson testified Petitioner had no objective findings and no indication on the MRI that he had a tear. He also noted that the Petitioner did not make a full effort on examination. On cross-examination, he testified Petitioner resisted the examination and that would not be possible if he a rotator cuff tear as it would hurt too much to resist. (RX 1, p.36) Dr. Nicolson authored an addendum report after reviewing the MRI on April 2, 2014. (RX 1, p.21) He found the MRI showed Petitioner had no rotator cuff tear and diagnosed a rotator cuff strain and subacromial bursitis. (RX 1, p.21)

Petitioner testified on cross examination that he did not perform any side jobs or projections while he was off work. Petitioner testified that he "did what his body would allow him to do." Petitioner also testified that Dr. Chhaddia kept him off work because Respondent had no light duty available.

The Respondent presented surveillance video on various days from February 2012 to October 2014. (RX 13) Petitioner performs various activities including driving, removing snow with a leaf blower, carrying items from the trunk of his car, filling a car with a gas from a plastic gas can, and shopping. On April 28, 2014 surveillance video documents Petitioner lifting multiple bags of potting soil into the trunk of his vehicle from a retail store. On April 29, 2014, surveillance video documents Petitioner removing bags from his trunk and beginning a landscaping project in his yard, lifting bags over his shoulder, bending down to dump the soil onto the ground and working with the soil from a bent and kneeling position. On May 2, 2014, surveillance video documents petitioner washing a full size van with a power washer and standing on the van's bumper to wash the roof of the van. (RX 13) On July 11, 2014, surveillance video documents petitioner riding a bike on a bike trail. (RX 13)

On May 1, 2014 Petitioner presented to Dr. Bernstein for a Respondent IME related to his neck and low back diagnosis. (RX 3) Dr. Bernste notes that Petitioner claims his low back worked itself out and is improved. He reviewed the June 25, 2013, lumbar MRI showing very mild age related degenerative changes without disc herniation or nerve root compression. Dr. Bernstein reviewed the cervical MRI from July 25, 2013 describing multilevel degenerative change and the EMG from July 9, 2014 and July 16, 2013 which do not show cervical radiculopathy. Dr. Bernstein found petitioner, at most, suffered strains of the cervical and lumbar spine as a result of the work accident on June 3, 2013. He had no permanent injury to either the neck or low back. He recommended a conditioning and strengthening program and normal recreational activities on his own. He opined petitioner was at MMI for the neck and low back injury, and that no injection therapy was indicated, necessary or causally related to the work incident.

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On May 13, 2014, Petitioner had an initial evaluation for work conditioning. (RX 8) He demonstrated the ability to work at the medium physical demand level. However, Dr. Chhadia continued him off work without restrictions.

On May 28, 2014 Petitioner returned to Dr. Nicolson for another IME. He opined Petitioner should continue with work conditioning. (RX 1) He saw nothing on examination for additional surgery or treatment beyond the work conditioning. He noted Petitioner had some pain and mild impingement signs. He recommended Petitioner's surgeon would evaluate him for MMI status after the treatment. He opined Petitioner was not a surgical candidate.

On June 18, 2014 Petitioner presented to Dr. Vender for Respondent's IME as it related to the bilateral carpal tunnel syndrome. Dr. Vender noted that Petitioner had complaints of numbness and tingling in his hands since January 2013. (RX 4) He had an appointment scheduled with Dr. McNally for this condition prior to his June 3, 2013 accident. Petitioner advised that even after his carpal tunnel surgeries, he still had continued complaints to his hands. He notes diffused pain to his hands. Dr. Vender recommended an EMG that was conducted that day. Dr. Vender diagnosed Petitioner with status post bilateral carpal tunnel release and left ulnar neuropathy at the level of his elbow. He documented the neruopathy would not be related to his work injury and is not related to his carpal tunnel surgeries. He recommended an elbow pad during the day and a splint at night. He would not require any work restrictions. The EMG found residual abnormalities of both median nerves at both carpal tunnels which are not uncommon following surgery. He also had arthritis in his right hand not related to his work accident. Dr. Vender opined Petitioner was at MMI for both carpal tunnel releases and did not require work restrictions. . He further opined the diagnosis was not related to the June 3, 2013 work injury as the symptoms were present before then.

Petitioner returned to work with restrictions in July 2014. He testified he continues to work light duty and works as a bidder and a supervisor.

On July 25, 2014, Petitioner presented to Dr. Aaron Bare for a second opinion. Petitioner testified the examination was for an IME. Petitioner read the cover letter with records on cross examination, and the records tendered to Dr. Bare indicate his attorney sent the records. The letter makes no indication the appointment was for an IME. The letter documents counsel sent the records at Petitioner's request. Petitioner testified Dr. Bare "did not want to get involved," and performed a minimal examination. The records indicate he performed an examination and reviewed the diagnostic tests. (RX 5) The records state Petitioner is at MMI and does not require additional medical treatment. Dr. Bare's record states the reason for the examination is for left arm and shoulder pain. Dr. Bare's assessment was pain in left shoulder, status post left shoulder arthroscopy, continued arm and scapular pain. His treatment recommendation was for conservative care. He found Petitioner had muscle fatigue and a second surgery would not benefit Petitioner. Dr. Bare specifically states Petitioner has done well and has reached MMI. He recommended an FCE as he was ten months post surgery and that no other treatment is required or necessary as it pertains to the left shoulder.

Dr. Chhadia testified via evidence deposition on September 22, 2014. (PX B) He provided a history of the first appointment, testifying Petitioner indicated he had burning in the top of the shoulder and had pain at night. He documented Petitioner had no prior history of shoulder injury or pain before June 3, 2013. He reviewed the MRI from June 25, 2013 and testified Petitioner had a full thickness rotator cuff

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tear. He testified he performed an arthroscopic surgery on October 3, 2013. The tear was a full thickness to a high grade partial tear. He also performed left carpal tunnel syndrome release. The biceps had tenosynovitis consistent with his diagnosis of biceps tendon strain and tendonitis. He notes the tear was only a partial tear during surgery even though Petitioner's MRI showed a full tear. In regards to petitioner's carpal tunnel syndrome, he testified it was due to his repetitive overuse work.. He did not testify to the type of work Petitioner performed, but indicated Petitioner used vibratory tools and repetitive lifting in awkward positions. He also was not aware Petitioner was a working supervisor. His opinion does not take into account Petitioner's actual job duties or the amount of time Petitioner uses tools on a routine basis.

Dr. Chhadia testified the EMG on July 9, 2013 documented Petitioner's carpal tunnel syndrome. He found petitioner did not have cervical radiculapathy. He could not opine that the MRI of the neck showed degenerative changes that were caused by the work accident or by his work activities. He performed a second surgery on December 19, 2013 for the left hand carpal tunnel.

Petitioner had a second shoulder MRI on April 2, 2014. Based on the MRI and petitioner's complaints, Dr. Chhadia recommended a second surgery indicating Petitioner has additional findings not present at the time of the surgery yet related to the original injury. (PX B, p.31) The subscapularis and infraspinatus had some changes that could be causing pain and surgery could improve. Later, he testified he could not opine that the current finding on the MRI are related to the work accident. (PX B, p.80),

On January 28, 2015 Dr. McNally testified via evidence deposition. (PX H) He could not recall a specific work accident but indicated Petitioner could have told him and he simply did not write it down. He admitted his records are not perfect and the history could have been left out. He could not recall if he recommended the MRI or Dr. Chhadia's appointment, but both would have been reasonable based on his review the June 3, 2014 office note as Petitioner had an impingement. Dr. McNally testified that working in construction could exacerbate carpal tunnel. He did not indicate Petitioner's job duties. He found the shoulder and neck could have been the same injury. He testified the neck was related to the work accident. He later testified he was not aware of the work accident (PX H,p.20)

Petitioner testified that he wants additional treatment for his left shoulder, including the recommended surgery, and indicated he wanted to treat with a different doctor.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has met his burden of proof. This finding is supported by the Petitioner's testimony and the medical evidence. The Arbitrator finds credible Petitioner's testimony that he injured his left shoulder when he caught himself from falling off a ladder on June 3, 2013. And while the initial medical report from Dr. McNally does not specifically detail the incident, there is mention that something happened at work involving the Petitioner's left shoulder. Petitioner's testimony regarding the events on June 3, 2013 was not rebutted. Accordingly, the Arbitrator concludes that the Petitioner did have an accident arising out of and the course of his employment on June 3, 2013.

2. Regarding the issue of causation, the Arbitrator finds that the Petitioner has met his burden of proof

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with regard to the whether his left shoulder condition is related to the accident from June 3, 2013. However, the Arbitrator further finds that the Petitioner failed to prove that his other alleged complaints involving both his hands, his feet and his back are causally related to his June 3, 2013. This finding is supported by the medical evidence. With regard to the Petitioner's shoulder condition, Petitioner's treating physician - Dr. Chhadia, and Respondent's IME – Dr. Nicholson agree that there is a causal relationship between the June 3, 2013 events described by Petitioner and his shoulder condition.

As for the Petitioner's other conditions involving his hands, feet and back, the evidence is less compelling with regard to the question of causation. The medical evidence indicates the Petitioner's complaints with his hands and feet pre-date the accident date of June 3, 2013. Dr. McNally's and Dr. Chhadia's blanket assertions that the Petitioner's type of work could cause carpal tunnel fall short of establishing that the Petitioner's bi-lateral carpal tunnel or the alleged bi-lateral foot condition was either directly caused by the traumatic June 3, 2013 incident (where Petitioner caught himself from falling using only his left hand) or was manifested on that date. There was no evidence indicating the Petitioner's work activities were sufficiently repetitive to have caused these conditions - given the Petitioner's own description of his job as a project manager indicate his activities varied significantly throughout the day and were different each day. Thus, the Arbitrator finds persuasive the opinions of Dr. Vender, who indicated that Petitioner's carpal tunnel syndrome was not related to his June 3, 2013 accident, given the pre-existing complaints noted in the Petitioner's medical records. The Arbitrator also notes that there were no expert opinions presented to establish causation with regard to the Petitioner's feet and back.

Based on the above, the Arbitrator concludes that the Petitioner's left shoulder condition is causally related to his June 3, 2013 work accident and that the Petitioner's other alleged conditions in his hands, feet and back are not related.

3. Regarding the issue of medical expenses, based on the above conclusions, the Arbitrator finds that the Petitioner's medical treatment for his left shoulder from June 6, 2013 through Dr. Bare's July25, 2014 office visit are reasonable, necessary and causally-related to Petitioner's accident of June 3, 2013. After performing his examination and reviewing the diagnostic tests, he found Petitioner at MMI and specifically stated Petitioner would not improve with additional treatment. As such, the Respondent shall pay any all related medical expenses for Petitioner's left shoulder condition through July 25, 2014 subject to the fee schedule. Respondent shall receive a credit for any medical expenses it has already paid and shall hold the Petitioner harmless for any related medical expenses paid through its group insurance. Respondent shall also reimburse the Petitioner for any related medical expenses Petitioner himself has paid out of pocket . Petitioner's claim for medical expenses related to Petitioner's hands, feet and back are denied.

4. Regarding the issue of TTD, the Arbitrator finds that the Petitioner has met his burden of proof and is awarded TTD from June 28, 2013 through April 29, 2014. This finding is supported by the medical and investigative evidence. The medical evidence show that as early as June 12, 2014, Petitioner would be at MMI according to Dr. Nicolson. Dr. Chhadia did not return Petitioner to work based on Petitioner's subjective complaints of pain until Petitioner requested a light duty note on July 11, 2014. However, the April 29, 2014 surveillance video clearly shows Petitioner performing physical activities beyond his restrictions. Accordingly, TTD terminates as of the date of the surveillance video depicting Petitioner capable of returning to work at some capacity.

16IWCC0179

5. Based on the findings above, the Petitioner's request for additional medical care is denied. This is based on the medical and investigative evidence. The investigative evidence show that the Petitioner was capable of doing some physical work with no evidence of any physical pain or discomfort as of April 29, 2014. Even more persuasive is the medical evidence that shows Petitioner was at MMI for his left shoulder with a full duty release and no need for surgery according to Dr. Bare on July 25, 2014.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☒ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RUSSELL BUFFA,

Petitioner,

vs. NO: 13 WC 27893

BLUELINE FOOD SERVICE DIST.,

16IWCC0138

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causation, and nature and extent, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof, except for the correction of the following clerical error and deletion of a portion of the decision as outlined below.

On page 1, the Arbitrator wrote, "...Petitioner reported the accident on March 9, 2013, and a Report of Injury was generated by Respondent's risk manager." However, the Commission notes that the Report of Injury was done on May 9, 2013 (not March). Also, Petitioner testified that he reported the injury on May 6th to Mark Thompson, the branch director. This is consistent with the "Authorization for Treatment" signed by Mr. Thompson on May 6, 2013, and Petitioner's initial visit to Concentra on May 7, 2013. The decision is hereby corrected to reflect these facts.

On page 3, we delete the sentence that states, "Dr. Mirkin acknowledged that in the past he has changed his favorable causation opinion to an unfavorable opinion upon request for respondents." (Citation omitted.) The Commission notes that Petitioner entered into evidence a workers' compensation decision from Missouri in an attempt to impugn Dr. Mirkin's credibility. In that case, Dr. Mirkin initially opined that the claimant's condition was causally related to his work injury on the basis that the claimant had not had any treatment for his condition in the few years prior. However, after Dr. Mirkin was provided with records showing that the claimant had, in fact, received ongoing treatment for his condition, he changed his opinion. This is hardly an

example of having "changed his favorable causation opinion to an unfavorable opinion upon request for respondents." Rather, Dr. Mirkin revised his opinion based on new evidence. Therefore, we hereby strike that sentence from the Arbitrator's decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 11, 2015, is hereby affirmed and adopted with the correction of a clerical error and deletion of a portion of the Decision as outlined above.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $8,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 2 9 2016

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

SE/
O: 020916
49

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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BUFFA, RUSSELL
Employee/Petitioner

Case# **13WC027893**

BLUELINE FOOD SERVICE DISTRIBUTION
Employer/Respondent

16IWCC0138

On 2/11/2015, 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 0.08% 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:

0969 THOMAS C RICH PC
#6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

5365 BUSSE, BUSSE & GRASSE PC
KENNETH LUBINSKI
20 N WACKER DR SUITE 1363
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF **Madison**)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Russell Buffa
Employee/Petitioner

v.

Blueline Food Service Distribution
Employer/Respondent

Case # **13** WC **27893**

Consolidated cases: _____

16IWCC0138

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 **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **December 18, 2014**. 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. [x] 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. [x] Was timely notice of the accident given to Respondent?
F. [x] 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. [x] 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. [x] 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 **April 24, 2013**, 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 $**36,274.69**; the average weekly wage was $**697.59**.

On the date of accident, Petitioner was **56** years of age, ***married*** with **0** dependent children.

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**all paid** for TTD, $- for TPD, $- for maintenance, and $- for other benefits, for a total credit of $**all paid**.

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

ORDER

Respondent shall pay reasonable and necessary medical services outlined in Petitioner's group exhibit, as provided in Section 8(a) of the Act. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $418.55/week for 20 weeks, because the injuries sustained caused the 4% loss of the person as a whole, as provided in Section 8(d)2 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.

Signature of Arbitrator

2/9/15
Date

FEB 11 2015

FACTS

Petitioner filed a claim for injury to his low back sustained on April 24, 2013, while employed by Respondent as a warehouse worker in its freezer. (AX2). Petitioner testified that he was the only employee who worked in the freezer. (T.7). After accepting Petitioner's claim, paying all temporary total disability benefits, paying medical expenses, and having Petitioner examined by an orthopedic specialist who testified that Petitioner's lifting incident caused injury to Petitioner, at the hearing Respondent's counsel disputed accident, causal connection, notice, liability for medical expenses and the nature and extent of Petitioner's injury. (T.4).

Petitioner was the sole witness to testify. Petitioner testified that his employment required him to wear a special freezer suit. (T.8). Petitioner testified that on the above date, he was in the freezer stacking 25 to 35 pound boxes onto a pallet by hand when he felt pain in his back. (T.8). He described his onset of injury as follows:

> Q: On April 24, 2013, since it's disputed, can you describe for the Court what happened that day?
> A: Yes, sir. I was in the freezer in my freezer suit stacking 25-, 35-pound boxes onto a pallet by hand; and when I was stacking them on by hand, I felt back pain; and I stopped for a second. Then I kept working, thinking that it would go away or was nothing serious.
>
> Q: And ultimately, sir, did you continue performing the same job as a freezer man?
> A: Yes.
>
> Q: And what did you notice about your low back complaints over the next week, week and a half?
> A: Over the next six, seven days, as each day went, it got progressively worse to where I got shooting pains down my leg. When I even raised my head, it got so bad that I couldn't work anymore. (T.8).

When his symptoms got worse, Petitioner reported the accident on March 9, 2013, and a Report of Injury was generated by Respondent's risk manager. (RX9). While establishing notice, this report is computer generated and was clearly not prepared by Petitioner. *Id.* Petitioner reviewed the incident report and testified without rebuttal that he was not using a truck to move product onto the pallet, but rather was stacking the boxes by hand. (T.9, 10). He acknowledged that he told each of his medical providers, including Respondent's examiner, that he was moving product by hand. (T.10). Respondent produced no witnesses to rebut Petitioner's testimony.

When Petitioner reported the accident to his supervisor, he was ordered to treat with Respondent's physician at Concentra. (T.9). There, Petitioner was given x-rays and prescribed physical therapy which minimally improved his condition. (T.12; PX3). On June 11, 2013,

Petitioner was seen by Dr. David Raskas, a board certified orthopedic spine specialist who took the following history:

> The patient's onset of pain occurred on 4/24/13, where he was doing his normal routine of working in his freezer suit or boiler suit in a deep freeze cooler where he has a heavy labor job of stacking pallets with 25 to 50 pound boxes, each pallet having 35 to 40 boxes each. He has been doing the same routine for around 24 months. On Wednesdays it is a double load stated by patient where on Wednesdays there is a 41-pallet objective, which a typical objective is 21 [sic]. (PX4, 6/11/13).

Dr. Raskas also noted that Petitioner was required to wear a thermal suit and that his pain intensified upon arriving home that evening. (PX4, 6/11/13).

Dr. Raskas noted that Petitioner was a former drug user and smoker, but also noted that Petitioner rehabilitated himself to the point where he no longer uses those substances. *Id.* Dr. Raskas' examination showed moderately limited range of motion, tenderness and positive orthopedic signs. *Id.* He diagnosed a lumbar strain with a possible disc injury along with left SI joint dysfunction. *Id.* Dr. Raskas also recommended an MRI, which was performed on June 19, 2013. (PX4, 6/11/13; PX5).

Petitioner returned to Dr. Raskas on June 24, 2013, and Dr. Raskas agreed with the radiologist that annular tears were present at the L4-5 level. (PX4, 6/24/13). He recommended SI joint and epidural injections. *Id.* These improved Petitioner's condition significantly. (T.12; PX4). As of his last visit, Dr. Raskas noted Petitioner was having only minimal back pain with occasional stiffness and was tolerating work. (PX4, 8/13/13).

Respondent had Petitioner examined by Dr. Peter Mirkin, who testified, "I can find an annular tear in any 50 year old on an MRI." (RX13, p.33). In addition, when asked if Petitioner sustained an acute injury, Dr. Mirkin stated:

> Well, whether it's acute or not I think you have to depend on what the patient tells you. He says I was lifting at work and had back pain that particular day, unless he's blatantly lying to me I have no reason to not think he had a back strain that particular day. Now certainly I can't tell you why there was a delay of two weeks to go get treatment, I have seen people get hurt and not seek treatment for a long time in some cases. *Id.* at 32.

Respondent's counsel attempted to interject the issue of whether Petitioner's prior unfortunate drug use and hepatitis aggravated Petitioner's condition (*id.* at 39); however Dr. Mirkin gave the following testimony on cross-examination:

Q: Does Hepatitis C cause annular tears?

A: Not that I'm aware of.

Q: Does intravenous drug use cause annular tears?
A: Not that I'm aware of. *Id.* at 44.

Dr. Mirkin acknowledged that he was not aware of the level at which Dr. Raskas identified an annular tear, although he purportedly reviewed the radiology report and records which described same. *Id.* at 29, 45. In short, Dr. Mirkin's testimony supports the opinion that Petitioner's condition of ill-being is causally related to his lifting incident at work. Dr. Mirkin acknowledged that in the past he has changed his favorable causation opinion to an unfavorable opinion upon request for respondents. *Id.* at 45, 46; (RX13, Pet.Exh.B).

Dr. Raskas testified that Petitioner's MRI was of diagnostic quality and that he personally viewed an annular tear at L4-5 in addition to the typical age related changes one would expect in every 57-year-old patient. (PX8, p.6, 7, 9). His assessment of a lumbar strain was an initial working diagnosis. *Id.* at 21, 22. Dr. Raskas testified that is a tear in the outer wall of the disc that causes some of the disc material to protrude into that tear, and allows chemicals from within the disc to "communicate" with the tear and produce pain. *Id.* at 7. Since Petitioner failed to improve with physical therapy and non-steroidal anti-inflammatory medication, Dr. Raskas recommended injections to reduce inflammation. *Id.* at 8. Dr. Raskas testified that time away from heavy lifting and the cold environment in Respondent's freezer dramatically increased the odds of successful treatment. *Id.* at 8. Dr. Raskas testified that after Dr. Granberg performed the recommended epidural steroid injection and the sacroiliac joint injection, Petitioner experienced marked improvement. *Id.* at 9, 11.

Dr. Raskas linked Petitioner's annular tear to the repetitive heavy lifting done for Respondent on April 24, 2013. *Id.* at 18, 19. Dr. Raskas also testified that Petitioner's history of drug use and hepatitis C had absolutely no relation to Petitioner's injury or symptoms. *Id.* at 25, 26. He further testified that two weeks was not an unusual or unreasonable period of time between injury and treatment for a variety of reasons, including optimism toward improvement and physician appointment availability. *Id.* at 22, 23.

Although Petitioner reported minimal symptoms following his injections, Dr. Raskas testified that an increase in symptoms commensurate with the increased activity, especially laborious job duties like those performed by Petitioner, is expected. *Id.* at 11, 12. Dr. Raskas testified that both Petitioner's injury and his ongoing symptoms are causally related to his 24 April 2013 work injury. *Id.* at 12, 13.

At Arbitration, Petitioner testified that at times his pain is hardly noticeable. (T.14). However, there are times when it is intensely debilitating and affects his entire left side, which is consistent with his history and mechanism of injury. (T.14). He wakes up every 3 to 4 hours at

night with back pain. (T.16). He takes Aleve and Extra Strength Tylenol and utilizes disposable heating pads for his symptoms. (T.14, 15). His hobby of bike riding has been curtailed. (T.15, 16).

CONCLUSION

Issue (C): Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

"To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment." *Sisbro, Inc. v. Industrial Comm'n,* 797 N.E.2d 665, 671 (2003). If the injury coincides with these definitions and is traceable to a definite time, place, and cause, then said injury is accidental within the meaning of the Act. *Laclede Steel Co. v. Indus. Comm'n*, 128 N.E.2d 718, 720 (Ill. 1955).

"In the course of employment" refers to the time, place and circumstances surrounding the injury. *Lee v. Industrial Comm'n,* 656 N.E.2d 1084 (1995); *Scheffler Greenhouses, Inc. v. Industrial Comm'n,* 362 N.E.2d 325 (1977). That is to say, for an injury to be compensable, it generally must occur within the time and space boundaries of the employment. *Sisbro supra.* An injury arises out of one's employment if its origin is in a risk connected with or incidental to the employment so that there is a causal relationship between the employment and the accidental injury. *Orsini v. Indus. Comm'n*, 509 N.E.2d 1005 (1987). In order to meet this burden, a claimant must prove that the risk of injury is peculiar to the work ***or*** that he or she is exposed to the risk of injury to a greater degree than the general public. *Id.* Stated another way, "An injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he [or she] had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. [Citations]. A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties." *Caterpillar Tractor Co. v. Industrial Comm'n*, 541 N.E.2d 665 (Ill. 1989); *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (Ill. 2003).

For the reasons set forth below, the Arbitrator finds that Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent.

Petitioner testified without rebuttal that he sustained injury to his low back while lifting heavy boxes in a deep freezer while wearing a thermal suit. (T.7, 8). This occurred in the course and scope of his employment and was a risk peculiar to and distinctly related to his employment with Respondent. While Respondent offered a report which indicated that Petitioner was not lifting these boxes by hand, this was completed by one of Respondent's risk managers rather than Petitioner himself. (RX9). Petitioner credibly testified without rebuttal at Arbitration to his

mechanism of injury, and his testimony is consistently corroborated in each medical history in the record, including the Concentra clinic to which Petitioner was sent by Respondent. (PX3). Petitioner's initial therapy evaluation at Concentra detailed the following:

> THERAPY INITIAL EVALUATION
> Patient is referred for therapy with medical diagnosis of back pain
> Mechanism of Injury: Patient reports that he was lifting repetitively
> Chief Complaint: pain in left hip and down leg intermittently
> Exacerbating Factors: pain down the leg with step down, sitting to long
> Alleviating Factors: standing and walking makes leg pain leave

(PX3, 5/8/13).

Accordingly, the Arbitrator finds that Petitioner is a credible witness and that he successfully traced his injuries to a definite time, place, and cause. Therefore, his injury is accidental within the meaning of the Act. *Laclede Steel Co. v. Indus. Comm'n*, 128 N.E.2d 718, 720 (Ill. 1955); *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (Ill. 2003).

Issue (E): Was timely notice of the accident given to Respondent?

There is no legitimate dispute as to notice. Respondent's own report dated May 9, 2013, shows that it received notice of Petitioner's 24 April 2013 injury well within the statutory 45-day notice period. (RX9). Petitioner clearly provided timely notice under the Act.

Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?

When a preexisting condition is present, a claimant must show that "a work-related accidental injury aggravated or accelerated the preexisting [condition] such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition." *St. Elizabeth's Hospital v. Workers' Compensation Comm'n*, 864 N.E.2d 266, 272-73 (5th Dist. 2007).

Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it is *a* causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (Ill. 2003). [Emphasis original]. "Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." *Fierke v. Indus. Comm'n*, 723 N.E.2d 846 (3d Dist. 2000). Employers are to take their employees as they find them. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (Ill. 2003); *A.C. & S. v. Indus. Comm'n*, 710 N.E.2d 837 (1st Dist. 1999) citing *General Electric Co. v. Indus. Comm'n*, 433 N.E.2d 671, 672 (Ill. 1982). If a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (Ill. 2003); *Rock Road Constr. v. Indus. Comm'n*, 227 N.E.2d 65,

67-68 (Ill. 1967); *see also Illinois Valley Irrigation, Inc. v. Indus. Comm'n*, 362 N.E.2d 339 (Ill. 1977).

The Supreme Court's decision in *Sisbro, Inc.* highlighted that even though a workers' compensation claimant has a preexisting condition which may make him or her more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672-73 (Ill. 2003). The Supreme Court noted that although another incident could have triggered the same result, where a work-related injury is shown to be an *actual* causal factor in bringing about an employee's disabling condition, recovery should *not* be denied simply because a normal daily activity *could have* brought on claimant's disabling condition. *Id.* at 674-77.

Circumstantial evidence, especially when entirely in favor of the Petitioner, is sufficient to prove a causal nexus between an accident and the resulting injury. *Gano Electric Contracting v. Indus. Comm'n,* 631 N.E.2d 724, 728 (4th Dist. 1994); *International Harvester v. Industrial Comm'n,* 442 N.E.2d 908 (Ill. 1982). A causal connection between work duties and a condition may also be established by a chain of events including petitioner's ability to perform the duties before the date of the accident, and inability to perform the same duties following that date. *Darling v. Indus. Comm'n of Illinois*, 530 N.E.2d 1135, 1140 (1st Dist. 1988).

Petitioner testified that following the unrebutted accident, his condition progressively worsened and "got so bad that he couldn't work anymore." (T.8). Dr. Raskas testified that the repetitive lifting done on 24 April 2013 caused an annular tear at L4-5. (PX8, p.18, 19). Dr. Raskas visualized this annular tear an MRI of diagnostic quality, which was also appreciated by the radiologist who conducted same. (PX5; PX8, p.6, 7). This tear was separate and distinct from typical age related changes typically seen in patients within Petitioner's age group. (PX8, p.6, 7, 9). Petitioner's condition showed a markedly favorable response to the treatment recommended by Dr. Raskas based on his diagnosis. (PX4; PX6). While Respondent's §12 physician, Dr. Mirkin, declined go as far as to say Petitioner's annular tear was acute and/or traumatic, he candidly acknowledged that Petitioner sustained an acute injury on April 24, 2013, which at least caused a strain or "transient" aggravation of the degeneration of his spine. (RX13, p.32, 33). He also agreed that Petitioner's past substance abuse had nothing to do with his work-related injury. *Id.* at 44.

The Arbitrator finds the causation opinion of Dr. Raskas to be more persuasive than that of Dr. Mirkin, who was not aware of the level at which Dr. Raskas identified an annular tear despite allegedly reviewing the objective radiology report and related records. *Id.* at 29-30, 45. Additionally, the evidence in the record raises serious concerns about Dr. Mirkin's credibility. (RX13, Pet.Exh.B). Dr. Mirkin believed that Petitioner's aggravation was temporary, but failed to give any logical explanation for the failure of conservative treatment short of injections, and for the latter Petitioner's positive response following same. (RX13).

The record evidences that Petitioner sustained at the least an aggravation of any pre-existing condition, and at the most, an annular tear. Respondent disputed causal connection at length on account of Petitioner's age and degeneration in his spine. However, the law is clear that where a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (Ill. 2003); *Rock Road Constr. v. Indus. Comm'n*, 227 N.E.2d 65, 67-68 (Ill. 1967); *see also Illinois Valley Irrigation, Inc. v. Indus. Comm'n*, 362 N.E.2d 339 (Ill. 1977). Therefore, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to his work injury of April 24, 2013.

Issue (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?

Upon establishing causal connection and the reasonableness and necessity of recommended medical treatment, employers are responsible for necessary medical care required by their employees. *Plantation Mfg. Co. v. Indus. Comm'n*, 691 N.E.2d 13 (2000). This includes treatment required to diagnose, relieve, or cure the effects of claimant's injury. *F & B Mfg. Co. v. Indus. Comm'n*, 758 N.E.2d 18 (1st Dist. 2001).

The record shows that Petitioner exhausted all conservative measures short of the injections recommended by Dr. Raskas. (PX3; PX4). The injections, however, provided significant relief of Petitioner's increased symptoms which were the direct result of the 24 April 2013 injury. (PX4; PX6). Therefore, the Arbitrator finds that the treatment leading up to and including the injections administered by Dr. Granberg were reasonably necessary in the quest to relieve Petitioner of the effects of his work-related injury.

Respondent shall pay the medical expenses outlined in Petitioner's group exhibit and hall have credit for any amounts already paid, pursuant to §8(j) of the Act.

Issue (L): What is the nature and extent of the injury?

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011, are to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of the Act; (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. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

(i) **Level of Impairment**: Neither Party submitted an AMA rating. The Arbitrator therefore considers the remaining factors.

(ii) **Occupation**: Petitioner is currently unemployed. (T.7,49). Accordingly, the Arbitrator gives no weight to this factor.

(iii) **Age**: Petitioner was 56 years old at the time of his injury and had significant spinal degeneration as a result of his age. (AX1; PX5). He has diminished healing capacity as a result thereof. The Arbitrator places some weight on this factor.

(iv) **Earning Capacity**: There is no direct evidence of reduced earning capacity contained in the record.

(v) **Disability**: Petitioner credibly testified to continued symptoms commensurate with his level of activity. Petitioner testified that at times his pain is hardly noticeable. (T.14). However, there are times when it is intensely debilitating and affects his entire left side, which is consistent with his history and mechanism of injury. (T.14). Dr. Raskas testified that this was typical for Petitioner's type of injury. (PX8, p.11, 12). Petitioner testified that he wakes up every 3 to 4 hours at night with back pain. (T.16). He takes Aleve and Extra Strength Tylenol and utilizes disposable heating pads for his symptoms. (T.14, 15). His hobby of bike riding has been curtailed. (T.15, 16). The Arbitrator places some weight on this factor.

Based upon the foregoing, the Arbitrator finds that Petitioner sustained serious and permanent injuries that resulted in the 4% loss of his body as a whole.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jacqueline Toney,

Petitioner,

vs. NO: 13 WC 30507

Chicago Transit Authority,

Respondent.

ORDER

This matter comes before the Commission on the Commission's Motion to Dismiss 13 WC 30507 *Sua Sponte*. This claim was consolidated with 13 WC 28646 and arbitrated together. On April 1, 2015 both these claims were subject to a decision in 13 WC 28646, in which the Arbitrator denied compensation. Petitioner sought review, but only identified claim number 13 WC 28646. The Commission affirmed and adopted the Decision of the Arbitrator with clerical changes. While 13 WC 30507 was resolved, at least with regard to any action by the Commission, when it affirmed the Decision of the Arbitrator which disposed of both claims, the instant claim remains in the records of the Commission as pending decision, and that status would remain until the matter is disposed of. Therefore, the Commission dismisses 13 WC 30507 *sua sponte*.

IT IS THEREFORE ORDERED BY THE COMMISSION that 13 WC 30507 is hereby DISMISSED.

DATED: FEB 19 2016

Ruth W. White

RWW/dw
R-6/15/15
46

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joel Sanchez,
Petitioner,

vs. NO: 13WC 34650

Banner Home Construction,
Respondent,

16IWCC0134

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Respondent, herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 14, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $40,678.80. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 24 2016
MJB/bm
o-2/22/16
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

SANCHEZ, JOEL
Employee/Petitioner

Case# 13WC034650

16IWCC0134

BANNER HOME CONSTRUCTION
Employer/Respondent

On 4/14/2015, 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 0.10% 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:

1072 EPSTEIN, JACK R LAW OFFICES
4346 W 26TH ST
SUITE 2000
CHICAGO, IL 60623

0507 RUSIN & MACIOROWSKI LTD
THEODORE J POWERS
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ 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
19(B) ARBITRATION DECISION

Joel Sanchez
Employee/Petitioner

v.

Banner Home Construction
Employer/Respondent

Case # 13 WC 034650

Consolidated cases: D/N/A

16IWCC0134

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was originally heard in Elgin, Illinois, by then Arbitrator Luskin on January 8, 2015. After Arbitrator Luskin was appointed to the Commission, the matter was reassigned to Arbitrator Molly C. Mason and re-heard by said Arbitrator in the city of **Chicago**, on **March 24, 2015**. 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 **9/12/13**, 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 multiple current conditions of ill-being *are* causally related to the accident.

Petitioner's average weekly wage was $**600**.

On the date of accident, Petitioner was **48** years of age, *married* with **2** dependent children.

The medical services Petitioner has received to date were reasonable, necessary and causally related to the accident.

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

Respondent shall be given a credit of $**20,330.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**20,330.00**.

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

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $114.00 to Illinois Medi-Car, $3,223.02 to Illinois Orthopedic Network, $185.00 to Archer Open MRI, and $2,332.78 to Metro Anesthesia Consultants as provided in Sections 8(a) and 8.2 of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $400/week for 79 5/7 weeks, commencing 9/13/13 through 3/24/15, as provided in Section 8(b) of the Act, with Respondent receiving credit for the temporary total disability benefits it has paid to date.

Prospective Medical Treatment

Respondent shall authorize and pay for prospective care, including but not limited to a left hip consultation with Dr. Domb, as previously recommended by Dr. Sompalli and the lumbar spine surgery recommended by Dr. Dixon.

Penalties and Fees

For the reasons set forth in the attached decision, the Arbitrator declines to award penalties or fees.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

Molly C Mason
Signature of Arbitrator

4/14/15
Date

APR 14 2015

Petitioner testified he worked for Respondent for 3 to 4 months before his accident.

Petitioner testified that Francisco, Miguel and a young guy named Rosalio or Rosalino were present at the time of his accident. It is also possible that Adan was there.

Petitioner testified that, immediately before the accident, he was putting glue between sheets of wood in order to begin building walls. He was standing with his left foot on top of a piece of wood to secure it. He began leaning forward in order to begin applying glue when he slipped and fell through a hole that was intended to be a stairwell opening. The hole did not have any kind of safety cover over it. He realized he was falling head first and began turning in the air so as to avoid hitting his head. He fell a distance of about 12 to 14 feet, into the basement. He managed to land on his feet but with most of his weight on his left leg. At impact, his body "responded like a spring" and went to the right. In order to avoid hitting his head, he put his right hand out. He struck his hand against a concrete support structure that had a metal base. He ended up hitting his head but "only a little."

Petitioner testified he felt pain in his left knee, left "fibia," groin, back, right hand and head after the accident. Initially, however, he did not feel too bad. He called out to his co-workers and told them to wait for him because he believed he would be able to resume working after resting a while. By about 40 minutes after the accident, his pain was more intense and he asked Francisco to take him to a hospital. Another individual, the son of "Mr. Walter," ended up driving him to Elmhurst Memorial Hospital. "Mr. Walter" is an individual who assigned work to Respondent at the jobsite.

The Emergency Room records (PX 1) indicate that Petitioner's preferred language is Spanish.

Petitioner testified he gave a history of the accident to hospital personnel. The first test he underwent at the hospital was a blood test.

The "quick view" triage history reflects that Petitioner "fell from ladder approx. 10 ft," landing on gravel, and complained of a headache as well as left leg and right wrist pain.

Petitioner initially saw a physician's assistant, Christopher Ferron. Ferron described Petitioner as losing his balance at a construction site and falling from the first floor into the basement. Ferron indicated Petitioner fell feet first, landing initially on his left leg. After the left leg gave out, Petitioner "fell onto his right side on an outstretched right arm."

Ferron indicated that Petitioner rated his left leg pain at 9/10 and "worse with movement." He also noted that Petitioner complained of pain in his entire left leg but denied numbness or tingling. He further noted that Petitioner complained of "some mild lumbar pain and discomfort with movement."

Ferron noted that Petitioner denied any history of past medical problems.

Joel Sanchez v. Banner Home Construction
13 WC 34650

Procedural Background

A 19(b) hearing was previously held in this case on January 8, 2015 before then Arbitrator Luskin. After Arbitrator Luskin was appointed to the Commission, the case was reassigned to Arbitrator Mason, with the parties being given the option of the Arbitrator issuing a decision based on the January 8, 2015 transcript. After Respondent objected to proceeding in this manner, Arbitrator Mason conducted a new 19(b) hearing on March 24, 2015.

Arbitrator's Findings of Fact - Hearing of March 24, 2015

Petitioner testified through a Spanish-speaking interpreter.

The parties agree Petitioner sustained an accident while working for Respondent on September 12, 2013. Arb Exh 1. Petitioner testified that, two years before this accident, he held two jobs. During the day, from 8 AM to 5 PM, he worked at a window company where he cut, assembled and installed windows. He was required to lift up to 60 to 70 pounds. He performed this job for about 1 ½ years. During the same period, he worked at a restaurant from 7 PM to closing. The restaurant typically closed around midnight. He prepared food and washed dishes. He was required to lift up to 40 to 50 pounds.

Petitioner denied having any back injuries or experiencing any back or leg pain during the time he worked at the window company and restaurant. When these jobs came to an end, he worked at various offices through a temporary agency for about two months. He denied having any back injuries or experiencing any back or leg pain during this period. He then started working for Respondent.

Petitioner testified his job for Respondent consisted of cutting wood to various measurements and transporting the wood to carpenters. Essentially, he did what he was asked to do. The work was "pretty heavy." He regularly had to carry pieces of wood that were 20 feet long and 2 inches thick. He did not know how much the pieces weighed but they were heavy.

Petitioner testified his supervisor at Respondent was an individual named Francisco.

Petitioner testified that, during his tenure with Respondent, he worked 10 or 11 hours per day, Monday through Friday. He did not work on Saturdays. He regularly worked at least 50 hours per week and sometimes more. Regardless of how many hours he worked, Respondent paid him $1200 every two weeks. He was paid via check. Francisco drove the company truck to a location near his house and handed his check to him. He was always paid in this manner.

Ferron indicated that Petitioner was in a wheelchair. He deferred any gait analysis. He noted a small contusion to the left forehead, mild tenderness in the lower lumbar region, moderate edema and tenderness to the anterior aspect of the left knee, proximal tibia, moderate medial joint line tenderness in the left knee, no tenderness in the left hip and moderate edema noted to the right distal forearm over the distal radius.

Ferron ordered Norco for pain and X-rays of the following body parts: lower left leg, left hip, lumbar spine, right forearm, pelvis and thoracic spine. The lower left leg X-ray showed an oblique lateral tibial plateau fracture with 4 mm of depression at the articular margin, tibiotalar degeneration, mild patellofemoral degeneration and a moderate effusion. The left hip X-ray was negative. The lumbar spine X-rays showed levoscoliosis and multi-level spondylosis with mild chronic compression of L2 and L3. RX 6. The right forearm X-rays showed a non-displaced oblique fracture through the radial styloid and arthritic changes. The pelvis X-rays were negative, with the indication for the X-ray stating: "post fall, left hip pain today." The thoracic spine X-rays showed mild dextroscoliosis and no acute findings. PX 1.

The Emergency Room physician, Dr. Hall, indicated he went to Petitioner's room twice but never had the opportunity to examine Petitioner because, on both occasions, Petitioner "was in X-ray."

At discharge, Christopher Ferron, P.A. prescribed Motrin and instructed Petitioner to avoid bearing weight on his left leg and follow up with orthopedics the next day. PX 1.

Petitioner testified he went home after leaving the Emergency Room and later received a call from Dave Kirchmann of State Farm Insurance. Petitioner testified he asked Kirchmann whether he could undergo treatment closer to home because it would be complicated for him to travel to Elmhurst Memorial Hospital. Kirchman said "no problem." Petitioner testified he and Kirchmann then agreed on St. Anthony Hospital.

Respondent offered into evidence a Form 45 prepared by Pat Sheedy. The report is dated September 13, 2013, the day after the accident. The report reflects that Petitioner, a carpentry laborer, was injured at 1:45 PM on September 12, 2013 when he "fell from 1st floor to basement" while "laying plywood on joists" at a home that was under construction. The report also reflects injuries to the left foot and right hand. Petitioner's average weekly wage is described as "$12 x 40" and the duration of his employment is shown to be 3 to 4 weeks. RX 5.

On September 16, 2013, Petitioner saw Dr. Goldflies. The doctor noted he was seeing Petitioner for evaluation of a right wrist fracture and left tibial plateau fracture sustained on September 12th "secondary to falling off root-top [sic] at a construction worksite." He noted that Petitioner was "in severe pain" but denied paresthesia or numbness of the upper or lower extremities. He noted that Petitioner had undergone X-rays at Elmhurst Memorial and was currently taking Tylenol #3.

Dr. Goldflies indicated he examined Petitioner's right wrist and left knee. He described flexion and extension of both body parts as limited secondary to the fractures. He obtained X-rays and applied a short arm cast to Petitioner's right wrist and an immobilizer to Petitioner's left knee. He ordered CT scans of the left knee and right wrist/hand. PX 2.

On September 19, 2013, Petitioner underwent a left knee CT scan. The radiologist compared the results with the X-rays taken three days earlier. He noted that the scan "again demonstrated a comminuted fracture of the lateral tibial plateau." He indicated that the comminuted nature of the fracture made it "difficult to assess the degree of depression." He indicated the distal femur and fibula appeared to be intact. He noted a "large hemorrhagic effusion." His impression was: "severely comminuted lateral tibial plateau fracture." PX 2.

Petitioner also underwent a right wrist CT scan on September 19, 2013. The images were obtained through the cast. The radiologist noted non-displaced comminuted fractures involving the distal end of the radius and a chip fracture through the radial styloid. PX 2.

Petitioner saw Dr. Sompalli on September 20, 2013. The doctor noted a referral from Dr. Goldflies. He also noted the history of a construction site accident on September 12th. He indicated he examined Petitioner's left knee and right upper extremity. He reviewed the radiographic studies and scheduled ORIF left tibia and right radius surgery for September 24th. He also ordered a variety of pre-operative studies, including an EKG. Petitioner underwent the EKG on September 24, 2013. Because the study showed abnormalities, the surgery had to be rescheduled.

On the morning of September 24th, a nurse noted that Petitioner complained of 6/10 right wrist pain, 7/10 left tibial pain and an inability to put any pressure on his left leg. Petitioner was given Tylenol with codeine. A medical student examined Petitioner but indicated he deferred a back examination. Petitioner also saw Dr. Dahodwala for a cardiac consultation. The doctor admitted Petitioner to St. Anthony Hospital for a venous ultrasound of his lower extremity and overnight monitoring of his cardiac rhythm. A duplex sonography of both legs performed the next day did not show abnormalities. A chest CT scan showed no specific evidence of pulmonary embolism. Petitioner was discharged in the evening, with instructions to return the next morning for surgery.

On September 26, 2013, Dr. Sompalli performed the following surgical procedures: open reduction and internal fixation of the left lateral tibial plateau fractures, using plates, a right closed reduction and percutaneous screw fixation of the right distal radius fracture using screws and a repair of a left lateral meniscus tear.

On September 27, 2013, Lisa Schramm, R.N. noted that Petitioner reported "intermittent decreased sensation" of his left lower extremity. Schramm indicated she did not formally assess this complaint secondary to the bandaging.

On October 1, 2013, Petitioner was discharged from St. Anthony Hospital and transferred to the Rehabilitation Institute of Chicago [hereafter "RIC"]. At discharge, Dr. Sompalli instructed Petitioner to avoid bearing weight on his left leg for five weeks and to follow up with him on October 8, 2013.

A physician's assistant, Allison Elenbaas, PA, examined Petitioner at RIC on October 1, 2013, noting a history of the accident and subsequent treatment. Elenbaas noted that Petitioner complained of pain in his left knee, left hip and right wrist. On left hip examination, Elenbaas noted tenderness to palpation over the greater trochanter. She also noted that Petitioner's right wrist splint and left leg cast were in place. She ordered a left hip X-ray. PX 3, pp. 33-35 of 622. RX 10.

Dr. Huang evaluated Petitioner shortly after admission, noting the following: "reports he is obeying the weight bearing restrictions. Does report some left hip pain in addition to his knee and wrist pain. He reports he's had this since the accident." PX 3, p. 304 of 622.

On October 2, 2013, Lawrence Gross, P.T. noted a complaint of "global numbness distal to the [left] mid hip at night." PX 3, p. 18 of 622.

On October 2, 2013, Petitioner underwent left hip X-rays. The X-rays were negative.

On October 8, 2013, Christine Gin, R.N. noted a complaint of "L groin and upper LE into buttock rated 7/10 with exercises and during ambulation." PX 3, p. 531 of 622.

On October 9, 2013, Petitioner was fitted with a wrist brace and hinged knee immobilizer.

On October 16, 2013, Evelyn Newton, R.N. noted a complaint of 7/10 pain in the left medial hamstring insertion and minimal left groin/upper left leg pain. PX 3, p. 521 of 622. On October 17, 18 and 19, 2013, RIC nurses noted complaints of left foot and medial hamstring pain rated 8/10. PX 3, pp. 607-608 of 622.

Petitioner was transferred from RIC to Park House Nursing and Rehabilitation Center on October 21, 2013, with plans for readmission to RIC at such time that Petitioner's weight bearing restrictions were lifted. PX 3, pp. 444 and 570 of 622.

On October 22, 2013, Petitioner followed up with Dr. Sompalli. The doctor noted that Petitioner rated his pain at 5/10 and denied any paresthesia or numbness of his left leg or right upper extremity. The doctor sent Petitioner to the X-ray department for X-rays of his left tibia/fibula, pelvis and right wrist. He directed Petitioner to return in four weeks. PX 2.

Petitioner returned to Dr. Sompalli on November 19, 2013. The doctor noted that Petitioner "states that he has been having groin pain that is exacerbated when he is sitting." He

also noted that Petitioner denied any paresthesia or numbness of his lower extremities. He indicated that Petitioner presented with X-rays of the pelvis and left knee.

Dr. Sompalli described Petitioner's gait as within normal limits. He noted flexion of 0 to 100 of the left knee and flexion/extension of the right wrist from 0 to 50 degrees. With respect to the knee and wrist, he instructed Petitioner to return in four weeks. With respect to the left hip, he indicated there were "no abnormalities in imaging studies." He directed Petitioner to continue attending therapy. PX 2.

On November 23, 2013, Petitioner was readmitted to RIC for "acute inpatient rehabilitation." On that date, RIC providers listed the following as "problems" for Petitioner: arthralgia of the pelvic region and thigh, closed fracture of tibial plateau and closed fracture of radius. PX 2, PX 3, p. 613 of 622.

On November 27, 2013, Petitioner underwent a multi-planar MRI of the left hip at Northwestern Memorial Hospital. The interpreting radiologist noted: 1) no avascular necrosis, fracture or significant osteoarthritis; 2) an anterosuperior labral undersurface tear and a posterior labral detachment; 3) a Grade 1 vastus lateralis muscle origin strain; 4) moderate left and mild right facet arthropathy at L5-S1 with prominent subchondral marrow edema but no discrete fracture seen; 5) an "indeterminate 10 x 4 mm subcutaneous structure overlying the posterior lateral right femoral diaphysis posterior to the vastus lateralis muscle"; and 6) left quadrates femoris muscle edema "that can be seen in ischiofemoral impingement." The radiologist indicated that a targeted ultrasound could be performed for further evaluation of the "indeterminate" structure. PX 4, 5. There is no evidence indicating that Petitioner ever underwent this ultrasound.

Petitioner was discharged home from RIC on December 10, 2013. The following day, he began attending a "day rehab" program at RIC. On that date, Andrea Klusman, P.T. [hereafter "Klusman"], noted that Petitioner complained of left hip pain. She described the characteristics of this pain as follows: "described as pain from groin through upper hip into back bone, some tendinous pain." PX 3, p. 37 of 780. The same day, December 11, 2013, a different therapist, Sarah Snyder, P.T. [hereafter "Snyder"], noted that Petitioner "reported increased pain" in his left knee during ramp- and curb-related therapy, while attempting to increase left knee flexion. PX 3, pp. 428-429 of 780. On December 12, 2013, another therapist, Allison Wehunt, P.T., noted that Petitioner was unable to perform reciprocal stepping "due to discomfort at L posterior knee." PX 3, p. 416 of 780.

On December 13, 2013, Dr. Supanwanid of RIC conducted a "day rehab" evaluation. He noted that Petitioner complained of "pain in the back and occasionally to the L hip and knee." He also noted a complaint of foot numbness. PX 3, p. 48 of 780.

On December 17, 2013, Snyder noted that Petitioner "reported increase in L knee pain" and complained of tenderness in the posterior medial aspect of the knee. PX 3, p. 390 of 780.

On December 23, 2013, an occupational therapist noted that Petitioner complained of left hip and knee pain. PX 3, p. 665 of 780.

The following day, December 24, 2013, Petitioner underwent left knee and lumbar spine X-rays. The radiologist who interpreted the left knee films noted almost complete healing "with no change in alignment and position compared to study on 11/19/13." He indicated that only a tiny fracture line remained visible at the subarticular region of the lateral plateau. A different radiologist interpreted the lumbar spine X-rays as negative for fracture or dislocation and showing "degenerative osteoarthritis and possibly disc disease with bilateral facet arthopathy of L5-S1." PX 2.

Petitioner also saw Dr. Sompalli on December 24, 2013, with the doctor noting that Petitioner was "full weight bearing on the knee at home." The doctor recommended additional therapy. He directed Petitioner to return in five weeks with new X-rays. He noted that Petitioner had brought along an MRI disc but that the MRI was "inaccessible." PX 2.

On January 9, 2014, Petitioner saw Dr. Supanwanid of RIC for a "day therapy" evaluation. The doctor noted that Petitioner was still complaining of pain in his left hip/groin, back and left knee as well as numbness over the left lateral knee and distal leg. He also noted that Petitioner was relying on various pain medications, including Hydrocodone and Lidoderm. On lateral left leg examination, he noted patchy areas of altered sensation to light touch. After noting the previous left hip MRI results, he suggested EMG/NCV testing, indicating he would have to obtain authorization for same from Petitioner's case manager. PX 3, pp. 127-129 of 780.

Petitioner continued engaging in physical and occupational therapy thereafter. PX 4.

In a progress note dated January 23, 2014, Klusman noted that Petitioner was making progress, balance- and walking-wise, but was continuing to complain of left knee and left hip pain during exercise and functional activity. PX 3, p. 94 of 780.

On January 28, 2014, Petitioner underwent left knee and right wrist X-rays. The interpreting radiologist noted an internally fixed and healing fracture of the proximal left tibia and an internally fixed, healing fracture of the distal right radius. PX 2.

Petitioner also saw Dr. Sompalli on January 28, 2014. The doctor noted that Petitioner complained of 6/10 left knee pain but denied any paresthesia or numbness in his lower extremities. He indicated he planned to seek "work comp approval" for a left knee arthroscopy. He referred Petitioner to Dr. Chunduri for evaluation of his lower back pain and indicated that, if this pain persisted after the evaluation, Petitioner should see Dr. Domb "for evaluation of his left labral tear" [with reference to the left hip MRI]. PX 2.

Petitioner saw Dr. Chunduri on January 31, 2014. The doctor noted that Petitioner reported experiencing 8/10 knee, low back and left leg pain since falling at work on September

12, 2013. The doctor also noted that Petitioner's low back pain and left leg numbness, tingling and weakness had been "present since the injury."

On back examination, Dr. Chunduri noted paralumbar and buttocks tenderness, greater on the left, decreased extension, lateral bending and rotation, decreased ankle dorsiflexion strength, decreased medial malleolus sensation, decreased great toe dorsiflexion strength, decreased sensation in the mid dorsal foot and positive straight leg raising on the left. He diagnosed lumbago with left radiculitis. He indicated that Petitioner "was injured at work, resulting in his current symptoms." He recommended CT and MRI scans of the lumbar spine and directed Petitioner to return to him in one week. PX 2, 7.

On February 10, 2014, Petitioner underwent a lumbar spine CT scan. The interpreting radiologist noted degenerative facet disease at L4-L5 and L5-S1 with ligamentum flavum and facet joint hypertrophy along with "mild diffuse disc bulges that contribute to central canal narrowing." PX 2, 7. RX 7.

Petitioner returned to Dr. Chunduri on February 13, 2014, with the doctor noting the recent CT scan results. The doctor indicated that the CT did not show any significant nerve compression. Based on Petitioner's ongoing radicular complaints, he recommended a lumbar spine MRI and EMG of the left lower extremity. He noted that Petitioner had previously undergone a left hip MRI but that this MRI was not available. He instructed Petitioner to stay off work and to bring this MRI with him to the next visit. PX 7.

Petitioner underwent the recommended lumbar spine MRI on February 17, 2014. The radiologist described the study as "limited by motion." He noted a congenitally small spinal canal, Grade 1 spondylolisthesis of L5 on S1 with questionable bilateral L5 spondylolysis, mild to moderate diffuse disc bulging at L5-S1 "which contributes to mild bilateral foraminal stenosis and mild central canal stenosis," hypertrophic degenerative change of the facet joints, most significant at L4-L5 and L5-S1 and a small posterior disc bulge at L4-L5 "which contributes to mild central canal and bilateral foraminal stenosis." PX 7. RX 8.

On February 27, 2014, Dr. Sompalli performed a left knee arthroscopy. In his operative report, he noted an anterior cruciate ligament tear. He opined that this tear was "most likely" due to Petitioner's accident.

On March 4, 2014, Dr. Sompalli examined Petitioner's left knee and recommended physical therapy. He anticipated the need for Synvisc injections and possibly additional surgery in the future "because of [the] articular surface damage in [the] plateau secondary to the plateau fracture." He directed Petitioner to remain off work. PX 7.

On March 7, 2014, Dr. Arayan evaluated Petitioner and performed a left lower extremity EMG. He recorded a history of the work accident and subsequent care. He indicated that Petitioner was currently complaining of 9/10 pain in his left leg along with numbness and tingling in the same extremity. On examination, he noted decreased sensation to light touch in

the left lower leg compared with the right. He also noted 3-/5 left hip flexion, compared with 5/5 on the right, and an antalgic gait.

Dr. Arayan described the EMG results as abnormal, albeit "limited by patient pain." He found electrodiagnostic evidence of a left L5 and S1 lumbar spine radiculopathy. He found no electrodiagnostic evidence of a distal left lower extremity peripheral neuropathy. PX 7.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Boone Brackett of Westgate Orthopaedics on March 10, 2014. See below for a summary of Dr. Brackett's deposition testimony.

On March 11, 2014, Dr. Supanwanid of RIC evaluated Petitioner and noted that "day therapy" had been on hold since late January due to Petitioner's left knee pain and surgery. He also noted that "day therapy" was being reinstituted. He indicated that Petitioner complained of a little pain in his left knee, pain in his hip, back and left leg and "constant numbness from the left hip down to the toes." He described Petitioner's gait as antalgic. He indicated Petitioner used in a cane in his right hand while walking. He noted that Petitioner had recently undergone an EMG and was seeing Dr. Chunduri for his back and hip issues. He referred Petitioner to Dr. Stanos at a chronic pain center for medication management of multiple pain complaints. PX 3, pp. 123-125 of 780.

Petitioner returned to Dr. Chunduri on March 17, 2014. The doctor noted that Petitioner complained of 8/10 pain in his low back, radiating down his left leg, and in his left hip, radiating to his groin. He also noted that Petitioner described his left leg as "essentially constantly numb." He described Petitioner's gait as antalgic. His lumbar spine examination findings were unchanged. He noted positive left hip tenderness to palpation and with extension, flexion and rotation of the left hip. He recommended an epidural injection and indicated he needed to gain access to the left hip MRI. He directed Petitioner to remain off work. PX 7.

In a progress note dated March 20, 2014, Klusman noted that Petitioner was making "slow and steady progress" but had been "limited this interim due to L knee, L hip and low back pain." PX 3, p. 58 of 780.

Petitioner returned to Dr. Sompalli on March 24, 2014. On that date, the doctor noted that Petitioner was attending therapy only twice a week when he had recommended three sessions per week. He also noted that some of the therapy was directed to the wrist even though Petitioner had already reached maximum medical improvement with respect to the wrist. He recommended that Petitioner participate in knee therapy three times per week and remain off work. He also recommended a patellar tendon strap. PX 7.

On April 17, 2014, Dr. Chunduri administered a left L5-S1 epidural steroid injection. PX 7.

On April 21, 2014, Dr. Sompalli noted that Petitioner reported some left knee improvement and was seeing Dr. Chunduri for his back. He recommended a home exercise program and released Petitioner to seated work with respect to his knee. He directed Petitioner to return in six weeks. PX 7.

On April 24, 2014, Dr. Chunduri noted that Petitioner reported no improvement following the injection. He referred Petitioner to a spine surgeon and directed him to stay off work. PX 7.

On May 2, 2014, Petitioner saw Dr. Dixon, a neurosurgeon affiliated with Illinois Orthopedic Network. Dr. Dixon obtained a history of the work accident and subsequent treatment. He noted he had been provided with the lumbar spine MRI report but not the scan itself. He also noted Petitioner was still undergoing knee-related care. On examination, he noted normal strength in both legs except for 3/5 weakness of the quadriceps and hamstring on the left "due to knee instability" and 4/5 strength in the left tibialis anterior and EHL. After discussing various spine-related treatment options, he directed Petitioner to return in one month and to stay off work in the interim. At a subsequent visit, on May 30, 2014, Dr. Dixon reviewed the lumbar spine MRI scan and EMG. He directed Petitioner to return in one month, pending intervening left knee care. He instructed Petitioner to remain off work in the interim. PX 7.

On June 2, 2014, Dr. Sompalli recommended a series of Supartz injections for Petitioner's left knee. He administered several of these injections thereafter, with the last injection taking place on July 21, 2014. He kept Petitioner off work during this period. PX 7.

Petitioner returned to Dr. Dixon on August 29, 2014. On re-examination, the doctor noted normal strength in both legs except for 3/5 weakness of the quadriceps and hamstring on the left "due to knee instability" and 4/5 strength in the left tibialis anterior and EHL. Dr. Dixon discussed various treatment options with Petitioner and indicated Petitioner planned to consult with Dr. Chunduri again concerning another injection. He directed Petitioner to return to him in one month and to stay off work in the interim.

Dr. Dixon indicated he disagreed with Dr. Brackett's assertion that Petitioner was magnifying his symptoms. He indicated that Dr. Brackett made this assertion "without review of the MRI films of the lumbar spine or any mention of the EMG findings."

Dr. Dixon opined that Petitioner "is suffering from radiculopathy due to spondylolisthesis and stenosis at L5-S1 and L4-L5, respectively." He further opined that these conditions were "almost certainly exacerbated to the point of becoming symptomatic by his work-related fall." He indicated Petitioner required additional spine-related care in order to be able to return to work. PX 7.

On September 18, 2014, Dr. Chunduri administered another left L5-S1 epidural steroid injection. He directed Petitioner to remain off work. PX 7. A week later, Dr. Chunduri noted

that Petitioner reported some improvement but was still complaining of numbness and tingling in his left leg. He recommended that Petitioner follow up with Dr. Dixon and remain off work. PX 7.

Dr. Sompalli testified by way of evidence deposition on September 18, 2014. PX 12. He testified he specializes in orthopedic trauma. He does not treat spinal conditions. PX 12 at 5.

Dr. Sompalli testified he first treated Petitioner in September or October 2013, at the referral of Dr. Goldflies. Petitioner provided a history of slipping and falling at a wet construction site. After examining Petitioner and reviewing the radiographic studies, he diagnosed a Schatzker Type 2 tibial plateau fracture and a distal radius fracture. PX 12 at 6. While he would typically not address a distal radius fracture via surgery, he did so in Petitioner's case in order to allow early right wrist motion, given that Petitioner experienced fractures in opposite extremities, i.e., the right upper extremity and left lower extremity. PX 12 at 7, 15. If he had merely casted Petitioner's right wrist, Petitioner's mobility would have been delayed. PX 12 at 15. Petitioner had depression and gapping in his tibial plateau fracture, which required insertion of a plate and screws. Such a fracture causes pain, sometimes down the leg, along with swelling and burning. The burning sensation could result from peroneal nerve involvement. PX 12 at 10.

Dr. Sompalli testified he last saw Petitioner in August 2014, at which point Petitioner still had left knee pain. It was his impression Petitioner was developing traumatic arthritis, "which is what happens" as a consequence of a tibial plateau fracture. He decided to administer a series of Supartz injections to address the arthritis. PX 12 at 10. Petitioner also exhibited some valgus instability of the left knee. PX 12 at 14. During the left knee arthroscopy, he noted articular damage, i.e., "multiple cracks" in the tibial cartilage secondary to the fracture. PX 12 at 14, 40. In the future, Petitioner might need to have the plate and other surgical hardware removed. PX 12 at 16-17, 30. In contrast, Petitioner's right wrist is doing very well. PX 12 at 16. Petitioner also has a complaint of low back pain radiating down his leg but he does not treat back conditions. PX 12 at 16.

Dr. Sompalli opined that the costs associated with the knee and wrist care and surgery were reasonable, necessary and related to the work accident. PX 12 at 17.

Under cross-examination, Dr. Sompalli testified that, as of August 2014, Petitioner was at the end of the road, treatment-wise, with respect to his left knee and right wrist. Petitioner has damaged cartilage in his knee. The type of fracture Petitioner sustained tends to result in chronic pain. PX 12 at 22. A very low percentage of patients with damaged cartilage go on to require knee replacement surgery. PX 12 at 20. In Petitioner's case, serial knee X-rays have shown the alignment to be good. PX 12 at 22. When he last examined Petitioner, Petitioner still had tenderness around the joint line but no swelling or atrophy. PX 12 at 23-25. When you administer Supartz injections, you administer a series of five and then wait six to eight weeks to determine whether there is improvement. PX 12 at 24. With respect to the knee, Petitioner does not require a brace or gait assist. PX 12 at 26. Petitioner does not require restrictions

with respect to his wrist but, with respect to his left knee, is restricted from lifting over 10 pounds, due to his pain. PX 12 at 29. He can only address restrictions insofar as the wrist and knee are concerned. PX 12 at 30. He is not able to state whether Petitioner will require more surgery for his traumatic arthritis. PX 12 at 31. The initial left leg surgery was open, not arthroscopic. PX 12 at 31. When you operate on the type of leg fracture Petitioner had, the one knee structure you can easily visualize is the lateral meniscus. He does not recall whether he was able to visualize the anterior cruciate ligament. PX 12 at 31. From a clinical perspective, he did not have a reason to look for an anterior cruciate ligament tear, since Petitioner did not have a positive Lachman's pre-operatively. PX 12 at 32. After the first surgery, Petitioner could not undergo a left knee MRI, due to the plate, so he had to perform a second, diagnostic surgery. He provisionally diagnosed a medial meniscal tear but it turned out that it was the anterior cruciate ligament that was torn. PX 12 at 33. He cannot say whether that tear stemmed from the accident because he cannot recall looking at the anterior cruciate ligament during the first surgery. PX 12 at 33. He prescribed therapy three times weekly for a period of weeks. He cannot recall prescribing "day therapy" for Petitioner. Whether such a regimen was appropriate may depend on whether the therapy also involved the back. PX 12 at 35. With respect to the left knee and wrist, Petitioner did not need eight hours of therapy per day. PX 12 at 35. As of March 24, 2014, he found the wrist to be at maximum medical improvement. PX 12 at 36. There are two schools of thought, operative and non-operative, when it comes to treating tibial plateau fractures. He is in the operative "camp" based on his training. PX 12 at 39. In his opinion, surgical fixation results in a better outcome with respect to the type of split, depressed fracture Petitioner had. PX 12 at 39. Petitioner speaks "very broken, very little" English, so he always had an interpreter available when he saw Petitioner. PX 12 at 39.

On September 25, 2014, Petitioner returned to Dr. Chunduri, with the doctor noting ongoing complaints of 6/10 lower back pain and numbness/tingling down the left leg to the big toe. On examination, Dr. Chunduri noted positive straight leg raising on the left at 45 degrees and decreased sensation in the left leg compared with the right. He recommended that Petitioner follow up with Dr. Dixon due to his failure to respond favorably to the recent injection. He directed Petitioner to remain off work. PX 7.

On September 27, 2014, Petitioner returned to Dr. Sompalli, with the doctor noting a complaint of 5/10 left knee pain, associated with flexion/extension and walking. On left knee examination, the doctor noted full extension, flexion to 100, no effusion, mild joint line tenderness, negative valgus and varus stress testing and intact sensation in the left lower extremity. Dr. Sompalli indicated that he told Petitioner "there is not much else to be done for his knee." He found Petitioner to be at maximum medical improvement with respect to the knee, noting that the knee might remain painful, "as is what happens with tibial plateau fractures." He did not believe that further therapy would be helpful. PX 7. RX 9.

Dr. Dixon testified by way of evidence deposition on October 21, 2014. PX 11. Dr. Dixon testified he obtained Illinois licensure in 2003. PX 11 at 3. He is a neurosurgeon. PX 11 at 5.

Dr. Dixon did not independently recall Petitioner and thus relied on his notes. PX 11 at 5-6. Dr. Chunduri, a pain physician, referred Petitioner to him for consideration of the appropriateness of back surgery. PX 11 at 6-7. He initially examined Petitioner on May 2, 2014, at which time Petitioner gave a history of the accident and primarily complained of back and left leg pain. PX 11 at 7-8. Based on his examination, he concluded that Petitioner was suffering from a radiculopathy on the left side "which included pain derangements of sensation as well as weakness." PX 11 at 9. At a subsequent visit, on May 30, 2014, he reviewed Petitioner's lumbar spine MRI scan. PX 11 at 9. He interpreted the MRI as showing a broad-based disc protrusion with central canal and lateral recess stenosis with some nerve root compression at L4-L5 and Grade 1 spondylolisthesis at L5-S1. PX 11 at 10. Both the L4-L5 disc and the L5-S1 disc would have been contributing to Petitioner's symptoms. PX 11 at 10.

Dr. Dixon testified his notes show Petitioner fell on September 12, 2013, while laying tile. PX 11 at 11. Petitioner's spondylolisthesis and stenosis pre-existed this accident. In his opinion, Petitioner's spondylolisthesis was congenital. More likely than not, the spondylolisthesis became symptomatic when Petitioner fell. PX 11 at 12. Petitioner's pre-existing conditions made him more vulnerable to having significant and refractory pain due to the fall. PX 11 at 12. The lower extremity weakness he detected on examination was consistent with the EMG and MRI. PX 11 at 13. He discussed various treatment options with Petitioner but "tabled" the idea of back surgery because of the left knee surgery. PX 11 at 14. He last saw Petitioner in August 2014. At that time, he read Dr. Brackett's report. He disagrees with Dr. Brackett's opinion that Petitioner is magnifying his symptoms, since Dr. Brackett voiced this opinion without reviewing the EMG or lumbar spine MRI. PX 11 at 16. He also disagrees with Dr. Brackett's opinion that Petitioner does not need additional back care in order to be able to return to work. PX 11 at 16. In his view, there is a significant possibility that Petitioner will need a decompressive laminectomy with interbody instrumented fusion. PX 11 at 17. He regularly performs this surgery. He performs between three and five surgeries per week. PX 11 at 18. He believes Petitioner was unable to return to work as of his last visit in August 2014, due to his demonstrable neurologic weakness and severe pain. PX 11 at 19.

Under cross-examination, Dr. Dixon could not recall whether Petitioner had difficulty communicating in English. He relies on interpreters in such cases. PX 11 at 19-20. He has not seen Petitioner for two months and does not know his current condition. He cannot speak to whether Petitioner is currently able to work. PX 11 at 20. Spondylolisthesis is progressive but can improve with conservative care. PX 11 at 21. When he examined Petitioner, he consistently noted 3/5 quadriceps and hamstring weakness on the left and 4/5 strength in the left tibialis anterior and EHL. PX 11 at 22. He attributes these findings to Petitioner's left knee condition, based on the EMG results, because the weakness Petitioner exhibited is not referable to either the L5 or S1 nerve root. PX 11 at 22. He did not perform an orthopedic knee examination. PX 11 at 23. The weakness does not necessarily have to stem from instability. It can be pain-related. PX 11 at 24. He does not know specifically how Petitioner fell but Petitioner told him he did not have pain before he fell. He does not know when Petitioner first reported back pain after the fall. PX 11 at 25. He takes Petitioner at his word in terms of his lack of symptoms before the accident. PX 11 at 26. Petitioner may have been experiencing left

leg numbness but he did not note this. PX 11 at 27. When he examined Petitioner, he did not note sensory deficits. PX 11 at 27. If Petitioner is experiencing stocking-glove numbness of his entire leg, that would typically be associated with a neuropathy but the EMG excluded this. PX 11 at 28. The EMG does not provide a physiological basis for a complaint of numbness in the entire left leg. PX 11 at 29. He does not agree with Dr. Brackett's conclusion that Petitioner was magnifying his symptoms. PX 11 at 30. A patient who has spondylolisthesis would typically experience pain when standing or walking but he could also experience severe pain while sitting or lying flat. PX 11 at 32. Over time, Petitioner could have become symptomatic absent trauma. PX 11 at 36.

On December 5, 2014, Petitioner filed a 19(b) petition and a petition for penalties and fees. Arb Exh 2.

Respondent's Section 12 examiner, Dr. Brackett, testified by way of evidence deposition on December 8, 2014. RX 4. Dr. Brackett testified he has been a medical doctor since 1961. He obtained board certification in orthopedic surgery in 1969 and board certification in neurological orthopedic surgery in 1982. RX 4 at 4-5.

Dr. Brackett testified he regularly treats individuals with orthopedic injuries involving the hands, arms, knees and spine. He was on his own until 2013, when he sold his practice. He stopped performing spine surgery at that point, due to the cost of liability insurance. After he sold his practice, he began working for Perry Memorial Hospital and "Locum Tenens," a company that provides substitutes for physicians who are ill or on vacation. In these capacities, he continues to perform non-spine surgery. RX 4 at 5-7.

Dr. Brackett testified he examined Petitioner once, on March 10, 2014. RX 4 at 7. He prepared a report in connection with his examination. After receiving additional information, he later prepared two supplemental reports. RX 4 at 8.

Dr. Brackett testified he has an independent recollection of examining Petitioner but needed to refer to his reports for specific details. RX 4 at 8.

Dr. Brackett testified that, on March 10, 2014, Petitioner presented with an interpreter who "did a very good job." RX 4 at 9-10. Via the interpreter, Petitioner indicated he was working on the first floor of a house immediately before his accident. It had rained. The floor was wet and he had mud on his shoes. He slipped and fell through a hole in a stairwell, initially landing with all of his weight on his left leg and then breaking his fall with his right hand. RX 4 at 10.

Dr. Brackett testified that Petitioner denied having any problems with his right hand or left leg before the accident. Petitioner complained of pain in his front left pelvic area, his back, his right wrist and down his left leg. RX 4 at 11. He also complained of numbness in his entire left leg, from the iliac crest to the sole of his left foot. RX 4 at 11. When Petitioner walked, he leaned quite heavily on a cane, which he held in his right hand. Petitioner used his left hand to

support his left knee. Petitioner indicated he used his left hand to do this because of right wrist pain. RX 4 at 11.

Dr. Brackett opined that Petitioner's complaint of left leg numbness was either factitious or indicative of either "some bizarre neurological disease." Each area of a leg is enervated by a particular nerve root. In order for an individual's entire leg to be numb he would have to have global involvement of the nerve roots, "which is just plainly impossible to have without concomitant wasting of muscle." RX 4 at 12.

Dr. Brackett testified that, during his examination, Petitioner was alert and cooperative. Petitioner did not appear to be in any acute distress. RX 4 at 13. On left knee examination, the doctor noted three healed arthroscopic portals and a healed lateral scar. Petitioner had equal and normal measurements in both calves, knees and thighs. RX 4 at 13. Petitioner's right knee range of motion was normal. His left knee range of motion was "not as complete" but he could flex to about 105 degrees. The left knee was stable to stress testing. RX 4 at 14. On straight leg raising to 90 to 100 degrees, Petitioner did not complain of radiating pain but did complain of back pain. This was "not normal." Straight leg raising should duplicate sciatic radiation, if present, but Petitioner did not voice radicular complaints. RX 4 at 15. Petitioner voiced no back complaints during "Tisch" testing. This was an inconsistent finding. RX 4 at 16. FABRE testing of the hip joint was negative, although Petitioner complained of slight pain in both hips during this testing. RX 4 at 17. Petitioner's ankle and knee reflexes were symmetrical. RX 4 at 17.

Dr. Brackett acknowledged he did not have access to any previous radiographic studies when he examined Petitioner. RX 4 at 19-20. As part of his examination, he obtained X-rays of Petitioner's pelvis, right wrist, lumbar spine and left knee. The pelvis X-rays were not remarkable. The right wrist X-rays showed a healed styloid fracture with two parallel screws. RX 4 at 19. The lumbar spine X-rays showed some arthritic change in the lower two lumbar areas, with a very slight loss of lumbar curve, and Grade 1 to Grade 2 spondylolisthesis, or vertebrae slippage, at the L5-S1 interspace. RX 4 at 19. The left knee X-rays showed the presence of a reverse tibial plate and five screws, a "distal healed lateral plateau fracture" and adequate joint space. RX 4 at 18.

Dr. Brackett described Petitioner as exhibiting a "very exaggerated type of limp." Petitioner's gait was "factitial, meaning fraudulent to some degree." RX 4 at 20.

Dr. Brackett testified that at a later time, prior to his supplemental report of June 2, 2014, he received the initial X-ray films from Elmhurst Memorial Hospital. The left leg X-rays showed "very slight skiving," or shaving off, of the subchondral portion of the lateral portion of the lateral tibial plateau. They also showed a "slight depression" of the lateral tibial plateau. This depression was not so large as to "demand" open reduction/internal fixation. Rather, you "could argue about whether" fixation should be performed. This "could go either way." Surgical fixation was not the wrong thing to do. RX 4 at 21. The right wrist X-rays showed a radial styloid fracture which was very minimally displaced. Dr. Brackett testified that, during his

47 years in practice, he always casted and never pinned such fractures. While he would not have operated on Petitioner's right wrist, he did not fault Petitioner's surgeon for doing so. "That's certainly something that two people could disagree on." RX 4 at 22. The hip X-rays looked good. There was no obvious loss of joint cartilage. RX 4 at 22. The lumbar spine X-rays showed Grade 1 spondylolisthesis and some degenerative changes. RX 4 at 22-23.

Dr. Brackett testified he reviewed Dr. Sompalli's operative reports but did not review any of Petitioner's rehabilitation records. RX 4 at 23.

Based on his examination, X-ray review and experience, Dr. Brackett opined that, as of June 2, 2014, Petitioner did not require any additional right wrist care. RX 4 at 24.

Dr. Brackett acknowledged he examined Petitioner only a couple of weeks after Dr. Sompalli operated on Petitioner's left knee. During that operation, Dr. Sompalli found a "ball valve type of finding on an anterior cruciate ligament," meaning that, when the ligament avulsed from the femur, it rolled up into a ball and could have led Dr. Sompalli to believe he was dealing with a medial semilunar cartilage tear or a meniscal tear. RX 4 at 25. Dr. Brackett opined that, during the first left leg surgery, it would have been difficult for Dr. Sompalli to evaluate the medial semilunar cartilage through the lateral joint. On the other hand, if Petitioner indeed had a torn anterior cruciate ligament at the time of that surgery, that tear would have been "not so difficult to evaluate." RX 4 at 25-26.

Dr. Brackett opined that he found no indication, either via symptoms or his examination, of any condition of ill-being in Petitioner's left hip. RX 4 at 27.

Under cross-examination, Dr. Brackett testified he no longer practices out of the Westgate Orthopedics office. He typically uses that office only for examinations and depositions. RX 4 at 32-33. He no longer has any ownership interest in Westgate Orthopedics. RX 4 at 33. At the present time, he writes about 15 to 20 IME reports each year and gives about 15 depositions each year. RX 4 at 33. Not all of those IMEs and depositions are for defendants but most of them are. RX 4 at 34. He has performed the surgeries Dr. Sompalli performed "countless times," with the exception that he might have operated on only one radial styloid fracture. He typically casted such fractures. RX 4 at 34. He agrees that the conditions Dr. Sompalli treated via surgery were caused by the work accident of September 12, 2013. RX 4 at 34. He agrees that these conditions would have residual effects for some time. RX 4 at 34-35. The wrist fracture would have residual effects for a maximum of six weeks and the knee condition would have effects for "maybe three months." RX 4 at 35. Dr. Brackett acknowledged he did not read Dr. Sompalli's or Dr. Dixon's depositions. What he knows of these doctors' opinions is based on his review of their reports and his review of the initial Emergency Room X-rays and the X-rays he took on his own. RX 4 at 35-36.

Petitioner testified he returned to Dr. Dixon on March 23, 2015, the day before the rehearing. Dr. Dixon discussed lumbar spine surgery with him. [In his note of March 23, 2015, Dr. Dixon indicated that Petitioner's low back and left leg remained symptomatic despite the

intervening injections. He went on to state that Petitioner "continues to have numbness and pain in the right leg including the toes." His examination findings were unchanged. He recommended a L4-L5/L5-S1 decompression and interbody fusion with instrumentation. He instructed Petitioner to remain off work. PX 7.] Petitioner testified he is scheduled to return to Dr. Dixon on April 20, 2015. He wants to undergo the recommended lumbar spine surgery because of his pain and numbness. Dr. Dixon is keeping him off work pending surgery.

Petitioner clarified he currently has two dependent children, both daughters. One of those daughters is 21 years old but she is disabled due to a head injury. The other is 17 years old.

Under cross-examination, Petitioner testified he has experienced numbness in his entire left leg since the accident. The numbness extends from his back down to his toes. He experiences this numbness about 90 to 95% of the time. When he returned to Dr. Dixon the day before the rehearing, he complained to the doctor of left leg numbness. Dr. Dixon touched his leg. In his opinion, Dr. Dixon's examination was more thorough than Dr. Brackett's. He has always felt that Dr. Brackett's examination was "very superficial." Dr. Brackett stuck needles in both of his legs. Dr. Dixon also stuck needles in his legs but was more focused on his back. Dr. Brackett's physical examination lasted 40 minutes but he was in the doctor's office for an hour.

Over objection, Petitioner testified he came to the United States in August 2004. His wife and children continue to live in Mexico. They have always lived there. Before he worked at the restaurant, he worked through temporary agencies for three years and also worked as a taco maker. Before that, he worked at the airport in Mexico City. When he lived in Mexico, he also worked as a taco maker for six years. He is now 48 years old.

Petitioner testified he does not recall exactly when he began working for Respondent but he is sure he worked there for three or four months, and not just a few weeks, before the accident. He remembers getting a call from David Kirchmann of State Farm after the accident but he does not recall being asked about the duration of his employment. He is unable to recall much of his conversation with Mr. Kirchmann because he was in a lot of pain when they spoke. He was also very concerned about whether/when he would be able to return to work because he needed to be able to pay for his disabled daughter's medication. He told Mr. Kirchmann he was worried about this.

Petitioner acknowledged receiving checks from State Farm until State Farm suspended payment. [A letter in PX 7 reflects that Respondent discontinued the payment of temporary total disability benefits on June 20, 2014, based on Dr. Brackett's examination.]

Petitioner testified that Pat Sheedy did not hire him to work for Respondent. It was Francisco who took him to Respondent. He always earned $1200 every two weeks, regardless of how many hours he worked. Respondent did not ask him to complete any tax forms. It was Francisco who gave him his checks. The checks did not have stubs attached to them. During

the time he worked for Respondent, he did not add up his earnings. Respondent never told him he would be earning $12 per hour.

Petitioner acknowledged he did not file income tax returns. Over objection, he acknowledged he did not have a legal Social Security number at the time of the accident. He was born on August 31, 1965.

Petitioner testified the accident occurred when he slipped and fell through an opening over an area where stairs were going to be built. He fell approximately 12 to 14 feet. He recalled testifying at a previous hearing, in January, but he did not recall testifying he fell 9 to 10 feet. He recalls telling the arbitrator at that hearing that he fell from a height that was a little higher than the ceiling of the hearing room. He does not recall telling anyone he fell 9 feet. He does not recall telling Emergency Room personnel how far he fell. Right now he would estimate he fell 12 to 14 feet. He is sure he fell from a height a little higher than the ceiling of the hearing room. He never measured the distance because his job did not require him to take such measurements. He never said he fell head first. He said he turned in the air, while falling, in order to land in a standing position. He felt he was going to land on his head but he was able to turn and thus land in a standing position. He did not land correctly, however. He landed on gravel, with most of his weight on his left leg, and then "sprang" to the right. He experienced an immediate onset of pain in his lower back and pain and numbness in his left leg. At the Emergency Room, he was experiencing severe lower back pain and numbness in his entire left leg. Before the accident, he never experienced any lower back pain or even achiness. Two years before the accident, he regularly worked at least twelve hours per day and his back never bothered him. He always complained of left leg numbness to Dr. Dixon. He also complained of this to the therapists at RIC. He further complained of groin pain. He still has this pain. He uses a cane. Dr. Sompalli prescribed this. Apart from Dr. Sompalli's recommendation, he uses the cane because he experiences left knee and groin pain when he walks a lot. He would like not to have to rely on the cane. He was in a wheelchair before he graduated to a cane. Dr. Sompalli never told him to stop using a cane. He received the cane the last day he was at RIC. Dr. Sompalli released him to work but Drs. Chunduri and Dixon have told him to stay off work. Because of his knee complaints, he avoids stairs and tries not to walk much.

On redirect, Petitioner testified he complained to Dr. Dixon of left leg numbness on March 23, 2015. If Dr. Dixon wrote down that he complained of his right leg, that is a mistake. It is his left leg that is the problem. When he underwent therapy, he would complain about certain exercises. He asked to undergo testing. He has not undergone any treatment or surgery for his groin complaints. He does not speak English. If an interpreter was available, he communicated through that individual. No interpreter was available at the Emergency Room but a nurse who knew a little Spanish did try to talk with him. At RIC, there were two occasions on which an interpreter was not available. He wants to undergo the recommended back surgery because he is in pain.

Respondent did not call any witnesses.

Arbitrator's Credibility Assessment

Petitioner's testimony concerning his pre-accident activity level and the mechanics of the accident was detailed and highly credible. The voluminous RIC records support Petitioner's testimony that he complained of left leg, hip and groin numbness and that he had difficulty performing various exercises during therapy.

Respondent's examiner, Dr. Brackett, described Petitioner's gait and complaints as exaggerated, while readily acknowledging he saw Petitioner in the early post-operative phase, only two weeks after the left knee arthroscopy. Drs. Sompalli, Chunduri and Dixon did not note any symptom magnification. The numerous therapists who saw Petitioner at RIC did not note malingering or lack of effort. Petitioner did not come across as a fabricator at the hearing. Rather, he presented as an individual who is understandably concerned about his injuries and who is willing to undergo back surgery in an effort to get better.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal connection between his undisputed work accident and his multiple claimed current conditions of ill-being?

The Arbitrator finds that Petitioner established a causal connection between his undisputed work fall and his various claimed current conditions of ill-being, namely his left leg/knee, right wrist, hip/groin and lower back conditions. The Arbitrator further finds that Petitioner established causation with respect to the treatment rendered to date, including but not limited to the left knee arthroscopy of February 27, 2014, and the need for future care (see below).

In making the foregoing findings, the Arbitrator relies in part on Petitioner's testimony as to his ability to perform physically strenuous duties prior to the accident, his denial of any pre-accident left leg, back or right wrist complaints and the lack of evidence of any new, post-accident trauma. The Arbitrator also relies in part on Petitioner's detailed account of his fall and landing. In the Arbitrator's view, it matters not that Petitioner might have fallen a distance of 9 or 10 feet versus 12 feet. What is significant is that Petitioner fell from a height, contorting himself so as to land on his feet, landed with most of his weight on his left foot and leg and then rebounded to the right. The force of the fall was sufficient to cause a significant, splintered fracture of the tibial plateau along with a lateral meniscal tear and a distal radius fracture of the right wrist. From the outset, Petitioner voiced other complaints, relative to his left hip and lower back, but these complaints were overshadowed by the other, immediately noticeable fractures, which required emergent care. It makes sense to the Arbitrator that the left hip and lower back complaints resurfaced at such time that Petitioner began bearing weight, increasing his activity level and performing therapeutic exercises. While left hip X-rays did not show any fracture, the left hip MRI, ultimately performed on November 27, 2013, showed significant pathology, including a labral tear, with the radiologist recommending an ultrasound that was apparently never performed. Dr. Chunduri twice expressed a desire to

review the left hip MRI but it appears he never did so. The left hip cannot logically be excluded as a cause of Petitioner's ongoing complaints.

In finding causation as to the lower back, the Arbitrator also relies on Dr. Dixon's testimony that the fall caused Petitioner's congenital pars defect/spondylolisthesis to become symptomatic. Overall, the Arbitrator found Dr. Dixon more persuasive than Respondent's examiner, Dr. Brackett. Dr. Brackett saw Petitioner on one occasion, did not review the EMG or MRI scans and admitted that the vast majority of the medical-legal consulting he performs is for defendants.

In finding causation as to the need for the left knee arthroscopy of February 27, 2014, the Arbitrator relies in part on Petitioner's credible testimony concerning his pre-accident activity level and the manner in which he landed on his left leg. The Arbitrator also relies on the RIC therapy notes, which document ongoing left knee complaints, and Dr. Sompalli's testimony. At his deposition, Dr. Sompalli explained that, following the initial left leg surgery, he could not explore the etiology of Petitioner's persistent left knee complaints via MRI, due to the plate, and thus was compelled to perform a diagnostic procedure, i.e., an arthroscopy. He expected to find a medial meniscus tear during that procedure but instead found an anterior cruciate ligament tear. He could not directly attribute this tear to the work accident, since he could not recall looking for such a tear during the first surgery, but there is no evidence suggesting Petitioner was having problems with his left knee before the accident. The Arbitrator also notes that, under cross-examination, Dr. Brackett conceded that the conditions Dr. Sompalli addressed via surgery were caused by the work accident. RX 4 at 34.

Much has been made of Petitioner's complaint of numbness in his left leg, hip and groin. While the physician's assistant who evaluated Petitioner at the Emergency Room indicated Petitioner denied numbness in his extremities, a therapist recorded a complaint of intermittent left leg numbness only two weeks after the accident. She indicated this complaint could not be fully addressed due to Petitioner's post-operative bandaging. On October 2, 2013, a different therapist noted a complaint of distal left hip numbness, especially at night. These entries support Petitioner's testimony that he tried to alert his providers to the numbness, despite some communication difficulties. Dr. Brackett described Petitioner's complaint of numbness as "factitious" but there is no evidence indicating the doctor ever reviewed the RIC records, the EMG results or the lumbar spine MRI. Dr. Brackett testified he found "no indication" of a left hip condition on examination (RX 4 at 27) but the Arbitrator finds this testimony unpersuasive since there is no evidence Dr. Brackett's examination was informed by the left hip MRI. Dr. Brackett readily admitted he reviewed only X-rays. As stated above, it appears to the Arbitrator that no hip specialist has attempted to correlate Petitioner's complaints with the positive left hip MRI. More than a year ago, Dr. Sompalli noted that this MRI showed a labral tear and recommended Petitioner see Dr. Domb if he remained symptomatic after seeing Dr. Chunduri. Petitioner clearly remains symptomatic and apparently has never seen Dr. Domb.

What is Petitioner's average weekly wage?

At the hearing, Petitioner claimed an average weekly wage of $600 while Respondent claimed $480. Arb Exh 1. Neither party offered any time cards, paychecks or payroll records into evidence.

Petitioner testified he always received his checks from his supervisor, Francisco. Francisco would drive a company vehicle to a location near his home and personally deliver his check to him. Petitioner testified he received a check every two weeks. He also testified that, throughout his three- or four-month tenure with Respondent, he received $1200 every two weeks, regardless of how many hours he worked. He indicated the checks lacked any accompanying stubs or explanatory information.

Respondent did not call any witness to rebut Petitioner's testimony concerning his earnings. The only wage-related evidence Respondent offered was a Form 45 (authored by Patrick Sheedy) dated September 13, 2013 reflecting that Petitioner was hired "3-4 wks" earlier and earned "$12 x 40." RX 5. Under cross-examination, Petitioner denied being hired by Sheedy and indicated it was Francisco who put him in touch with Respondent and interacted with him post-hiring. Petitioner also denied being told he would be paid $12 per hour.

Petitioner's testimony concerning the duration of his employment, the method by which he was paid and the fixed amount he received every two weeks was detailed and credible. Petitioner provided a rational explanation for his failure to produce any checks – namely, that the checks he received lacked stubs or any other tear-off information he could have retained. Petitioner's testimony that he typically worked about 50 hours per week is echoed in the records from RIC. PX 3, p. 38 of 780. The Arbitrator relies on Petitioner's credible testimony in finding his average weekly wage to be $600.

Is Petitioner entitled to temporary total disability benefits?

At the hearing, Petitioner claimed he was temporarily totally disabled from September 13, 2013 through March 24, 2015 (the date of rehearing) while Respondent claimed he was temporarily totally disabled from September 13, 2013 through March 10, 2014 (the date of Dr. Brackett's Section 12 examination). Arb Exh 1.

The Arbitrator has previously found in Petitioner's favor on the issue of causation. The Arbitrator concludes that Petitioner's causally related lower back and hip/groin conditions remain unstable and that he has not reached maximum medical improvement. The Arbitrator also notes that Dr. Dixon did not release Petitioner to any form of employment on August 29, 2014 or March 23, 2015 and that Dr. Chunduri instructed Petitioner to remain off work on September 25, 2014. PX 7. In reliance on Interstate Scaffolding, Inc. v. IWCC, 236 Ill.2d 132 (2010), the Arbitrator finds that Petitioner was temporarily totally disabled from September 13, 2013 (the day after the accident) through March 24, 2015 (the date of the 19(b) rehearing), a period of 79 5/7 weeks, with Respondent receiving credit for the temporary total disability benefits it paid prior to March 25, 2015. Arb Exh 1. Having previously found Petitioner's

average weekly wage to be $600, the Arbitrator awards temporary total disability benefits at the rate of $400 per week.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims the following outstanding medical bills:

Illinois Medi-Car (PX 6)		
11/23/13	$	63.00
12/10/13	$	51.00
Illinois Orthopedic Network (PX 7)	$	3,223.02
Archer Open MRI (PX 9)		
7/30/14, left knee X-ray	$	185.00
Metro Anesthesia Consultant (PX 10)		
9/18/14 (epidural steroid injection)	$	2,332.00
TOTAL:	$	5,854.02

The Arbitrator awards the two Medi-Car bills, subject to the fee schedule, noting these bills relate to transportation provided to Petitioner prior to Dr. Brackett's Section 12 examination, during the time Petitioner was non weight bearing and undergoing long-term therapy at RIC.

The remaining bills relate to post-IME treatment of the disputed lower back and left knee conditions. The Arbitrator awards these bills, subject to the fee schedule, having already found that Petitioner established causation as to those conditions and as to the need for treatment of those conditions.

Is Petitioner entitled to prospective care?

Based on the foregoing findings as to causation and instability of Petitioner's lower back and hip/groin conditions, the Arbitrator finds that Petitioner is entitled to prospective care as deemed necessary for those conditions, including but not limited to the left hip consultation with Dr. Domb recommended by Dr. Sompalli on January 28, 2014 and the lumbar spine surgery recommended by Dr. Dixon on March 23, 2015.

Is Respondent liable for penalties and fees?

Respondent paid temporary total disability benefits for a significant period (Arb Exh 1), apparently suspending same in June 2014, based on Dr. Brackett's opinions. Respondent also paid for much of Petitioner's medical care. Petitioner filed a petition for penalties and fees on

December 5, 2014, about one month before the original 19(b) hearing. Arb Exh 2. The petition is generic in nature and does not include any demand for payment of specific medical bills. There is no evidence indicating that Respondent learned of the claimed bills prior to the original January 8, 2015 hearing. The post-hearing reassignment of this case arose from unusual circumstances. Although the Arbitrator finds Dr. Brackett unpersuasive, the Arbitrator declines to award penalties and fees in this case, noting the foregoing and the wage dispute.

STATE OF ILLINOIS)
) SS.
COUNTY OF DU PAGE)

☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARIA HULL-GECAS,

Petitioner,

16IWCC0144

vs.

NO: 13 WC 35302

EDWARD HOSPITAL,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, prospective medical treatment, wage rate and penalties and fees and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The presiding arbitrator found Petitioner sustained an accident while pushing a patient on a gurney on July 17, 2013, that resulted in a temporary aggravation of a preexisting pelvic condition but found Petitioner failed to prove a causal connection between the labral tear in her right hip and said accident. The Commission disagrees with the arbitration finding that the labral tear was unrelated to the July 17, 2013, accident.

The Commission acknowledges a discrepancy between Petitioner's medical records and her testimony with respect to the onset of the pain to her right hip. The medical records indicate

Petitioner's initial complaint was lumbar spine pain that radiated into her thoracic spine and the pain to her right hip began on July 19, 2013. Petitioner testified that onset of the right hip pain was immediate. The Commission does not find this discrepancy to be fatal, noting that Petitioner consistently and credibly attributed her right hip pain to her July 17, 2013, accident. Of greater importance, the Commission notes absent from Petitioner's medical history is any records of prior problems involving her right hip and finds no evidence of any intervening event to explain how her right hip became symptomatic subsequent to her July 17, 2013, accident. The Commission concludes Petitioner's labral tear occurred as a result of the claimed accident but later became symptomatic due to Petitioner's engaging in activities of everyday living.

In considering the question of causal connection, the Commission was afforded the opportunity to review surveillance footage of Petitioner that was taken on November 12, 2013, and November 17, 2013, respectively. The footage taken on November 12, 2013, while showing Petitioner ambulating without a noticeable limp, is too brief to allow for a credible determination of whether or not what is depicted in the footage was representative of Petitioner's ability to walk. The footage taken on November 17, 2013, was of sufficient length for the Commission to conclude Petitioner, on that date, was capable to performing light yardwork, namely blowing leaves in her yard. The footage showed Petitioner walking in her yard while waving a leaf blower in a side-to-side manner. There is no evidence of Petitioner having any problem walking until she raises her head and appears to look in the direction the video camera filming her. Petitioner proceeded to place the leaf blower in her left hand and her right hand on her right hip and began to walk with a noticeable limp.

The Commission, while finding Petitioner's behavior suspicious and a probable exaggeration of her true condition, nevertheless, finds the September 22, 2013, MRI scan of Petitioner's right hip that revealed the labral tear to be more compelling evidence of her condition. The clinical documentation far outweighs Petitioner's antics as documented by Respondent's surveillance footage.

The Commission finds Petitioner's July 17, 2013, accident resulted in the labral tear in her right hip, a condition found by Dr. Nho, Petitioner's treating physician, to require surgical intervention in the form of a right hip arthoscopy, labral repair, possible acetabular rim trimming, debridement, synovectomy, femoral osteochondroplasty and capsular plication. Dr. Nho has kept Petitioner off work while the surgery was pending. The Commission, accordingly, authorizes the surgery as proposed by Dr. Nho and modifies the awarded TTD benefits to run through the date of the arbitration hearing.

The Commission affirms and adopts the arbitration decision findings on all other matters.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $376.10 per week for a period of 38 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this

award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay for the proposed surgical intervention and subsequent aftercare as proposed by Dr. Nho under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the reasonable and necessary medical expenses incurred in connection with the treatment of her causally related condition through April 9, 2014, pursuant to Section 8 and 8.2 of the Act

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $18,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 - 2016
KWL/mav
O: 04/07/15
42

Thomas J. Tyrrell

Michael J. Brennan

DISSENT

I respectfully dissent from the decision of the majority. Arbitrator Doherty's findings are well reasoned, her review of the medical evidence is thorough and persuasive. This decision is correct and should be affirmed in its entirety.

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

16IWCC0144

HULL-GECAS, MARIA
Employee/Petitioner

Case# 13WC035302

EDWARD HOSPITAL
Employer/Respondent

On 6/2/2014, 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 0.05% 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:

0391 HEALY SCANLON LAW FIRM
KEVIN T VEUGELER
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
SEAN BROGAN
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

16IWCC0144

Maria Hull-Gecas
Employee/Petitioner

v.

Edward Hospital
Employer/Respondent

Case # 13 WC 35302

Consolidated cases: _____

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 **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Wheaton**, on **April 9, 2014**. 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. [x] 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [x] 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. [x] 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. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other attorney's fees, evidentiary objections over Respondent's investigator report and surveillance video

16IWCC0144

FINDINGS

On the date of accident, **July 17, 2013**, 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 **through 11/17/13**. SEE DECISION

In the year preceding the injury, Petitioner earned $**29,336.35**; the average weekly wage was $**564.16**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **2** dependent children.

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

Respondent shall be given a credit of $**9,958.38** for TTD, $**0** for TPD, $**0** for maintenance, and $**1,377.00** for other benefits, for a total credit of $**11,335.38**. ARB EX 1.

Respondent is entitled to a credit of $**0** under Section 8(j) of the Act. ARB EX 1.

ORDER

Respondent shall pay Petitioner temporary partial disability benefits of $376.10 for a period of 17-4/7 weeks commencing 7/18/13 through 11/17/13. Respondent shall receive credit for amounts paid.

Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in connection with the treatment of her casually related condition through 11/17/13 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

Petitioner's request for prospective medical care under Section 8(a) of the Act is denied.

Petitioner's request for penalties and fees under the Act is denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

Carolyn Doherty
Signature of Arbitrator

5/31/14
Date

ICArbDec19(b)

JUN - 2 2014

FINDINGS OF FACT

Petitioner testified that she works for Respondent has a tech support in the OB area. Her duties require her to provide support to the OB doctors, preparing the operating room for all procedures, assisting during surgery, and moving equipment and patients in and out of the operating room. Petitioner testified that she had to be able to lift over 50 pounds in order to lift and move patients.

On 7/17/13, Petitioner was at work with other techs and a nurse. Petitioner testified that she received a call to transport a patient to the post-delivery unit on a gurney. Petitioner testified that she pushed the patient in a gurney up to the second floor. Petitioner testified that the gurney she was pushing was larger than a standard gurney and carried more attached equipment. Petitioner testified that the patient was large and estimated her weight to be 250 pounds. Petitioner is five feet tall and of slight build. Petitioner pushed the gurney into an elevator to travel up one floor. She testified that the process of moving the patient required Petitioner to push the cart while stopping and starting through many sets of security doors. Petitioner estimated that she stopped and then started to push the cart carrying the patient approximately 8 times during the transfer through the crowded floors, halls and doors of the hospital.

Petitioner testified that while pushing the gurney into the NICU she stopped at the NICU desk. In order to start the pushing process again, Petitioner pulled the gurney back and then began to fully lunge forward to push the gurney. It was at that point, the Petitioner felt pain in her right buttock through her right hip. Petitioner testified that the NICU flooring was "rubber" and "sticky" and different from the other floors in the building.

Petitioner testified that she felt pain in her right buttock and hip. Petitioner testified that immediately after the accident, she sought treatment in the ER because employee health was not available. The ER record of 7/18/13 indicates, " 35 yo female presents for back pain. Patient was helping push/lift a post-op OB patient who was heavy set. Patient then experience [sic] sharp low back pain. Radiation up the back. No leg weakness, numbness/tingling..." PX 1. Mild paraspinal lumbar tenderness was noted on exam. On cross exam, Petitioner testified that she told the ER doctor that she had right hip and buttock pain but he wrote it as a back problem. Petitioner was discharged with medication and told to follow up the next day, 7/19/13.

On 7/19/13, Petitioner was examined by Dr. Link at Edwards corporate health. She reported pain on the right thoracic and lumbar areas after moving a patient in the OB/GYN. PX 1. Petitioner denied leg complaints, numbness or tingling. Petitioner was taken off work until follow up on 7/22/13 and was prescribed ibuprofen and flexeril as needed under a diagnosis of thoracic, lumbar back pain/strain. PX 1. On 7/22/13, Petitioner returned for follow up and Dr. Link noted her condition was unchanged. Dr. Link noted, "she now has some buttock pain that started over the weekend, two days ago. ... Denies any other leg complaints, numbness, tingling or weakness." Petitioner testified that she had pain and burning in her right buttock radiating down her thigh and into her groin. Petitioner testified that the pain was down the front and back of her right leg. The diagnosis remained thoracic back pain, lumbar back pain and hydrocodone was added to the prescribed medication. Petitioner was kept off work until follow up on 7/25/13. On 7/25/13, Petitioner complained of "having worse pain since she had to assist her daughter with an EpiPen yesterday" after her daughter was stung by a bee and Petitioner had to lift and carry the 3 year old child. Petitioner was sent to physical therapy and told to stay off work until her follow-up on 8/2/13. PX 1.

On 7/31/13, Petitioner first visited Edwards occupational health and saw Dr. Kelley. Dr. Kelley noted, "History/mechanism of injury: pushing a gurney with a post op patient – 220 lbs by herself was fine until she came across a non skid floor. Started transferring the patient and when she returned to her unit, she started to have pain. Pain is located on R low back and thoracic area. States that recently, picked up her daughter who is having an allergic reaction and hurt herself again. Patient has been off work since the injury. States now her pain radiated up to the back of the knee." Petitioner was instructed on exercises in PT.

On 8/2/13, Petitioner saw Dr. Link who continued PT and kept Petitioner off work. On 8/15/13, Dr. Kelley noted that physical therapy was not helpful and that there was no improvement in symptoms. Petitioner reported that her back pain worsened over the prior weekend when she sneezed in bed and felt sharp pain in her low back. Petitioner reported her current pain in the right low thoracic area, right lumbar areas and right buttock area. Petitioner reported limited ADL's due to pain and pain at 6/10. X-rays were ordered of the lumbar and thoracic spines which were normal, with the exception of some mild thoracic scoliosis. Dr. Kelley noted that due to the location of the symptoms she did not suspect any radicular component and did not recommend an MRI. Rather, she recommended a referral to physical medicine and rehab physician for evaluation. PX 1. Petitioner was discharged from PT on 8/15/13.

Petitioner saw Dr. Mathew on 8/21/13. Dr. Mathew noted that Petitioner's low back thoracic pain started on 7/17/13 from an injury at work. Petitioner reported pushing a gurney with a post op patient by herself. Dr. Mathew noted, "it got stuck on the floor, but she kept on pushing hard. She had an acute onset of pain and tightness throughout the back." Dr. Mathew noted Petitioner's treatment to date and the progressive worsening of Petitioner's symptoms. Dr. Mathew prescribed a Medrol Dosepak, modified activities and more PT. If the symptoms did not improve, Dr. Mathew recommended an MRI. Petitioner was continued off work for three weeks until the follow up. PX 2. Petitioner began PT at Flexeon Rehab. PX 3. On 9/13/13, Petitioner followed up with Dr. Mathew and reported that she completed three weeks of PT with continued pain in her lower back and right posterior buttocks and groin. Petitioner described the pain as shooting and burning worse with standing and walking. Petitioner reported feeling weak and occasionally losing balance. Dr. Mathew ordered a lumbar MRI and a right hip MRI based on Petitioner's complaints of right hip pain on range of motion.

The 9/22/13 right hip MRI was read to show a "localized linear tear through the base of the anterosuperior aspect of the right acetabular labrum" and osteitis pubis. The lumbar MRI was unremarkable. PX 2. On 9/27/13, Dr. Mathew explained the MRI results and that the linear labrum tear could be the cause of her hip pain and that the back pain could be due to right SI joint instability caused by the hip pain. Dr. Mathew recommended cortisone injection followed by physical therapy. If the pain did not subside Petitioner was to get a surgical referral. PX 2.

On 10/8/13, Petitioner sought care from her own physician, Dr. Nho. Dr. Nho noted a consistent history of accident while transferring a patient from the OR and immediate pain to Petitioner's low back followed a few days later by right hip pain. PX 4. Dr. Nho read the MRI to note a labral tear and noted Petitioner's complaints of pain at 10/10 aggravated by all activities. The diagnosis was right hip labral tear and Petitioner was sent for a diagnostic and therapeutic steroid injection. Dr. Nho noted that if the injection provided lasting relief no surgery would be necessary but if the relief were only temporary then surgery would be likely. PX 4. Petitioner had the hip injection on 11/5/13 with Dr. Nho and on 11/26/13

Petitioner reported ongoing symptoms. Dr. Nho's impression was right hip labral tear secondary to underlying femoroacetabular impingement. Dr. Nho recommended a right hip arthroscopy, labral repair, possible acetabular rim trimming, debridement, synovectomy, femoral osteochondroplasty, and capsular plication. PX 4. As of 1/21/14, Petitioner was kept off work while the surgery was pending. PX 4.

Petitioner attended a Section 12 exam with Dr. Lieber on 12/23/13 and Dr. Lieber's dep was taken on 3/6/14. RX 4. Dr. Lieber is board certified and testified that he has been treating patients with hip disorders for 25 years. Dr. Lieber testified that Petitioner gave a history of pushing a large patient on a cart post op and developed back and posterior right buttock pain. RX 4, p. 7. He does not recall Petitioner reporting anything wrong with the condition of the floor that contributed to her accident or anything wrong with the gurney she was pushing. RX 4, p. 7. Petitioner complained of "some buttock pain with radiation down the front of her hip. She had pain in her right hip at night as well as difficulty with ambulation up and down stairs. She had pain with bending, popping in her hip, and locking; that was it." RX 4, p. 8. Petitioner did not present low back complaints. Dr. Lieber conducted a physical examination of Petitioner's hip including a range of motion examination. He found that Petitioner's range of motion for her right leg was "severely restricted due to pain." RX 4, p. 9. Dr. Lieber reviewed the right hip MRI from 9/22/13 and determined "that she showed evidence of osteitis pubis and an equivocal labral tear." RX 4, p. 10. He defined osteitis pubis as an inflammation of the cartilaginous fibrous disc area in the center of the pelvis area. He noted the degenerative condition is usually associated with childbirth. RX 4, p. 10.

Dr. Lieber further testified that the MRI showed an equivocal labral tear and explained that "...I wasn't that impressed that there was a tear and that this was just an MRI, not an MRI arthrogram. And MRIs, though they certainly can evaluate the hip joint and the labral tissue, but it at times can be inconsistent or not as sensitive as other tests such as an MRI arthrogram. And I wasn't really that convinced that it was that significant of a labral tear to my reading. I'm not necessarily denying this. I just wasn't that impressed with it." RX 4, p. 11. Even assuming a tear exists, Dr. Lieber testified that Petitioner's complaints of low back and right posterior buttocks pain immediately following the incident does not correlate with a tear at the anterosuperior aspect of the right acetabular labrum. RX 4, p. 12.

Dr. Lieber testified that he reviewed surveillance video of Petitioner holding a leaf blower and showing movement and activity that did not "square" with Petitioner's demonstrated lack of range of motion during his exam of Petitioner's hip. RX 4, p. 12. Dr. Lieber opined that Petitioner's right hip pain and low back inflammation was not related to her incident of 7/17/13 at work. He testified, "based upon the mechanism of injury, as well as the diagnostic findings, there does not appear to be a correlation between the event of July 2013 and that of the positive findings and physical exam and review of records that I utilized for my evaluation in December of 2013." He does not believe that Petitioner sustained any distinct injury to the right hip as a result of the incident. He opined Petitioner could return to her job and that she did not need additional treatment. RX 4, p. 13-14.

On cross exam, Dr. Lieber testified that he did not review the records of Dr. Nho. RX 4, p. 17. He further testified that the acetabulum of the pelvis is the pelvic aspect of the hip joint and that there is a cartilaginous fibrous rim around the acetabulum which is defined as the labrum. RX 4, p. 21. He further testified that patients with labral pathology could have complaints of catching or locking of the hip joint. RX 4, p. 22.

Dr. Lieber again testified that he examined video footage of Petitioner using a leaf blower on 11/17/13. He did not observe Petitioner with a gait abnormality on the video. RX 4, p. 22. He determined that the video supported his determination that Petitioner's complaints on physical exam were out of proportion and not consistent with the purported objective findings on the MRI. RX 4, p. 23. Dr. Lieber relied on this video in rendering his opinion. RX 4, p. 23. On cross exam, Dr. Lieber testified that he believed Petitioner sustained an aggravation of her preexisting degenerative pelvis condition in the incident and that Petitioner reached MMI for those symptoms as of October 1, 2013. Any symptoms after 10/1/13 were not related to the incident but rather solely to the degenerative condition. RX 4, p. 31. Again, he testified that he disagreed with the three physicians who saw a labral tear on the MRI and also testified that her current symptoms and complaints are not consistent with a labral tear. RX 4, p. 39. Based on his review of the video surveillance activities of 11/17/13, Petitioner is faking her symptoms based on his opinion that Petitioner's symptoms as of 10/1/13 were no longer related to the accident. RX 4, p. 40. Again, in his opinion, "... after October 1 any treatment in association with the July event is inappropriate in association with that event." RX 4, p. 42.

Petitioner's last visit to Dr. Nho was on 4/4/14. Dr. Nho continued to recommend surgery and kept Petitioner off work. At trial, Petitioner testified that she continues to have pain in her right hip. She testified that her hip pain affects the way she walks and that she is unable to exercise, run, or play with her children. She has gained weight. Petitioner further testified that she continues to take mediation as needed.

Respondent called Mr. Robert Nightingale to testify in his capacity as the environmental health and safety manager responsible for the safety of all patients, visitors and employees at the hospital. Mr. Nightingale has 20 years experience in the as well as an undergraduate degree in environmental health and a masters degree in the area. Mr. Nightingale testified to performing a hazard analysis of the flooring on which Petitioner was pushing the gurney to see if the push forces she was required to use while pushing the gurney exceeded acceptable standards. They did not according to the witness. The Arbitrator notes that a different type of gurney was used in the experiment performed by Mr. Nightingale and that the subject person on the gurney was not as large as the described patient pushed by Petitioner. Furthermore, the Arbitrator notes that although Petitioner testified to the substance of the flooring as exhibited in RX 6 and that references to a relationship between her efforts to push the gurney on the flooring substance are contained in the medical records, she did not allege at trial that the gurney was stuck on the flooring or that the flooring in any way contributed to her difficulty in pushing the gurney. Rather, Petitioner alleges that she, as a small person, was maneuvering a large gurney carrying a large patient when she acutely felt the right hip pain.

Also called to testify was Mr. Salgado, the individual who took the surveillance video of Petitioner. Mr. Salgado has worked in the private investigation industry for 11 years and with his current agency for 7 years. He testified that he attempted to obtain video surveillance of Petitioner on a total of 5 days. Mr. Salgado testified that the edited version of the video contains video of Petitioner on all occasions where Petitioner could be seen. T. 107. He estimated that during the 5 days of surveillance, he obtained seven to ten minutes of footage depicting Petitioner. T. 128. Upon Petitioner's objection to the edited version of the video, marked as RX 3B, the Arbitrator sustained the objection. T. 147. The Arbitrator admitted the unedited version of the video surveillance at RX 3 A, over Petitioner's further objection. T. 147-148.

Mr. Salgado testified that on 11/17/13, he obtained video of Petitioner using the leaf blower and that he stopped the video as soon as he thought Petitioner noticed him. In response, Petitioner testified that she was working with a leaf blower weighing 5 pounds and that at the time she was in physical therapy which helped her lift light amounts of weight. T. 131. Petitioner further testified that she was told to modify her activities and was performing the exercises given her by the therapists at the time the video was taken. T. 132. Petitioner was not asked and did not comment on whether she "spotted" the investigator while leaf blowing on 11/17/13.

The Arbitrator reviewed RX 3 A, the unedited video, in its entirety. The Arbitrator initially notes the RX 3A was admitted over Petitioner's objection at trial based on Petitioner's pre-trial viewing of the unedited version and his impression that the unedited version was in fact edited. T. 147. Specifically, counsel objected stating, "3A which purports to be an unedited version certainly is edited or doesn't accurately represent the Petitioner's activities during the period of time that she was under surveillance." T. 147-148. The Arbitrator notes that upon fully viewing the unedited video, the video is in fact unedited. In addition, although there are discrepancies between the video itself and the dates of surveillance listed on the video disc cover, the Arbitrator finds that these discrepancies do no mandate a finding that the unedited video was edited. The Arbitrator makes no change to her ruling regarding the admissibility of RX 3 A.

On 11/17/13, Petitioner is seen outside her home using a leaf blower. Petitioner is seen using the blower, climbing a few house steps and then going back down the steps holding the blower. The Arbitrator notes that on the way down the steps while holding the leaf blower Petitioner briefly held the stair railing. It is not clear whether she did so due to pain or for balance while holding a bulky leaf blower. Petitioner is then behind a pickup truck for a few minutes and out of vision. She then emerges from behind the truck still using the blower and looking down at the ground. Petitioner then looks up, briefly focuses on something in the direction of the street, and then directly places her hand on her right hip. She then continues to walk and use the blower with only her left hand for a few seconds thereafter until the video ends. Mr. Salgado testified that Petitioner saw him and as soon as she saw him she grabbed her right hip. He then testified that he had to stop the video as he heard Petitioner call to her husband and presumed the husband would appear. It is clear to the Arbitrator from the video that Petitioner saw Mr. Salgado and placed her hand on her right hip in response to the surveillance.

Finally, using a wage statement provided to her counsel before trial and marked for identification as PX 8, Petitioner testified that she was hired as a part time employee and earned $17.50 per hour. T. 31, 60. Petitioner further testified that she earned an additional $1.75 per hour for nights and $1.50 per hour for weekends. T. 32. From July 2012-October 2012 Petitioner worked three 8 hour shifts for a total of 48 hours in a two week period. In October 2012 Petitioner began working 3 overnight 12 hour shifts for a total of 72 hours in a two week period. T. 33. Petitioner's gross pay for the period of July 2012 to July 2013 is $29,336.35. T. 34. The total earnings include Petitioner's additional night and weekend pay during that period. T. 33-38. Petitioner testified that she was available to work more than her scheduled hours, could work more than her scheduled hours and did work more than her scheduled hours during certain weeks. T. 33-34. Petitioner was asked, "so you were available to work, it was just whether or not your employer had work for you, is that fair?" and she answered "yes." T. 34. On cross-exam, Petitioner testified that she did work a 40 hour week on at least one occasion from looking at PX 8 but could not tell how many times between July 2012 and July 2013 as she did not look at every page of the wage document. T. 61. Petitioner was not redirected on this issue. T. 63-67, T. 142-143.

PX 8 was used during the direct and cross of the Petitioner on the issue of wage. Petitioner offered PX 8 as an exhibit, however, Respondent objected to the admission of PX 8 on the basis of hearsay at trial. T. 137-140. The Arbitrator sustained the hearsay objection and PX 8 was rejected. T. 140. In so ruling, the Arbitrator stated that Petitioner's testimony was sufficient on the issue of wage. T. 139-140. After further discussion on the record, the Arbitrator offered Petitioner the opportunity for recall to provide additional testimony as to how many weeks she worked over her scheduled hours using the wage document identified. Petitioner was not recalled. T. 142-143. The Arbitrator notes that Petitioner did not raise the propriety of this evidentiary ruling as a disputed issue for the Arbitrator to consider in rendering this Decision.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law.

C. Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent? F. Is Petitioner's current condition of ill-being causally related to the injury? K. Is Petitioner entitled to any prospective medical care? 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?

The Arbitrator finds that Petitioner sustained accidental injury to her left hip arising out of an in the course of her employment for Respondent on 7/17/13. Petitioner testified that she did not have any prior pain or difficulty with her left hip nor did she ever have treatment to her left hip before 7/17/13. On that date, Petitioner, a woman of petite build, was performing her duties as an OB technician for Respondent. Petitioner testified that she was in the process of transporting a large, 250 pound patient by pushing the patient on a gurney out of the OR and through the hospital. Petitioner maneuvered the gurney through the elevators, halls and doorways of the hospital. Petitioner testified that while pushing the gurney into the NICU she stopped at the NICU desk. In order to start the pushing process again, Petitioner pulled the gurney back and then began to fully lunge forward to push the gurney. It was at that point, the Petitioner felt pain in her right buttock through her right hip.

The Arbitrator notes Petitioner's testimony that the NICU flooring was "rubber" and "sticky" and different from the other floors in the building. The Arbitrator also notes references in the medical records that the gurney was hampered by the floor surface. In finding accident, the Arbitrator relies on the above cited testimony with regard to the mechanism of injury – pushing a heavy gurney. In so finding, the Arbitrator notes that Petitioner did not specifically allege any involvement of the flooring in her accident. Further, the Arbitrator notes that any discrepancy between the accident history in the initial ER records and Petitioner's testimony are not sufficient to prevent a finding of accident based on a preponderance of the credible evidence. Finally, in finding accident, the Arbitrator notes that the majority of treating records reflect that Petitioner developed immediate pain in her right thoracic and lumbar areas with right hip pain developing within a few days of the accident. Petitioner reported the symptoms on the same day and then treated consistently thereafter.

Petitioner underwent PT and conservative care through September 2013 when she saw Dr. Mathew. Dr. Mathew read the 9/22/13 right hip MRI to show a "localized linear tear through the base of the anterosuperior aspect of the right acetabular labrum" and osteitis pubis. PX 2. On 9/27/13, Dr. Mathew explained the MRI results and that the linear labrum tear could be the cause of her hip pain and that the back pain could be due to right SI joint instability caused by the hip pain. If the pain did not subside Petitioner was to get a surgical referral. PX 2.

On 10/8/13, Petitioner sought care from her own physician, Dr. Nho. Dr. Nho read the MRI to note a labral tear and noted Petitioner's complaints of pain at 10/10 aggravated by all activities. The diagnosis was right hip labral tear and Petitioner was sent for a diagnostic and therapeutic steroid injection. Dr. Nho noted that if the injection provided lasting relief no surgery would be necessary but if the relief were only temporary then surgery would be likely. PX 4. Petitioner had the hip injection on 11/5/13 with Dr. Nho and on 11/26/13 Petitioner reported ongoing symptoms. Dr. Nho's impression was right hip labral tear secondary to underlying femoroacetabular impingement. Dr. Nho recommended a right hip arthroscopy, labral repair, possible acetabular rim trimming, debridement, synovectomy, femoral osteochondroplasty, and capsular plication. PX 4. Petitioner was kept off work while the surgery was pending. PX 4.

On 11/17/13, Petitioner was depicted on video surveillance leaf blowing at her home. The Arbitrator notes Petitioner's testimony that she was attending physical therapy during this time, which was helpful, and that the leaf blower only weighed 5 pounds. The depiction of Petitioner using a leaf blower alone is not detrimental to Petitioner's credibility. However, the Arbitrator finds that depiction of Petitioner using a leaf blower, realizing she is under surveillance, and then immediately and dramatically grabbing her right hip as if in pain, is detrimental to her credibility. Such a finding also detracts from the credibility of Petitioner's subjective complaints of continued pain to her treating doctors on which the surgical recommendation, in part, is based.

During his Section 12 exam of Petitioner, Dr. Lieber conducted a physical examination of Petitioner's hip including a range of motion examination. He found that Petitioner's range of motion for her right leg was "severely restricted due to pain." RX 4, p. 9. Dr. Lieber reviewed the right hip MRI from 9/22/13 and determined "that she showed evidence of osteitis pubis and an equivocal labral tear." RX 4, p. 10. He defined osteitis pubis as an inflammation of the cartilaginous fibrous disc area in the center of the pelvis area. He noted the degenerative condition is usually associated with childbirth. RX 4, p. 10. Dr. Lieber explained the labral tear was equivocal as it was shown on an MRI rather than on a more sensitive MRI arthrogram.

The Arbitrator further notes that Dr. Lieber viewed the 11/17/13 video and determined that it depicted movement and activity that did not "square" with Petitioner's demonstrated lack of range of motion during his exam of Petitioner's hip. RX 4, p. 12. He determined that the video supported his determination that Petitioner's complaints on physical exam were out of proportion and not consistent with the purported objective findings on the MRI. RX 4, p. 23. Dr. Lieber opined that Petitioner's right hip pain and low back inflammation was not related to her incident of 7/17/13 at work. He testified, "based upon the mechanism of injury, as well as the diagnostic findings, there does not appear to be a correlation between the event of July 2013 and that of the positive findings and physical exam and review of records that I utilized for my evaluation in December of 2013." He does not believe that Petitioner sustained any distinct injury to the right hip as a result of the incident. He opined Petitioner could return to her job and that she did not need additional treatment. RX 4, p. 13-14. On cross exam, Dr. Lieber

testified that he believed Petitioner sustained an aggravation of her preexisting degenerative pelvis condition in the incident and that Petitioner reached MMI for those symptoms as of October 1, 2013. Any symptoms after 10/1/13 were not related to the incident but rather solely to the degenerative condition. RX 4, p. 31.

Based on the Arbitrator's review of the video from 11/17/13, and on the foregoing opinions of Dr. Lieber with regard to Petitioner's condition, that being a temporary aggravation of her preexisting degenerative pelvis condition, the Arbitrator finds causal connection for Petitioner's symptoms through 11/17/13. Accordingly, the Arbitrator finds that Respondent shall pay Petitioner's reasonable and necessary medical expenses incurred in the care and treatment of her injury through 11/17/13 pursuant to Sections 8 and 8.2 of the Act with Respondent receiving credit for amounts paid, if any. Furthermore, based on a finding of causal connection through 11/17/13 only, the Arbitrator further finds that Petitioner is not entitled to the requested prospective medical care under Section 8(a) of the Act, including the right hip surgery recommended by Dr. Nho.

G. What were Petitioner's earnings?

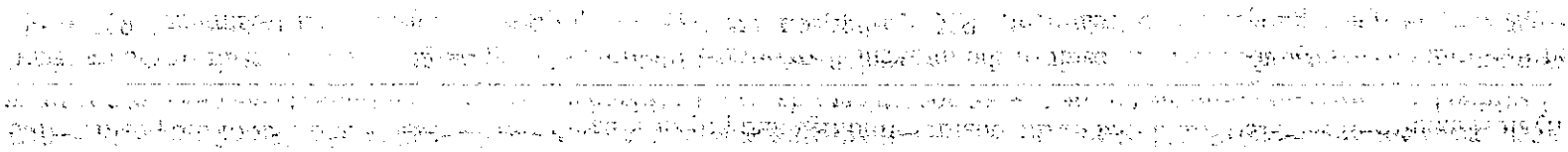
Based on the testimony offered at trial, the Arbitrator finds that Petitioner was hired as a part time employee and testified that she worked either a regularly scheduled 24 or 36 hours in a one week period. Petitioner worked a full 52 weeks before the injury of 7/17/13 and her total earnings during that period is $29,336.35. Using the first method of AWW calculation under Sylvester the Arbitrator finds that Petitioner's AWW is $564.16. Petitioner's TTD rate is $376.10.

L. What temporary benefits are in dispute? TTD/ TPD

Based on the Arbitrator's findings on the issues of accident, causal connection through 11/17/13, and on the off work authorizations of Petitioner's treating physicians, the Arbitrator further finds that Petitioner was temporarily and totally disabled for a period of 17-4/7 weeks commencing 7/18/13 through 11/17/13. Respondent shall pay same at the rate of $376.10. Respondent shall receive credit for amounts paid, if any.

M. Should penalties or fees be imposed upon the Respondent?

Based on the foregoing findings, the Arbitrator finds that Respondent's conduct was neither so unreasonable nor vexatious so as to merit the imposition of penalties or fees under Sections 19K, 19(l) or Section 16 of the Act.



STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David A. Alguire,
Petitioner,

vs. NO: 13 WC 35779

16IWCC0168

Chicago Transit Authority,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical expenses, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 15, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

16IWCC0168

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 10 2016

Joshua D. Luskin

o-02/24/16
jdl/wj
68

Ruth W. White

Charles J. DeVriendt

PROPERTY OF

Water in Motion

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

ALGUIRE, DAVID
Employee/Petitioner

Case# 13WC035779
13WC029062

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

16IWCC0168

On 9/15/2015, 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 0.26% 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:

1067 ANKIN LAW OFFICE
SCOTT GOLDSTEIN
162 W GRAND AVE SUITE 1810
CHICAGO, IL 60654

0515 CHICAGO TRANSIT AUTHORITY
DEREK FALLSTROM
515 W LAKE ST 6TH FL
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

☐ 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
19(b)

David Alguire
Employee/Petitioner

v.

Chicago Transit Authority
Employer/Respondent

Case # 13 WC 35779

Consolidated cases: 13 WC 29062

16IWCC0168

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 **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **July 8, 2015**. 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

16IWCC0168

FINDINGS

On the date of accident, **10-22-13**, 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 $**91,353.60**; the average weekly wage was $**1,756.80**.

On the date of accident, Petitioner was **57** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $**45,457.20** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**45,457.20**.

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

ORDER

Petitioner's bilateral knee condition is causally related to the incident of October 22, 2013.

Respondent shall pay reasonable and related medical expenses for the Petitioner's bilateral knee condition in the amount of $141.00 to Orthopaedics of North Shore pursuant to Section 8(a) and 8.2 of the Act.

Respondent is liable for past medical expenses incurred for treatment to Petitioner's bilateral knee condition.

Respondent liable for prospective medical care to Petitioner's bilateral knee condition, including but not limited to bilateral total knee replacement surgery prescribed by Dr. Silver.

Respondent shall pay Petitioner temporary total disability benefits of $ 1,171.07 / week for 89 1/7 weeks, commencing on October 23, 2013 through July 8, 2015, as provided in Section 8(b) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

Signature of Arbitrator

09-15-15
Date

SEP 15 2015

STATE OF ILLINOIS

COUNTY OF COOK

16IWCC0168

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

David Alguire 13 WC 35779

v.

Chicago Transit Authority

MEMORANDUM OF DECISION OF ARBITRATOR

This matter proceeded to trial on July 8, 2015. Petitioner testified that he works for the Chicago Transit Authority (CTA) as a machinist. He stated his job duties include running lathes, operating drill presses, and using grinders. Petitioner testified that he is responsible for cutting metal for parts for CTA buses and trains. He stated that certain tasks, such as removing screws from the bus floor board, require him to kneel down. Petitioner testified that he does not have to perform tasks involving kneeling every day.

Petitioner testified that over the 18 months prior to the October, 22, 2013 incident he felt general pain which he described as achy, normal discomfort. He filed a workers' compensation claim for repetitive trauma. Petitioner testified that he mentioned his discomfort from kneeling to his manager during a discussion about different techniques available for working on the bus floors.

Petitioner stated that on October 22, 2013 he was performing his normal job duties. He was cutting metal on a lathe when he twisted his right knee as he reached for a part on the other end of the lathe. His right foot "kinda stuck" to the rubber mat, as a result it twisted and he fell to the floor. Petitioner testified that he felt his right knee pop. At the time, he was standing on a rubber mat and was wearing safety shoes. Petitioner testified that he initially sought treatment at the emergency room and then sought treatment with Dr. Ronald Silver.

Petitioner stated that on October 23, 2013, Dr. Silver ordered an MRI of his right knee, which was performed on November 4, 2013. Dr. Silver also prescribed physical therapy. Petitioner stated he followed up with Dr. Silver after his MRI and Dr. Silver recommended surgery. He stated he underwent right knee surgery on January 15, 2014.

Petitioner testified that the day following his surgery, he was at his home. He stated he got up to go to the bathroom. As he washed his hands, he splashed water onto the hardwood floor. Petitioner stated that the tip of his crutch made contact with a wet spot on the floor and slipped. He fell onto his left knee. Petitioner testified that he was using crutches he was given either by Dr. Silver or at his emergency room visit.

Petitioner stated that after he slipped and fell onto his left knee he did not seek medical treatment but instead waited until his next appointment with Dr. Silver. At his next office visit, Dr. Silver recommended an MRI of Petitioner's left knee and then recommended surgery. Left knee surgery was performed on May 9, 2014.

As accident was not disputed, the Petitioner received workers' compensation benefits until June 29, 2014. He testified that Dr. Silver has recommended bilateral knee replacement surgery. Petitioner continues to treat with Dr. Silver.

On cross-examination Petitioner agreed he worked out of the South Shops. He testified that he had filed prior short term disability and workers' compensation claims. Regarding the repetitive trauma claim, Petitioner testified that he did not remember when he discussed the kneeling complaints with his supervisor. He stated he never completed any injury on duty paperwork regarding that claim.

Petitioner stated he was at his home the day after his right knee surgery when he fell injuring his left knee. He testified that he caused water to splash onto the floor of the bathroom in his home while washing his hands. He agreed this could've happened at any time while washing his hands. Petitioner stated there was nothing defective with the crutches at the time of his fall.

Petitioner stated he underwent an Independent Medical Examination (IME) with Dr. Joshua Jacobs on June 23, 2014. He testified he was truthful and honest with Dr. Jacobs during the examination. Respondent's doctor stated the Petitioner suffers from bilateral osteoarthritis and degenerative meniscal tears. Both conditions were pre-existing. The Petitioner could return to work with restrictions. Any work or home injury was simply a temporary exacerbation of a pre-existing condition. Petitioner was at maximum medical improvement, but agreed with Dr. Silver's opinion that the Petitioner needed bilateral total knee replacement surgery.

F. CAUSAL CONNECTION

The Arbitrator finds that both knee conditions were permanently aggravated, accelerated or exacerbated by his work accident on October 22, 2013..

Regarding Petitioner's right knee, Petitioner initially treated with Dr. Ronald Silver on October 22, 2013.. PX 1 p.7. Dr. Silver ordered an MRI, which revealed a torn medial meniscus of Petitioner's right knee. Id. at 10. Dr. Silver recommended arthroscopic surgery, which he performed on 1/15/2014. Id. at 11. The surgery consisted of partial medial and lateral meniscectomies, a synovectomy, removal of adhesions, and removal of loose cartilage. Id. Dr. Silver also noted severe cartilage damage. Id. Following the right knee surgery, Petitioner testified that his knee felt better temporarily.

Petitioner continues to treat with Dr. Silver for his right knee. Dr. Silver has recommended right knee replacement surgery. He opines that the need for the surgery is due to the October 22, 2013 accident.

Petitioner underwent an IME with Dr. Joshua Jacobs on June 23, 2014. RX 1 ex. 2. Dr. Jacobs is a Professor and the Chairman of the Department of Orthopaedic Surgery at Rush Medical College and the Senior Attending Orthopedic Surgeon at Rush University Medical Center. RX 1 ex. 1. Dr. Jacobs reviewed Petitioner's treatment records and physically examined him. RX 1 ex. 2. He diagnosed Petitioner with bilateral osteoarthritis of the knees. RX 1 p. 9. Dr. Jacobs testified that osteoarthritis is a wear and tear, degeneration, of the cartilage in the knee. Id. He testified that the right knee arthroscopic medial meniscal repair was related to the 10/22/2013 incident. RX 1 p. 15. However, Dr. Jacobs testified that the cause of Petitioner's current complaints is pre-existing osteoarthritis of his knees. RX 1 p. 11. He testified that he believes Petitioner's condition to be pre-existing because the findings on the radiographs showed joint space narrowing as early as the day of his injury and also Petitioner's history of knee pain for at least 18 months prior to this injury. Id. Dr. Silver had an opportunity to review Dr. Jacobs' report on 8/01/2014 and agreed that Petitioner has pre-existing degenerative arthritis of both knees. PX . While Dr. Jacobs did agree that Petitioner requires a right total knee replacement, he opined the need for that procedure was caused by Petitioner's pre-existing osteoarthritis. RX 1 pp. 12-13. He stated that Petitioner's osteoarthritis is progressive in nature and the typical outcome is a knee arthroplasty. Id. at 18.

Respondent disputes that the need for further medical treatment to Petitioner's right knee is causally connected to the October 22, 2013 injury. The Arbitrator disagrees. The Arbitrator finds the opinion of Dr. Jacobs less credible and persuasive than that of the treating physician, Dr. Silver. Dr. Jacobs based this opinion on his examination of Petitioner and review of the treatment records and diagnostics. Specifically, Dr. Jacobs indicated the findings on the radiographs of Petitioner's bilateral knees showed joint space narrowing as early as October 22, 2013, in addition to bilateral tricompartmental osteoarthritis. While it is true that Petitioner suffered from knee pain for at least 18 months prior to the injury, he did not a significant amount of lost time from work and had no prescription for knee surgery.

Based on the evidence presented by both parties and Petitioner's testimony, the Arbitrator finds that Petitioner's current right knee condition is causally related to the October 22, 2013 incident.

Regarding Petitioner's left knee, Petitioner testified that he injured his left knee on January 16, 2014, the day following his right knee arthroscopy. He stated he was at his home and proceeded to use the bathroom. Petitioner testified that while washing his hands he splashed water onto the hardwood floor of the bathroom. The tip of one of the crutches he was using came into contact with the water he had splashed on the floor and slipped. Petitioner testified that he fell to the floor. He testified there was nothing defective with the crutches. Petitioner testified that he did not seek immediate treatment after the fall, but waited until his next appointment with Dr. Silver to have his left knee examined.

Petitioner saw Dr. Silver on January 29, 2014 where an MRI of the left knee was prescribed and later performed on February 7, 2014. It revealed a left knee torn medial meniscus. Id. Dr. Silver recommended arthroscopic surgery. Dr. Silver felt the left knee injury was related to the original accident because Petitioner was allegedly using crutches when he

injured his left knee and the need for crutches was due to surgery on his right knee. Id. Petitioner underwent left knee arthroscopic surgery on May 9, 2014. He testified that he felt relief temporarily following surgery. Dr. Silver has since recommended left knee replacement surgery.

The Arbitrator finds that Petitioner's left knee condition is causally connected to the October 22, 2013 incident. Petitioner admittedly injured his left knee at home on or about January 16, 2014. The injury occurred when he slipped and fell on a wet floor. The floor was wet due to Petitioner himself splashing water on the floor while washing his hands. Although Petitioner testified he was using crutches at the time, because he was recovering from his right knee surgery, he testified that the crutches were in no way defective.

Accordingly, the Arbitrator finds causal connection between Petitioner's left knee condition and the October 22, 2013 accident.

J. MEDICAL

Based on the medical evidence and Petitioner's testimony, the Arbitrator finds that Respondent is liable for reasonable and related medical expenses related to both knees.

K. PROSPECTIVE MEDICAL

Based on the medical evidence and Petitioner's testimony, the Arbitrator finds that Respondent is liable for prospective medical expenses for treatment to both Petitioners' knees including bilateral total knee replacement surgeries.

L. TTD

Based on the medical evidence and Petitioner's testimony, the Arbitrator finds that TTD benefits were appropriately paid from October 23, 2013 to July 29, 2014 and shall receive a credit in the amount of $45,457.20 for the same. Further TTD benefits are due to the present.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Angela Lampkin,
Petitioner,

vs.

Chicago Board of Education,
Respondent,

NO: 14 WC 479

16IWCC0165

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses, temporary total disability, permanent disability and the Respondent's untimely filing of its proposed decision and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission affirms the Arbitrator's findings in regard to Petitioner's current left ankle condition and alleged CRPS condition but reverses the Arbitrator on whether Petitioner's pre-existing plantar fascia condition was aggravated by the November 5, 2013 work accident and whether Petitioner's current plantar fascia condition is related to the November 5, 2013 work accident. The Commission finds Petitioner consistently and continuously treated for the aggravation of her pre-existing plantar fasciitis after the November 5, 2011 work accident. Having exhausted all of the conservative methods of treatment, the Commission finds that the surgery was warranted for the plantar fasciitis condition. The Commission assigns no weight to the Arbitrator's speculation as to whether or not Petitioner would have needed the surgery regardless of the November 5, 2011 work accident.

The Commission notes that the Arbitrator took issue with Dr. Martin's September 17, 2014 "To Whom It May Concern" letter and found that it was generated for the purpose of litigation. Upon reviewing Dr. Martin's records it is evident that the doctor generated "To Whom It May Concern" letters after each encounter with the Petitioner and that they summarized, for the most part, what was contained within his treating records. As such, the Commission viewed the "To Whom It May Concern" letters as part and partial of the doctor's treating records and

16IWCC0165

finds that they were not generated for the purpose of litigation.

Petitioner's attorney claims that the above captioned claim was filed under Section 19(b) of the Act and that the Arbitrator should not have made a permanency determination. The Commission finds that the Request for Hearing Form, Line 10 states N & E is in dispute; on page 4 of the Arbitration Hearing transcript the Arbitrator orally stated disputed issues are...nature and extent and the parties agreed, and on page 2 of the Arbitration decision, the Arbitrator listed nature and extent as being in dispute. Given the above, the Commission finds the Arbitrator did not err in ruling on the issue of permanency. While the Petitioner's attorney also claims that the Arbitrator erred in accepting Respondent's alleged late proposed decision, the Commission notes that there is no remedy under the Act to address this claim.

As a matter of housekeeping, the Commission finds that "Respondent's proposal" should be stricken from case caption on page 1 of the Arbitrator's decision. The Commission notes that on page 2 of his decision the Arbitrator noted Petitioner is entitled to temporary total disability benefits through January 2, 2015, the date of Dr. Holmes second independent medical record, while on page 7 of his decision he states that Petitioner is entitled to temporary total disability through March 19, 2014, the date of Dr. Holmes' first independent medical evaluation. The Arbitrator further found Petitioner was temporarily totally disabled of 60-3/7 weeks. Upon reviewing the evidence, the Commission finds that the proper temporary total disability period is November 6, 2013 through January 2, 2015 for a period of 60-3/7 weeks. Additionally, while the Arbitrator indicated in the Order language that temporary total disability benefits should be awarded under Section 8(e) of the Act, the proper section is Section 8(b) of the Act. The Commission finds based on Petitioner's average weekly wage of $1,980.05 that Petitioner's temporary total disability rate should be should be $1,320.03 and not $1,320.69 as the Arbitrator indicated in his decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,320.03 per week for a period of 60-3/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $721.66 per week for a period of 13.36 weeks, as provided in §8 (e) of the Act, for the reason that the injuries sustained caused the 8% loss of use of the left foot.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for $73,544.53 paid to or on behalf of Petitioner on account of said accidental injury.

16IWCC0165

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 9 - 2016

MB/jm

O: 2/25/16

43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LAMPKIN, ANGELA
Employee/Petitioner

Case# **14WC000479**

16IWCC0165

CHICAGO BOARD OF EDUCATION
Employer/Respondent

On 8/10/2015, 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 0.16% 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:

1927 HUGHES SOCOL PIERS RESNICK
MARK WEINER
70 W MADISON ST SUITE 4000
CHICAGO, IL 60602

0559 CHICAGO BOARD OF EDUCATION
MICHAEL COHEN
1 N DEARBORN ST SUITE 900
CHICAGO, IL 60602

16IWCC0165

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ 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
RESPONDENT'S PROPOSAL

Angela Lampkin
Employee/Petitioner

v.

Chicago Board of Education
Employer/Respondent

Case # 14 WC 00479

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 **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago, April 30, 2015.** 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 *November 5, 2013*, 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* in part causally related to the accident.

In the year preceding the injury, Petitioner earned **$81,181.85**; the average weekly wage was **$1,980.05.**

On the date of accident, Petitioner was **47** years of age, ***single*** with **0** dependent children.

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$73,544.53** for TTD, **$ 0** for TPD, $ 0 for maintenance, and **$ 0** for other benefits, for a total credit of **$73,544.53**.

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 **$1,320.69**/week for **60 & 3/7** weeks, commencing *November 5, 2013* through **January 2, 2015**, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **November 5, 2013** through **January 2, 2015**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of **$73,544.53** for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of **$721.66/week** for **13.36** weeks, because the injuries sustained caused the **8%** loss of the left foot, 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.

Signature of Arbitrator

August 7, 2015
Date

AUG 10 2015

Angela Lampkin v. Chicago Board of Education
14 WC 0479

INTRODUCTION

This matter proceeded to hearing on April 30, 2015 before Arbitrator Steven Fruth. The disputed issues were: ***F:*** Is Petitioner's current condition of ill-being causally related to 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? TTD; ***L:*** What is the nature and extent of the injury?

Petitioner testified at hearing. Both parties submitted exhibits in evidence.

FINDING OF FACTS

Petitioner, age 47, a teacher at Oglesby School, tripped over a student's chair and fell on November 5, 2013. She felt sharp pain to the left foot and ankle. She was transported by ambulance to the Emergency Department of St. Bernard Hospital (PX #1) on November 5. X-rays were negative for fracture. Petitioner was discharged with the diagnosis of ankle sprain.

She followed up with Dr. Paul Martin, DPM, (PX #2) on the day of her accident. Petitioner's history of diabetes, irritable bowel syndrome (IBS), and hypertension was noted. Dr. Martin found tenderness over the left heel and the left lateral ankle and mid-foot. There was no edema or erythema. Dr. Martin found guarded full range of motion and no instability. There was no fracture. Dr. Martin diagnosed was left ankle sprain/strain, left foot sprain/strain, and plantar fibromatosis. He applied a fiberglass cast boot.

Dr. Martin addressed a letter To Whom It May Concern on November 5, 2013. In that letter Dr. Martin stated that Petitioner had an acute exacerbation of plantar fasciitis and that she should be off work until November 8. He wrote another To Whom letter on November 11, 2013 stating that Petitioner had an acute foot and ankle sprain in addition to chronic plantar fasciitis.

Petitioner's cast was repaired on November 12, 2013. There was no examination on that day. A short-leg cast was applied on November 26, 2013. On November 26 Dr. Martin noted Petitioner's persistent point tenderness over the talofibular and calcaneofibular ligaments. There was no tenderness at the peroneal tendon complex. He found the ankle mortise was stable. He also found intact sensation and no paresthesias. Dr. Martin noted that the ankle sprain was healing without event and that the plantar fasciitis was improved.

Petitioner returned to Dr. Martin on December 17, 2013. Dr. Martine noted she had recurrent plantar fasciitis preceding her accident. Petitioner reported resolution of her plantar and calcaneal pain but still had ankle stiffness and discomfort. She reported resolution of her plantar pain. On exam Petitioner's sensation was intact and there was no paresthesia. The ankle mortise was intact and stable. Dr. Martin found tenderness at the anterior talofibular (ATF) ligament. Dr. Martin noted that sprain was healing and that the

plantar fasciitis was improved. Orthotics were advised. Physical therapy was discussed and ordered.

Dr. Martin wrote To Whom letters on December 17, 2013, January 14, 2014, and February 11, 2014. On December 17 he stated Petitioner had had been immobilized for 6 weeks and had persistent tenderness with her ankle sprain and left "hand" (sic) plantar fasciitis. On January 14 he noted that physical therapy had been ordered and that Petitioner was unable to return to work. On February 11 he noted that Petitioner continued to have pain with activities with daily living. He advised continued physical therapy. He extended Petitioner off work with a return to work on March 10.

Petitioner started physical therapy on January 7, 2014 at Sports and Authority Physical therapy (Sports). Petitioner gave a history of being tripped by one of her students. She also gave a history being casted for plantar fasciitis before that due to failed injections. Petitioner reported that she had suffered a hairline fracture from her fall on November 5, 2013. She reported her pain at 4/10. The assessment was recent flare up of plantar fasciitis due to tripping injury at work. On February 27 Petitioner reported increased left foot pain which affected her gait and now caused knee pain. It was noted that Petitioner had not been compliant with the treatment plan due to other health issues. Petitioner was informed that she would be discharged if her noncompliance continued.

Petitioner returned to Dr. Martin on March 10, 2014. She reported that therapy had helped but that she had difficulty in keeping her schedule due to her IBS. She was having trouble navigating stairs. On exam he found full range of motion in the left ankle. He found no instability; in fact stability was good. There was no effusion. There was tenderness over the medial calcaneal tubercle at the origin of the plantar fascia. There was also tenderness of the posterior tibial tendon. There was no tenderness to the peroneal tendons. His assessment was bilateral plantar fasciitis, tibialas posterior tendinitis, and peroneal tendinitis. However, Dr. Martin did note that the tibial and peroneal tendinitis were not related to Petitioner's injury. He noted that Petitioner was still unable to work.

Dr. Martin renewed his order for therapy on March 31, 2014. Petitioner returned to Sports on March 31. She reported a flare-up around her left Achilles tendon at the plantar fascia origin. Abnormal gait with absent heel strike was noted. Petitioner continued with therapy through April 21. On April 21 Petitioner was unable to stand or walk for more than 30 minutes without increased pain. Petitioner also complained of pain with using stairs. She reported balance problems due to her pain. It was noted that Petitioner had achieved minimal progress. It was noted that Petitioner was still noncompliant with the therapy regimen due to other health problems.

Dr. Martin saw Petitioner again on April 12, 2014. She had continuing pain. On exam Petitioner had full range of ankle motion without instability. There was no note regarding effusion. The assessments were bilateral plantar fasciitis and ankle sprain/strain.

On May 9, 2014 Dr. Martin saw Petitioner again. On exam he found no paresthesias. Range of motion was full but was guarded. The ankle was stable and there was no effusion. He diagnosed sprain/strain of the foot, peroneal tendinitis, and plantar fasciitis. He recommended an MRI with contrast to assess the peroneal tendons. Petitioner returned on May 20 to discuss the MRI. Dr. Martin reviewed the CD images and noted attenuation without complete rupture of the ATF ligament. Peroneal tendons were intact. There was no

note regarding stability of the left ankle. Dr. Martin then noted that peroneal tendinitis was associated with the left ankle sprain.

Petitioner returned to Dr. Martin on June 9, 2014. She still left foot and ankle discomfort. There was point tenderness associated with the ATF ligament. There was no notation regarding range of motion or joint stability or effusion. Dr. Martin noted that the MRI showed attenuation of the ATF ligament without complete rupture. He applied a new cast to immobilize the ankle. In a To Whom letter of that date Dr. Martin described persistent effusion and persistent moderate to severe plantar fasciitis.

On July 14, 2014 Dr. Martin found a full range of motion with some guarding. He did not note whether he found effusion or instability. He noted Petitioner's primary problem was plantar fasciitis. He also noted that Petitioner had failed conservative care including orthotics, injectable corticosteroids, physical therapy, and immobilization. Petitioner declined another injection. A Topaz procedure was discussed. He continued to keep Petitioner off work.

Petitioner returned to Dr. Martin on August 15, 2014. Although Petitioner had continuing complaints of left ankle discomfort she was in no acute distress. He noted that Petitioner's ankle had been immobilized for a total of 3 months. Dr. Martin noted persistent instability at this exam. He found gross instability on Drawer, indicating ATF ligament rupture. There was no note regarding effusion. He was now diagnosing internal ankle derangement along with plantar fasciitis. Dr. Martin was recommending a Topaz procedure (radiofrequency ablation) for the plantar fasciitis and a Brostrom procedure for repair of the ATF ligament. In a To Whom letter of that date Dr. Martin noted persistent and severe pain of the left ankle and persistent instability consistent with ATF ligament rupture.

On August 20, 2014 Dr. Martin filled in a Health, Accident, & Disability Claim Form. He reported the date of first symptom or date of injury as May 16, 2014. His diagnoses were left lateral ankle sprain, severe, and left plantar fasciitis, recurrent. Dr. Martin noted Petitioner's total disability to be from May 16 to November 11, 2014. He also noted that Petitioner was unable to walk or stand for prolonged periods.

On September 11, 2014 Petitioner was admitted to Advocate Christ Medical Center (PX #3) for same-day surgery. Petitioner's admitting history and physical exam notes documented the medical history of diabetes mellitus, hypertension, irritable bowel syndrome (IBS), and anxiety. She was on medication for diabetes, hypertension, and IBS. She was noted at 5'4" tall and 260 pounds. Dr. Martin, assisted by Sarah Miller, DPM, performed a repair of a rupture of the left ATF ligament with a graft and micro-ablation of the plantar fascia. Petitioner had routine post-operative pain and was discharged.

Petitioner was seen at the Pain Center of Christ Medical Outpatient Center in Lockport by Dr. Ebby Jido on January 7, 2015 for an evaluation of her continuing complaints of left foot pain. Dr. Jido documented his assessment to Dr. Farbstein, Petitioner's primary physician. Dr. Jido noted Petitioner's history which included her fall in November 2013 when she plantar-flexed and "tore her tendon". Surgery under general anesthesia was on September 11, 2014. Dr. Jido noted that one of the ligaments was practically shredded. Petitioner reported that when she woke up from surgery she had severe pain with increased sensitivity. Petitioner complained that her foot was very sensitive to touch. It was painful to wear socks. Tourette-like symptoms of jerking were also reported by Petitioner. Dr.

Farbstein had apparently discussed the possibility of complex regional pain syndrome (CRPS) with Petitioner.

On exam Dr. Jido found no swelling or temperature changes. He noted paresthesias without specifying where in the foot. He found no allodynia (ordinary nonpainful stimuli causing pain). He diagnosed a sympathetically mediated pain, possible CRPS involving the left foot. He scheduled Petitioner for a nerve block injection with consideration for physical therapy after the injection.

On March 25, 2015 Dr. Jido wrote a narrative report To Whom It May Concern. This was included in PX #3. In that letter Dr. Jido reported that he had seen and treated Petitioner for CRPS. He stated that the condition occurred when Petitioner fell while teaching. He noted that Petitioner had flexed her foot when she fell and lacerated multiple ligaments in her left ankle. He noted that when petitioner awoke from her surgery she experienced severe pain with increased sensitivity over the left foot up into the shin. He stated his diagnosis was CRPS with a poor prognosis. He added that Petitioner's condition was unable to perform her duties as a teacher and was permanently disabled due to a condition which cannot be cured.

Petitioner was examined at Respondent's request pursuant to § 12 of the Act by orthopedic surgeon George Holmes, M.D. (RX #1 & RX #2) Dr. Holmes examined Petitioner on March 19, 2014. Dr. Holmes had reviewed medical records from Dr. Martin as well as x-rays taken on the date of the exam. Dr. Holmes summarized Petitioner's medical care up to the date of the exam from Petitioner's history and from Dr. Martin's notes.

Petitioner's chief complaint at the exam was shooting pain in the heel of the left foot, the arch of the foot, and the lateral aspect of the foot. She reported that she was unable to work as a teacher due to intolerable pain. On exam Dr. Holmes found full range of ankle, subtalar, and foot motion. The ankle mortise was stable. Petitioner complained of pain on palpation over a large area of the foot and ankle.

In his March 21 report (RX #1) Dr. Holmes found no objective, definable injury. He believed the mechanism of injury did not correlate with objective findings. He noted that there was no atrophy which would normally be associated with Petitioner's period of immobilization. Further, Dr. Holmes believed that petitioner's subjective complaints were causally related to her work injury, despite the absence of objective findings. Dr. Holmes questioned the prescription of a Medrol Dosepak. He stated that that prescription is contraindicated for patients with diabetes. While Petitioner's initial physical therapy was reasonable Dr. Holmes did not think additional therapy would be helpful given that lack of a definitive diagnosis

Dr. Holmes did not then believe Petitioner was at MMI. He recommended an MRI to better assess Petitioner's injury.

Dr. Holmes wrote an addendum on January 5, 2015 (RX #2) after a review of additional medical records. Those records included Dr. Martin's chart notes since the exam in 2014. He also reviewed the Form 45 First Report of Injury, the September 11, 2014 operative report, and physical therapy notes. After that review Dr. Holmes opined that Pettioner's surgery on September 11, 2014 was not medically necessary or related to Petitioner's work accident on November 5, 2013. His opinion was based on four factors:

1) There was no evidence of instability on physical examination by the podiatrist.
2) There was no evidence of talar tilt on examination.
3) The MRI did not indicate pathology that required surgical intervention. There was not a complete tear of the ATF ligament as noted on the MRI. Medical literature indicates that surgery is not indicate for a partial tear without instability
4) Petitioner's pain was not consistent with an ATF ligament injury. Petitioner's pain was consistent to sural nerve neuropathy. These disorders are more commonly associated with diabetes and related neuropathy.

Dr. Holmes also opined that the MRI did not show specific pathology of the plantar fascia. Therefore, Dr. Holmes did not believe that the Topaz surgery was medically indicated or necessary. The September 11, 2014 surgery would not have been a recommended course of treatment based on subjective complaints. Dr. Holmes found Petitioner was at MMI and was able to return to work prior to her surgery. He did note believe that medical care, including the surgery, subsequent to his examination on March 19, 2014 was related to Petitioner's injury.

CONCLUSIONS OF LAW

F: Is Petitioner's current condition of ill-being causally related to the accident?

The Arbitrator finds that Petitioner failed to prove that her current condition of ill-being was causally related to the workplace accident on November 5, 2013. The Arbitrator finds that Petitioner sustained a sprained left ankle and an aggravation to pre-existing plantar fasciitis as a result of the workplace injury on November 5, 2013

Petitioner presented evidence of causation opinions expressed by Paul Martin, DPM and Ebby Jido, M.D. in support of her claim of current ill-being. In a narrative letter dated September 17, 2014 addressed To Whom It May Concern Dr. Martin opined that Petitioner had sustained a rupture of her left anterior talofibular ligament as a direct result of her workplace injury on November 5, 2013. Dr. Martin also found that Petitioner had sustained an aggravation of pre-existing plantar fasciitis to her left foot as a result of the workplace injury in November 2013. Dr. Martin's September 15 letter is of the nature of a narrative report prepared for the purposes of litigation rather than in the course of care and treatment of Petitioners claimed injuries.

The Arbitrator does not find Dr. Martin's opinions that Petitioner sustained a rupture of her left anterior talofibular ligament as persuasive. A ligament is an essential component of the stability of a joint. A ruptured ligament would necessarily result in some degree of joint instability. Dr. Martin documented his assessment of the stability of Petitioner's left ankle throughout the course of his care and treatment of Petitioner's injury. He specifically noted findings of joint stability or lack of instability, along with full range of motion, on November 5, November 26, and December 17, 2013. He also found the left ankle was stable or lacking instability on March 10, April 12, and May 9, 2014. Petitioner consistently exhibited full range of ankle motion over that same period of time.

Dr. Martin first noted a finding of left ankle joint instability on August 15, 2014. 9 months passed from the time Petitioner tripped and fell to the first documentation of a clinical sign of ligament rupture. In addition, Dr. Martin's credibility is questionable when he states in his To Whom letters of August 15 and September 17 that Petitioner suffered from "persistent" instability when the clinical record clearly shows otherwise. The Arbitrator takes note that Dr. Martin's causation opinions are set forth in narrative "To Whom It May Concern" letters. These letters are of the type generated for the purposes of litigation rather than relating to therapeutic care. As such, the Arbitrator does not find the causation opinions within those letters persuasive.

The Arbitrator does find the opinion of Respondent's § 12 physician, Dr. Holmes, that there was no definable injury to Petitioner's left ankle to be persuasive. The Arbitrator also finds Dr. Holmes' opinion that surgery for Petitioner's ankle injury was not medically indicated

Dr. Jido prepared a letter dated March 25, 2015 addressed To Whom It May Concern in which he opined his diagnosis of Petitioner's condition was complex regional pain syndrome of the left foot. He stated that the condition occurred while Petitioner was at work as a teacher when she tripped and fell. He further opined that Petitioner's condition was permanently disabling and prevented Petitioner from engaging in her employment as a teacher. He further stated that the condition cannot be cured.

Dr. Jido's March 25, 2015 To Whom letter is also of the type of letter generated for the purposes of litigation rather than for therapeutic care. His opinions are based on his one clinical evaluation of Petitioner on January 7, 2015. At that time Petitioner gave a history of waking up with severe pain after her surgery on September 11, 2014. The clinical records following that surgery, both in the hospital and as out-patient, do not document pain complaints of that degree. In his clinical notes on January 7 Dr. Jido noted there was no swelling or temperature changes. These clinical signs are commonly associated with CRPS. He did not find allodynia which is also a clinical sign associated with CRPS. In his clinical notes Dr. Jido stated that Petitioner's condition was "possible" CRPS. Clearly, Dr. Jido had not come to a definitive diagnosis of CRPS on January 7, 2015.

Dr. Jido's causation opinion regarding CRPS is based on only one clinical encounter and, more importantly, the reliability of Petitioner's subjective complaints and history of her condition. Petitioner's history of awaking from her surgery in severe pain is clearly not true. In addition, the Arbitrator takes note of Petitioner's erroneous report to her physical therapist that she sustained a hairline fracture was also untrue. It is clear that Petitioner's reliability as an accurate reporter of her medical history and subjective comaplints is suspect.

Dr. Jido's causation opinion expressed in his March 25 To Whom letter is inconsistent with his own clinical notes. It is also dependent on the questionable reliability and accuracy of Petitioner's subjective complaints and her reports of her history. Therefore, the Arbitrator does not accept Dr. Jido's opinion that the trip and fall Petitioner experienced on November 5, 2013 caused or was related to the suspected complex regional pain syndrome.

Accordingly, the Arbitrator finds that Petitioner failed to prove that she sustained anything more than a sprained left ankle which aggravated pre-existing plantar fasciitis.

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?

For reasons stated above the Arbitrator finds that Petitioner sustained a left ankle sprain which resulted in an aggravation of pre-existing plantar fasciitis. The Arbitrator finds the opinions of Respondent § 12 physician, Dr. Holmes, persuasive regarding necessary and reasonable medical care. Dr. Holmes opined that, lacking a definitive injury, Pettioner's medical care up to March 19, 2014, the date of his examination of Petitioner, was reasonably necessary. The Arbitrator finds Dr. Holmes' opinion that surgery was not medically indicated for an incomplete tear of that ATF ligament.

The fact that Petitioner in fact had surgery repairing her ATF ligament does not, per force, prove that the surgery was necessary to cure or alieve any injury sustained on November 5, 2013. For reasons stated above the Arbitrator finds that Petitioner's clinical record failed to show clinical signs indicating a ligament tear before August 15, 2014. The passage of time between the injury and the appearance of documented ankle instability tends to break the chain of events causation and thus the medical necessity nexus.

In addition, the clinical records clearly show that Petitioner suffered from plantar fasciitis for some time before her injury on November 5, 2013. She had been treated in some fashion before her trip and fall at work. Common sense leads to the obvious conclusion that the fall could have aggravated that pre-existing condition. However, there is not clear evidence in the clinical records that the radiofrequency ablation of Pettioner's plantar fascia on September 11, 2014 was medical necessary to cure or alieve the aggravation of the plantar fasciitis. It is unknown, given Petitioner's history, whether she would have needed that procedure even if the fall had not aggravated the condition. The Arbitrator finds that Petitioner failed to meet her burden of proof that the radiofrequency ablation was medically necessary to cure or alieve any injury sustained in Petitioner's workplace fall on November 5, 2013.

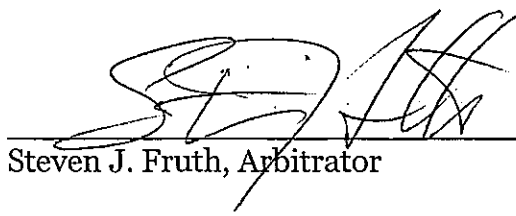
Therefore, the Arbitrator finds that the reasonable and necessary medical care for Petitioner's work-related left ankle injury was incurred from November 5, 2013 through March 19, 2014. Such medical expenses shall be paid by Respondent in accord with the Fee Schedule.

K: What temporary benefits are in dispute? **TTD**

In accord with the above stated findings that Petitioner sustained a sprained left ankle which aggravated her pre-existing plantar fasciitis and that she received reasonably necessary medical care through March 19, 2014, the Arbitrator finds that Petitioner is entitled to Total Temporary Disability benefits through March 19, 2014.

L: What is the nature and extent of the injury?

For the reasons stated above the Arbitrator finds that Petitioner sustained a sprained left ankle which aggravated pre-existing plantar fasciitis when she fell at work on November 5, 2013. The Arbitrator finds, based in review and consideration of all of the evidence, that Petitioner sustained an 8% loss of use of a foot as a result of her workplace injury on November 5, 2013.



Steven J. Fruth, Arbitrator

August 7, 2015
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal-denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jacob Bradford,
Petitioner,
vs.

16IWCC0131

NO: 14 WC2351

City of Peoria,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of nature and extent of Petitioner's permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 27, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 24 2016
KWL/vf
O-2/22/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0131

BRADFORD, JACOB
Employee/Petitioner

Case# 14WC002351

CITY OF PEORIA
Employer/Respondent

On 5/27/2015, 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 0.08% 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:

5354 STEPHEN P KELLY LLC
2710 N KNOXVILLE AVE
PEORIA, IL 61604

0980 HASSELBERG GREBE SNODGRASS
JOHN DUNDAS
124 S W ADAMS ST SUITE 360
PEORIA, IL 61602

STATE OF ILLINOIS)
)SS.
COUNTY OF **PEORIA**)

☐ 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 16IWCC0131

Jacob Bradford
Employee/Petitioner

v.

City of Peoria
Employer/Respondent

Case # **14** WC **2351**

Consolidated cases: _____

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 **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Peoria**, on **April 16, 2015**. 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 **01/19/2014**, Petitioner ***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 alleged 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 $**98,800.00**; the average weekly wage was $**1,900.00**.

On the date of accident, Petitioner was 32 years of age, ***single*** with **0** dependent children.

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

ORDER

- **The Arbitrator finds that the Petitioner's condition of ill-being was causally related to the work accident of January 19, 2014.**

- **The Petitioner sustained injuries sustained injuries to the extent of 2% loss of use of the man as a whole, in addition to the statutory loss of 12 weeks for the fracture of two vertebra set forth in Section 8 (d) (2) of the Act. The Respondent is entitled to credit for payment of said statutory benefits.**

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.

D. R. McCarthy
Signature of Arbitrator

May 19, 2015
Date

MAY 27 2015

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

1. The Petitioner was employed as a police officer for the City of Peoria for the past ten (10) years. Petitioner testified his job included doing police work out on the streets in the City of Peoria. This job required him to apprehend suspects, protect the public, and perform general police activities.

2. On January 19, 2014, Petitioner was engaged in work activities and trying to apprehend a suspect. There was snow on the ground when the Petitioner left his vehicle. The Petitioner was traversing a snowy driveway when he fell.

3. Petitioner testified he fell onto his back. Petitioner noted the wind got knocked out of him. Petitioner testified he had pain everywhere.

4. The Petitioner was transported to OSF St. Francis Medical Center immediately. Petitioner was transported on a board with a cervical collar.

5. Petitioner provided a history to OSF St. Francis Medical Center of having the wind knocked out of him when he landed on his back while working. The records reveal the Petitioner was transported by a backboard. (Petitioner's Exhibit #3)

6. Petitioner's complaints were that of a back pain and an x-ray and CT scan were performed. Petitioner was provided Norco by the medical facility on this date. (Petitioner's Exhibit #3)

7. The CT scan from the Petitioner's back revealed the Petitioner sustained a T3 anterior compression wedge fracture, in addition to, a T4 anterior compression wedge fracture, with a suspected compression fracture at T5. (Petitioner's Exhibit #3)

8. Petitioner testified he was released from the hospital on that date and went home. Petitioner testified he was bedridden for approximately a week with the exception of a few visits to the company doctor for the City of Peoria.

9. On January 20, 2014, the Petitioner was seen at the request of the Respondent by the company doctor. Petitioner was seen at OSF Occupational Health. These records reveal Petitioner had continued neck pain and continued back pain. The Petitioner was noted to have over a 15% compression fracture at the T3-T4 level. Petitioner was noted to be moving stiffly and was sent to Dr. O'Leary for an orthopedic consultation. (Petitioner's Exhibit #2)

10. On January 24, 2014, the Petitioner was seen by Dr. O'Leary. Dr. O'Leary is a board certified orthopedic surgeon in the Peoria area. Dr. O'Leary took a history from the Petitioner on January 24, 2014 of having neck and mid-back pain. The Petitioner also informed him that he could not sit very long without tremendous pain.

11. Dr. O'Leary noted that Petitioner sustained a painful injury and that this is a type of injury that you cannot brace. Petitioner was provided with restrictions by Dr. O'Leary and was provided instructions for care. (Petitioner's Exhibit #4)

12. Petitioner testified he was seen on two (2) occasions after Dr' O'Leary's visit at OSF Occupational Health (City doctor). Petitioner was seen on January 29, 2015 and February 25, 2014. The Petitioner is still having pain in the back and neck area that wrapped around his ribs. (Petitioner's Exhibit #2)

13. On March 4, 2014, Petitioner was seen by Dr. O'Leary. At that time, Petitioner was still having pain. Dr. O'Leary returned the Petitioner to work but no wearing the vest. Petitioner testified that his vest would have aggravated his condition of ill-being. (Petitioner's Exhibit #4)

14. The Petitioner returned to work, full-duty, for the City of Peoria sometime in April of 2014. Petitioner has been able to do his work for the City of Peoria since that time.

15. In November of 2014, Petitioner returned to Dr. O'Leary for continued complaints. Petitioner provided complaints of back pain and neck pain to Dr. O'Leary. Dr. O'Leary ordered an MRI. Dr. O'Leary noted that the areas of pain were in the upper back where they had been previously. His examination showed tenderness of the thoracic spine. (Petitioner's Exhibit #4)

16. Petitioner testified at the time of trial that he did not sustain any prior injuries or receive any treatment to his back predating January 19, 2014. Petitioner also did not miss any time from work prior to the work injury.

17. At the time of trial, the Petitioner testified he still continues to have stiffness and pain in his thoracic and cervical area. Petitioner has difficulty performing daily activities due to the pain. Petitioner is very cautious while performing any lifting activity, the pain as never gone away.

18. Wherefore, the Arbitrator finds that the Petitioner's condition of ill-being at the time of trial was causally related to the work accident occurring on January 19, 2014.

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

1. Pursuant to Section 8(1b) of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability, for accidental injuries occurring on or after September 1, 2011:

    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;
   ii. the occupation of the injured employee;
   iii. the age of the employee at the time of injury;
   iv. the employee's future earning capacity; and,
   v. evidence of disability corroborated by medical records.

2. With regards to (i) of Section 8(1b) of the Act, the Respondent chose not to have an AMA disability rating in this case. Therefore, this factor will not be discussed.

3. With regards to (ii) of Section 8(1b) of the Act, the Petitioner is employed as a police officer. The Arbitrator notes that this work, as a police officer, does include heavy labor. Petitioner will be put in circumstances that would expose him to dangerous situations such as altercations and protecting citizens.

4. With regards to (iii) of Section 8(1b) of the Act, the Petitioner at the time of injury was 31 years old. The Arbitrator considers the Petitioner to be a younger individual and concludes that the Petitioner's permanent partial disability would be more extensive than that of an older individual because he will have to live with the permanent partial disability longer.

5. With regards to (iv) of Section 8(1b) of the Act, the Petitioner's future earning capacity, at the present time, appears to be undiminished as a result of his injuries, because he has medically been returned to work to his full-time duties.

6. With regards to (v) of Section 8 (1b) of the Act, the Petitioner has demonstrated evidence of disability corroborated by his treating medical records. Records from both Dr. Moody and O'Leary show the petitioner had significant symptoms related to his injury. When released to full duty on March 25, Dr. O'Leary still noted a little pain with palpation at the T4-T5 region. When he returned to Dr. O'Leary on November 11, the doctor noted pain in the same areas as when he was previously seen. His exam showed generalized tenderness in the upper thoracic area. The Petitioner has credibly testified that he currently experiences pain in his low back. This also affects his cervical area. Petitioner also testified that he has problems rotating his neck. The Petitioner testified his complaints are present on a daily basis.

7. Therefore, applying Section 8(1b) of the Act, 820 ILCS 305/8(1b), the Petitioner has sustained accidental injuries that caused 2% loss of use of the man as a whole, in addition to payment of his two statutory fractures, for which he has previously been paid.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Carolyn Wallace,

Petitioner,

vs.

NO: 14WC 02509

16IWCC0139

FedEx Ground,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical, prospective medical, causal connection, temporary total disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 28, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

16IWCC0139

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $2,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 2 9 2016
o012116
DLG/mw
45

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

WALLACE, CAROLYN
Employee/Petitioner

Case# **14WC002509**

16IWCC0139

FEDEX GROUND
Employer/Respondent

On 5/28/2015, 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 0.08% 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:

5019 SEIDMAN MARGULIS & FAIRMAN LLC
RYAN A MARGULIS
500 LAKE COOK RD SUITE 350
DEERFIELD, IL 60015

1401 SCOPELITIS GARVIN LIGHT
GERALD F COOPER JR
30 W MONROE ST SUITE 600
CHICAGO, IL 60603

FINDINGS

On the date of accident, **12/23/2013**, 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 $**2,314.37 (12 weeks)**; the average weekly wage was $**192.86**.

On the date of accident, Petitioner was **50** years of age, ***single*** with **0** dependent children.

Issue of medical bills reserved by the parties by agreement for the purposes of this 19(b) hearing.

Respondent shall be given a credit of $**10,993.02** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**10,993.02**.

Respondent is entitled to a credit of $**0.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**192.83**/week for **69** weeks, commencing **12/24/2013** through **4/20/2015**, as provided in Section 8(b) of the Act. Respondent to be given credit for an amounts previously paid.

Respondent shall authorize and pay for the prescribed right knee total knee replacement and its *sequelae* as prescribed by Dr. Collins as such treatment is reasonable, necessary and causally related to the subject accident.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

Signature of Arbitrator

May 10, 2015
Date

ICArbDec19(b)

MAY 28 2015

The records reflect that the Petitioner came under the care of Dr. Roger Collins of Greenleaf Orthopedics on January 9, 2014 (P x 2). Dr. Collins noted a history of an initial accident in October 2013, subsequent to which the Petitioner wore a patellar brace. Dr. Collins then noted the history of the December 23, 2013 accident involving the pivot motion and the Petitioner feeling a "pop" in her right knee. Dr. Collins released the Petitioner from all work activity and referred her for physical therapy (P x 2).

During the initial physical therapy evaluation on January 21, 2014, the history of both the October 2013 incident and the December 23, 2013 accident were noted (P x 2). Ultimately the Petitioner underwent an MRI of the right knee which revealed a tear of the posterior horn of the medial meniscus, an MCL sprain and small to moderate joint effusion (P x 2).

On April 4, 2014, the Petitioner underwent surgical intervention at Advocate Condell Medical Center performed by Dr. Collins. The surgery revealed a medial mensicus tear as well as advanced chondromolacia of the patella, throughout the trochlea and the patellofemoral articulation. Large chondral fragments were also floating in the joint (P x 2). Post-operatively the Petitioner underwent a series of three Supartz injections.

As of July 23, 2014, Dr. Collins noted that the Petitioner had failed the post-operative treatment and the knee was giving way, causing the Petitioner to fall occasionally. Dr. Collins referred the Petitioner to his partner, Dr. Thomas Baier, who noted that the Petitioner was "bone on bone". Dr. Baier prescribed a total knee replacement and continued the off-work status pending the surgery.

Conclusions of Law

IN SUPPORT OF THE ARBITRATOR'S DECISION PERTAINING TO ISSUE (F), WHETHER PETITIONER'S CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS THE FOLLOWING:

On the issue of causation, the Arbitrator is faced with the divergent opinions of the treating physician, Dr. Collins, and the examining physician, Dr. Wolin. In assessing the opinions of these two physicians, the Arbitrator the opinions of Dr. Collins more credible than those of Dr. wolin. In reviewing Dr. Wolin's report, it is clear that he did not review the entirety of the Plaintiff's medical records, but rather only a few office visit notes. There is no evidence that Dr. Wolin reviewed the MRI films or the intraoperative films.

Further, Dr. Wolin claims that the Petitioner lacks credibility by not telling her treating physician about the October incident at work that predated the subject accident. This claim is directly contradicted by the medical records. Not only did the Petitioner tell Dr. Collins about the October accident, but she also relayed this information to the Emergency Department and the physical therapist at the initial evaluation. Therefore, not only did the Petitioner not hide this fact from her treater, but she told every treating facility/provider about the October incident.

Dr. Wolin also claims that the Petitioner has "symptom magnificent" without explaining his basis for such an allegation. Given the description from Dr. Baier that the Petitioner's knee was essentially "bone on bone", Dr. Wolin's assessment is not supported by the records.

The Arbitrator finds the opinions of Dr. Collins credible. In his testimony, Dr. Collins methodically described the extent of the damage found in the Petitioner's knee,

As previously discussed, the Arbitrator finds the opinions of Dr. Collins more credible than those offered by Dr. Wolin. Dr. Wolin's recommendation to release the Petitioner to full duty work is contrary to the diagnosed injury and "bone on bone" situation in the Petitioner's right knee. The treating medical records and the credible testimony of Dr. Collins establish that the Petitioner was temporarily and totally disabled from December 24, 2013 through December 26, 2013, and again from January 9, 2014 through the date of hearing, September 20, 2015.

In reviewing the records, the Petitioner was authorized off of work from the Emergency Department through December 26, 2013 with a presumed follow-up visit scheduled to re-assess restrictions. The Petitioner credibly testified that, due to the Christmas holiday and New Year's holiday, she was unable to present to an orthopedist until January 9, 2014. Such a gap spanning 17 days from the accident date does not refute the Petitioner's claim for temporary total disability. Petitioner's testimony on this point was undisputed.

A reasonable inference can be made that, since the Emergency Department restricted the Petitioner from work on December 23, 2013 and Dr. Collins restricted the Petitioner from work on Janauary 9, 2014, the Petitioner remained disabled from work in the interim. This is further supported by the need for surgery and the continued "off work" status post-operatively pending the prescribed right total knee surgery.

Based on the foregoing, the Arbitrator finds the Petitioner temporarily and totally disabled from December 24, 2013 through the date of hearing, April 20, 2015, a period spanning 69 weeks. Respondent is ordered to pay the accrued disability benefits for this time period.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRIAN JONES,

Petitioner,

vs.

NO: 14 WC 3039
14 WC 3338
14 WC 8433

SOUTHWEST AIRLINES,

Respondent,

16IWCC0137

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of nature and extent and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Pursuant to Will County Forest Preserve Dist. v. IWCC, 2012 Ill. App. LEXIS 109, 361 Ill. Dec. 16 (2012), permanent partial disability for shoulder injuries resulting in internal structural changes should be compensated under §8(d)2 of the Act instead of §8(e). Regarding the left shoulder, we find that Petitioner has sustained a greater loss of use of the left shoulder than the Arbitrator found and increase the award to 2% loss of use of the person as a whole under §8(d)2.

Regarding the right shoulder, the disability of which was analyzed under the five factors listed in §8.1(b), we find that more weight should have been given to Petitioner's age. He is only 46 years old and will have to work with his disability for an extended period of time. We also find that the treating medical records do corroborate some of Petitioner's testimony regarding his current disability. Although there is no recent medical record to indicate that Petitioner's right shoulder is "only 70%" or that he ices his shoulder, the last physical therapy records do indicate that Petitioner was still complaining of 2-3/10 pain at the time he was released to full duty. Therefore, we increase the award for the right shoulder to 8% loss of use of the person as a whole under §8(d)2.

16IWCC0137

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $474.38 per week for a period of 10 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained to the left shoulder caused the 2% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $511.18 per week for a period of 40 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained to the right shoulder caused the 8% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $25,200. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 2 9 2016

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

SE/
O: 1/20/16
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السعد بدا للاطمئنان

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JONES, BRIAN
Employee/Petitioner

Case# **14WC003039**

14WC003338
14WC008433

SOUTHWEST AIRLINES
Employer/Respondent

16IWCC0137

On 7/30/2015, 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 0.14% 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:

0154 KROL BONGIORNO & GIVEN LTD
CHARLIE GIVEN
120 N LASALLE ST SUITE 1150
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
QUINN BRENNAN
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

BRIAN JONES
Employee/Petitioner

Case #14 WC 3039
#14 WC 3338
#14 WC 8433

v.

SOUTHWEST AIRLINES
Employer/Respondent

16IWCC0137

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 Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on July 10, 2015. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

A. ☐ Was the 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 the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to the respondent?

F. ☐ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☐ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☐ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☐ What temporary benefits are due: ☐ TPD ☐ Maintenance ☐ TTD?

L. ☒ What is the nature and extent of injury?

M. ☐ Should penalties or fees be imposed upon the respondent?

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On August 3, 2011, August 16, 2012, and October 13, 2013, the respondent was operating under and subject to the provisions of the Act.

- An employee-employer relationship existed between the petitioner and respondent on the above dates.

- On the above dates, the petitioner sustained injuries that arose out of and in the course of employment.

- Timely notice of the accidents was given to the respondent.

- In the year preceding the injuries on August 3, 2011, and August 16, 2012, the petitioner earned $41,113.08; the average weekly wage was $790.64. In the year preceding the injury on October 30, 2013, the petitioner earned $45,566.97; the average weekly wage was $851.96.

- At the time of injuries, the petitioner was 42 through 45 years of age, married with two children under 18.

- The parties agreed that the respondent is not liable for any unpaid medical services provided to the petitioner for each injury.

- The parties agreed that the respondent paid all the temporary total disability benefits due the petitioner for each injury.

ORDER:

- The respondent shall pay the petitioner the sum of $474.38/week for a further period of 5.06 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 2% loss of use of his left arm.

- The respondent shall pay the petitioner the sum of $511.18/week for a further period of 20.24 weeks, as provided in Section 8(d)2/8(e) of the Act, because the injuries to his

right arm on August 16, 2012, and October 30, 2013, caused the permanent partial disability to petitioner to the extent of 4.048% loss of use of the person as a whole (8% loss of use of his right arm).

- The respondent shall pay the petitioner compensation that has accrued from August 3, 2011, through July 10, 2015, and shall pay the remainder of the award, if any, in weekly payments.

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.

Robert E. Williams

Signature of Arbitrator

July 30, 2015

Date

JUL 30 2015

FINDINGS OF FACTS:

On August 3, 2011, the petitioner, a provisioning agent, injured his left shoulder while pulling a liquor kit. The incident is the subject matter of claim #14 WC 8433. He received immediate medical care at Occupational Health Centers of Illinois (OHC) for his left shoulder, where he was prescribed therapy and medication for a left shoulder strain. Improved symptoms were noted by Dr. Amir and Dr. Ross at OHC through September 8th. He reported no improvement on September 15th and was evaluated by Dr. Kevin Tu on September 28th. Dr. Tu opined on January 18, 2012, that an MR arthrogram revealed a partial thickness left rotator cuff tear and no labral tear. Dr. Tu noted that the petitioner's symptoms had improved and that he had minimal difficulty with overhead activity and mild pain localized to the biceps tendon. The petitioner was released to full-duty activities. At a follow-up on February 15, 2012, the petitioner reported no difficulty with daily work activities.

On August 16, 2012, the petitioner injured his right shoulder while pulling a guard rail. The incident is the subject matter of claim #14 WC 3039. The petitioner received immediate medical care at OHC. On October 10, 2012, Dr. Tu evaluated the petitioner and released him to unrestricted work beginning October 15, 2012. The petitioner received physical therapy through October 12, 2012.

On October 30, 2013, the petitioner re-injured his right shoulder while pulling a garbage can. The incident is the subject matter of claim #14 WC 3338. He received medical care at OHC and started physical therapy. On March 21, 2014, Dr. Tu performed a right shoulder arthroscopic subacromial decompression and distal clavicle excision. His post-operative diagnosis was right shoulder impingement and right shoulder AC joint

arthropathy. The petitioner received physical therapy and on July 16, 2014, Dr. Tu released him to unrestricted work. At the petitioner's last follow-up on August 6, 2014, he reported occasional shoulder pain and manageable symptoms. The doctor noted 5/5 supraspinatus and infraspinatus strength and no AC joint tenderness.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The petitioner complains of stiffness in his left shoulder with low temperatures. He is hesitant to pick up his child and, due to vibration, mowing his lawn. He needs to ice his left shoulder after a lot of activities. The respondent shall pay the petitioner the sum of $474.38/week for a further period of 5.06 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 2% loss of use of his left arm.

An impairment rating by Dr. Bryan Neal on December 29, 2014, based on a right shoulder impingement syndrome diagnosis by Dr. Tu and the MRI was a 3% default with an adjusted impairment of 4% right upper limb impairment or 2% whole person impairment. There is no evidence concerning the impact of the petitioner's right shoulder injuries in regard to his occupation, age or future earning capacity, as delineated in Section 8.1(b)(ii) through (iv) of the Act. The petitioner currently works in a full-duty capacity as a provisioning agent for the respondent. He is able to perform his job duties without assistance. No reasonable inference can be made regarding the impact of the petitioner's right shoulder injuries on his occupation, age or future earning capacity. Regarding Section 8.1(b)(v), the petitioner complains of only a 70% improvement with his right shoulder, stiffness and cautiousness with activities, lifting and moving. He ices

and favors his right shoulder. He is cautious with his workload. The treating medical records do not corroborate the petitioner's testimony.

The respondent shall pay the petitioner the sum of $511.18/week for a further period of 20.24 weeks, as provided in Section 8(d)2/8(e) of the Act, because the injuries to his right arm on August 16, 2012, and October 30, 2013, caused the permanent partial disability to petitioner to the extent of 4.048% loss of use of the person as a whole (8% loss of use of his right arm).

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Emily Thomas,
Petitioner,
vs.

16IWCC0172

NO: 14 WC 3543

Pace,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of nature and extent of Petitioner's permanent partial disability, penalties and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 26, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $13,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 11 2016
KWL/vf
O-3/7/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0172

THOMAS, EMILY
Employee/Petitioner

Case# 14WC003543

PACE
Employer/Respondent

On 5/26/2015, 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 0.08% 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:

2356 FOHRMAN, DONALD W & ASSOCS
ADAM J SCHOLL
101 W GRAND AVE SUITE 500
CHICAGO, IL 60654

1505 SLAVIN & SLAVIN
NICOLE R NELSON
20 S CLARK ST SUITE 510
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

☐ 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 **16IWCC0172**

Emily Thomas
Employee/Petitioner

v.

Pace
Employer/Respondent

Case # 14 WC 3543

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 **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **1/30/15**. 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 **12/12/13**, 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 $**49,110.00**; the average weekly wage was $**944.44**.

On the date of accident, Petitioner was **60** years of age, ***single*** with **0** dependent children.

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**9,331.44** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**9,331.44**.

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

ORDER

Permanent Partial Disability
Respondent shall pay Petitioner permanent partial disability benefits of $566.66/week for 16.5 weeks, due to the injuries sustained which caused a 3.3% loss of a person as a whole, as provided in Section 8(d)2 of the Act. Further, Respondent shall pay Petitioner permanent partial disability benefits of $566.66/week for 6.15 weeks, due to the injuries sustained which caused a 3% loss of a hand, as provided in Section 8(d)2 of the Act

Penalties
Respondent shall pay to Petitioner penalties of $**1,559.45**, as provided in § 16 of the Act; $**4,677.25**, as provided in § 19(k) of the Act; and $**3,120.00**, as provided in § 19(l) of the Act.

TTD
Respondent shall pay to Petitioner a TTD underpayment of $23.06

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.

Signature of Arbitrator

MAY 21, 2015
Date

MAY 26 2015

Emily Thomas v. PACE
14 WC 3543

INTRODUCTION

This matter proceeded to hearing on January 30, 2015 before Arbitrator Steven Fruth. The disputed issues were: ***L.*** What is the nature and extent of the injury?; ***M.*** Should penalties and fees be imposed upon the Respondent?

Petitioner and claims adjuster Michele Pollard testified at hearing. Petitioner offered 6 documents which were received in evidence. Respondent did not offer any documents in evidence.

FINDINGS OF FACT

Petitioner, a 60 year old female, was employed as a bus operator with Respondent. On December 12, 2013, Petitioner testified that she was operating a bus that had no heat. Petitioner contacted her dispatcher and requested a bus exchange. In the process of walking from one bus to the other, petitioner slipped on ice and fell to the ground. Petitioner testified that she injured her face, left shoulder, left knee and left wrist when she hit the ground. The fall was witnessed by a co-worker, Rene Griffin.

Petitioner was taken by ambulance to Palos Community Hospital (Palos). At the emergency room, Petitioner gave a history of the accident and reported complaints of pain her left shoulder, left knee, and hands as well as a laceration and swelling of her upper lip. (PX 5) The emergency room physician referred Petitioner to her primary physician and recommended that she remain off work until December 16, 2013.

Petitioner was taken by her supervisor back to the PACE garage. There she filled out an incident report and submitted it to the safety manager along with her off work note.

On December 13, 2013 claims adjuster Michele Pollard of Underwriters Safety and Claims sent a letter to Petitioner along with an "Employee Information Form" and a HIPAA form. (PX 1) Petitioner testified that she received the documents, filled them out, signed them, and then immediately mailed them back.

Petitioner saw her primary physician, Dr. Zulfiqar Rizvi, on December 16, 2013. Dr. Rizvi noted restricted movement of the left shoulder and multiple injuries. (PX 4) Dr. Rizvi prescribed physical therapy and advised Petitioner to remain off of work. Petitioner gave the off work note to her employer.

On December 18, 2013 Petitioner had her initial physical therapy evaluation at Palos Community Hospital. The initial evaluation noted Petitioner's complaints of pain in her left shoulder, bilateral wrists and left side of her neck. (PX 5) Petitioner reported difficulty reaching overhead, reaching behind her back, reaching forward, completing any resistive activities, and pushing and pulling objects.

Petitioner followed with Dr. Rizvi on January 3, 2014. Petitioner's main complaint was her restricted motion of her left shoulder. Dr. Rizvi ordered additional

physical therapy and referred Petitioner to an orthopedic physician. (PX 4) Petitioner testified that she was unable to schedule an exam with an orthopedic physician because the claims adjuster denied the necessary authorization. She had physical therapy for her shoulder and also for her hand at Palos. Petitioner next saw Dr. Rizvi on January 17, 2014. She had continued shoulder pain with restricted movement as well as pain of the left wrist. Dr. Rizvi noted that Petitioner was still waiting for authorization to see an orthopedic physician. She was then given a brace for her left wrist complaints.

The orthopedic referral was finally approved. On January 28, 2014 Petitioner saw Brittany Macleod, PA at the Illinois Orthopedic Network (ION). Petitioner's chief complaint was her left shoulder. (PX 3) Petitioner reported that after a month of therapy her pain had not subsided. An MRI was prescribed as well as continued therapy. Petitioner was given another off work note. The MRI was done on January 29, 2014. On February 12, 2014, Petitioner saw by Gabriel Levi, M.D., a board certified orthopedic surgeon at ION. Dr. Levi examined Petitioner and reviewed the MRI findings. He diagnosed a left shoulder impingement. Dr. Levi noted that Petitioner had improved with physical therapy and advised continued therapy.

On February 13, 2013, the adjuster, Ms. Pollard, forwarded to Petitioner's counsel a notice of an § 12 examination. The evaluation was set for March 10, 2014 with Dr. Nikhil Verma. (PX 2) At the § 12 exam Petitioner gave a consistent history of the accident to the physician and related her symptoms. (PX 6) Petitioner reported her left shoulder was 80% improved, but still had persistent pain over the anterior and lateral aspects. Dr. Verma's diagnoses were left knee contusion, resolved and an AC joint sprain with mild impingement. Dr. Verma concluded that the diagnoses were causally related to the injury of December 12, 2013. He recommended an AC joint and subacromial injection with an additional 4 weeks of physical therapy. (PX6) Dr. Verma also stated that he saw no evidence of symptom magnification or exaggerated pain response. He opined that petitioner should achieve MMI after the additional 4 weeks of therapy.

Petitioner followed up with Dr. Levi on March 26, 2014. On that visit she reported her pain level was 2/10 and that she had pain with certain maneuvers, especially overhead. (PX 4) Petitioner told Dr. Levi that she felt ready to return to work. Dr. Levi released Petitioner to return to the work but advised her to continue with physical therapy.

Petitioner testified that she returned to the same job duties with Respondent. She also stated that she has not had any further medical treatment for her injuries since her visit with Dr. Levi on March 26, 2014.

Petitioner stated that on or about April 7, 2014 she received a check for TTD from December 13, 2013 through March 26, 2014. During that interim, Petitioner testified that it was very rough on her financially. She could not pay her bills and had to borrow money to survive.

Petitioner testified that as of the date of hearing, she still has difficulty with her left shoulder. Specifically she has discomfort raising her left arm and experiences pain with twisting. She also stated that her left hand still hurts when she is driving or lifting.

Ms. Pollard is a senior claims adjuster for Underwriters Safety and Claims. She handles all of the claims for Respondent and has been doing so for three years. Ms. Pollard testified that when she receives a claim, she conducts an investigation which involves obtaining the incident report, contacting the claimant, obtaining medical documentation, and then issuing benefits in a "timely manner" if the claim is considered compensable. If she cannot make a determination, then she comes up with a plan. Ms. Pollard stated that the respondent is involved in the process and they provide permission to her to set up IMEs and surveillance.

On direct examination, Ms. Pollard testified from her memory of Petitioner's claim. She did not bring the claim file to the hearing and therefore did not refresh her memory while testifying.

Ms. Pollard testified that she received notice of the claim from Respondent on December 16, 2013. She stated that she contacted the claimant directly and interviewed her over the telephone. She also reached out to Petitioner's medical providers and obtained records. Ms. Pollard's testified that based on the information that she received from the medical providers that she could not make a determination as to compensability at that time.

Ms. Pollard stated that on January 2, 2014 she contacted Respondent for authorization to set up an IME. She contacted Dr. Verma's office in January 14, 2014 and obtained an appointment for March 10, 2014. Ms. Pollard stated that she purposely scheduled the exam 60 days later in order to give her adequate time to obtain the medical records and send checks to the physician and Petitioner.

Ms. Pollard testified that she received Dr. Verma's report on March 14, 2014. She then immediately ordered the TTD check. She stopped the first check because she learned that Petitioner had returned to work on March 26, 2014. She cancelled the first check and ordered a second check that covered benefits through March 26.

On cross-examination, Ms. Pollard acknowledged her letter of December 13, 2013 to Petitioner was evidence of her first notice of the claim. (PX 1) She stated that the incident report that Petitioner filled out for Respondent on December 12, 2013 was provided to her along with the off work statement issued by Palos Community Hospital. Ms. Pollard also stated that she received from the petitioner the "Employee Information Form" and a HIPAA form that she requested Petitioner fill out. Ms. Pollard further acknowledged that she had received the off work note of Dr. Rizvi. Ms. Pollard testified that she still could not determine the compensability of the claim with the information provided. When asked multiple times what information she lacked, Ms. Pollard answered she could not recall.

Ms. Pollard further testified that she received Petitioner's medical records but could not determine the extent of Petitioner's injury. On January 2, 2014 Ms. Pollard

decided that she required an IME. Ms. Pollard maintained that she set up the exam on January 14, 2014 but admitted that she did not send notice of the exam to the Petitioner until February 12, 2014. Ms. Pollard stated that notice was not sent out until then because she learned that Petitioner hired an attorney on February 6, 2014. Ms. Pollard stated that she did not send notice to Petitioner in mid-January when Petitioner represented herself.

Ms. Pollard received all of Petitioner's medical records prior to the IME. She stated that she reviewed them but wanted to wait for the IME exam before making any decisions. She was asked what rebuttal she had to presumption of an unreasonable delay after 14 days and she responded that she did not have enough information and wanted to wait for the IME report. Ms. Pollard conceded that ordinarily decisions on compensability were made between 48 hours and 7 days.

Ms. Pollard testified that she received the IME report on March 14, 2014 and that it takes 7 days to issue a check. She stated that a check was printed but was not sent because she learned that Petitioner had returned to work. She then reissued a TTD check covering the time off work period.

On further cross-examination Ms. Pollard stated that she had questions about Petitioner's injury, but acknowledged that she did not have any evidence to contradict Petitioner's account of the injury. As part of her investigation, she never interviewed the co-worker who witnessed the accident. She then acknowledged that she was not disputing the actual accident.

There was no evidence that Respondent notified Petitioner in writing, in accord with § 19(l) of the Act, any reason for delaying payment of benefits.

CONCLUSIONS OF LAW

L. What is the nature and extent of the injury?

The Arbitrator has considered the five factors outlined by§ 8.1b of the Act in evaluating Petitioner's disability as a result of the injuries to her left shoulder and left hand and wrist and makes the following findings:

LEFT SHOULDER

With regard to subsection (i) of § 8.1b(b), the Arbitrator notes that no AMA guidelines impairment report was submitted into evidence. The Arbitrator therefore can give no weight to this factor.

With regard to subsection (ii) of § 8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as bus operator at the time of the accident and that she was able to return to work in her prior capacity following her injury. Driving a bus requires extensive use of the hands and shoulders. Driving also requires the operator to keep a vigilant lookout for traffic and road conditions. The Arbitrator gives great weight to this factor.

With regard to subsection (iii) of § 8.1b(b), the Arbitrator notes that Petitioner was 60 years old at the time of the accident. Statistically petitioner has a life expectancy of 24 years, and a worklife expectancy of 6 years. Petitioner has continuing aches and pains when she drives a bus. It is more likely that not that she will continue to suffer from these aches and pains for the rest of her worklife and beyond. The Arbitrator gives moderate weight to this factor.

With regard to subsection (iv) of § 8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner was able to return to her regular duties for the Respondent. Petitioner, despite some continuing complaints, is currently able to perform her job without restrictions. Therefore the Arbitrator gives this factor little weight.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner sustained a moderate injury to her left shoulder and lesser injuries to both of her hands and left knee. Petitioner credibly testified that she still has pain with her left arm with overhead and twisting movements. The Arbitrator gives great weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 3.3% disability to a person as a whole pursuant to §8(d)(2) of the Act . Respondent shall pay Petitioner 16.5 weeks of partial permanent disability benefits at the rate of $566.66 per week accruing from March 26, 2014.

LEFT HAND

With regard to subsection (i) of § 8.1b(b), the Arbitrator notes that no AMA guidelines impairment report was submitted into evidence. The Arbitrator therefore can give no weight to this factor.

With regard to subsection (ii) of § 8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as bus operator at the time of the accident and that she was able to return to work in her prior capacity following her injury. Driving a bus requires extensive use of the hands and shoulders. Driving also requires the operator to keep a vigilant lookout for traffic and road conditions. The Arbitrator gives great weight to this factor.

With regard to subsection (iii) of § 8.1b(b), the Arbitrator notes that Petitioner was 60 years old at the time of the accident. Statistically petitioner has a life expectancy of 24 years, and a worklife expectancy of 6 years. Petitioner has continuing aches and pains when she drives a bus. It is more likely that not that she will continue to suffer from these aches and pains for the rest of her worklife and beyond. The Arbitrator gives moderate weight to this factor.

With regard to subsection (iv) of § 8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner sustained a shoulder sprain with impingement. She

recovered sufficiently to be able to return to her regular duties for the Respondent. Petitioner, despite some continuing complaints, is currently able to perform her job without restrictions. Therefore the Arbitrator gives this factor little weight.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner sustained a moderate injury to her left shoulder and a lesser injury her left hand. Petitioner credibly testified that she still has pain with her left hand from activities incidental to operating a bus. The Arbitrator gives great weight to this factor.

After weighing the above factors, the Arbitrator finds Petitioner should be awarded 3% loss of use of the left hand as a result of the December 12, 2013 accident. Respondent shall pay Petitioner 6.15 weeks of partial permanent disability benefits at the rate of $566.66 per week accruing from March 26, 2014.

M. Should Penalties and Fees be Imposed upon the Respondent?

The Arbitrator concludes that Petitioner proved by a preponderance of the evidence that she is entitled to awards of penalties pursuant to § 19(k) and § 19(l), as well as attorney's fees pursuant to § 16 of the Act.

Petitioner sustained work-related injuries on December 12, 2013. The injuries were well documented by Petitioner with incident reports submitted to both the respondent and its insurance company. Petitioner received emergent medical care for her injuries with Palos Community Hospital. She was given an off work note by the emergency room physician which she provided to Respondent. Petitioner then followed with her treating physicians for her reported injuries and continued to receive off work notes through March 26, 2014, all of which were provided to Respondent.

Despite the overwhelming evidence of a work-related accident and Petitioner's disabled condition due to the work related injuries that was well documented by the medical providers, Respondent's adjuster did not determine compensability until after the IME. Ms. Pollard could not provide a credible explanation for withholding benefits from Petitioner. Her explanation was one of a bureaucrat seemingly unwilling to make a timely, reasonable decision.

The Arbitrator finds Ms. Pollard's testimony to be not credible. The Arbitrator takes note of Ms. Pollard's officious and dismissive demeanor in testifying at the hearing. Ms. Pollard often fell back on a stock answer that she was merely following protocol, an attitude indicating no genuine or reasonable effort to fairly evaluate Petitioner's claim in a timely manner. In fact, Ms. Pollard's testimony, rather than rebutting Petitioner's claim of unreasonable and vexatious delay, proved Petitioner's claim of unreasonable and vexatious delay. Respondent had no reasonable basis to deny Petitioner her entitled benefits.

Further, there was no evidence that Respondent notified Petitioner in writing of any reason for delaying payment of benefits as required by § 19(l).

Early on Ms. Pollard focused on what the injuries were rather than the obvious fact that Petitioner had sustained a work-related injury. While that approach may have been reasonable in assessing whether to approve proposed medical care it was patently unreasonable as being the basis for delaying payment of TTD. The medical records of treating caregivers provided more than enough evidence to show that Petitioner had sustained an injury arising out of and in the course of her employment by Respondent. There was ample evidence to support payment of TTD benefits. Respondent had no evidence to raise a reasonable suspicion that petitioner's injuries were not work-related. Instead, Respondent consciously delayed its decision until it obtained an IME scheduled four months after the accident. While Respondent has a statutory right to have a § 12 examination the Arbitrator does not find Ms. Pollard's reasoning for the § 12 exam to be credible. Petitioner's injury requiring emergent medical care and its relation to her employment were plain and simple.

The Arbitrator also takes note that Ms. Pollard authorized a TTD payment only to cancel it when she learned that Petitioner had returned to work. Reissuing the TTD check further delayed Petitioner's receipt of benefits to which she was entitled. Ms. Pollard stated that she needed to make sure that the right amount of TTD was paid. However, the Arbitrator takes note that TTD overpayments are neither unusual nor uncommon and are resolved with appropriate credit given at settlement or trial. While not dispositive of the issue, it is illustrative of Respondent's unreasonable and vexatious handling of Petitioner's claim.

It is the Arbitrator's finding that Respondent's actions in delaying payment of benefits were unreasonable and vexatious and thereby warrant assessment of penalties pursuant to §19(k) and §19(l) of the Act and payment of attorneys' fees pursuant to §16.

The temporary total disability benefits from December 13, 2013 through March 26, 2014 equaled $9,353.90 (14-6/7 weeks x $629.63). Pursuant to §19(k), Respondent shall pay to Petitioner penalties equal to 50% of the temporary total disability benefits, or $4,676.95.

Respondent shall further pay Petitioner penalties under §19(l) which equal $30.00 per day for each day benefits were withheld. Petitioner was off work a total of 104 days, which equals $3,120.00.

Respondent shall pay attorneys' fees to Petitioner's attorney in the amount of $1,553.39 [($4,676.95 +$3,090.00) x 20%] pursuant to §16 of the Act.

Lastly, as previously stated, TTD due Petitioner equaled $9,354.50. Respondent stipulated that it paid Petitioner $9,331.44. Respondent, being due credit for prior TTD payments, shall pay to Petitioner the difference owed of $23.06.

Arbitrator Steven J. Fruth

MAY 21, 2015
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gino DeFrancisco

Petitioner,

vs. NO. 14WC 17921

Sprint Nextel Corp.,

Respondent.

16IWCC0176

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, permanent disability, benefit rates, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 31, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $30,100.00.

16IWCC0176

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED:
SJM/sj MAR 1 1 2016
o-2/25/2016
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DeFRANCISCO, GINO
Employee/Petitioner

Case# 14WC017921

SPRINT NEXTEL CORP
Employer/Respondent

16IWCC0176

On 7/31/2015, 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 0.14% 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:

0154 KROL BONGIORNO & GIVEN LTD
CRAIG BUCY
120 N LASALLE ST SUITE 1150
CHICAGO, IL 60602

0507 RUSIN & MACIOROWSKI LTD
JIGAR S DESAI
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

16IWCC0176

☐ 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

Gino DeFrancisco
Employee/Petitioner

v.

Sprint Nextel Corp.
Employer/Respondent

Case # **14** WC **17921**

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 **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **July 8, 2015**. 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 _____

16IWCC0176

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Gino DeFrancisco
Employee/Petitioner

Case # 14 WC 17921

v.

Sprint Nextel Corp.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

At the time of the accident, Gino DeFrancisco ("Petitioner") was a 24 year old Customer Service Representative employed by Sprint Nextel Corporation ("Respondent") since March of 2011. Petitioner is right hand dominant. Petitioner is claiming a work related accident to his left shoulder occurred on February 4, 2014. On the date of the accident, Petitioner was walking into a back room where the power was out. As Petitioner entered the room, he tripped on an unseen chair and fell onto his left shoulder. During the fall, he jammed his shoulder before landing on it. He started feeling pain in his left shoulder and arm immediately after the accident.

Petitioner's first medical treatment was with Dr William Cox of McHenry County Orthopaedics on February 11, 2014. (PX2). Petitioner complained of pain at the anterolateral aspect of his left shoulder that worsened with activities above shoulder level. Upon examination, the Petitioner had full range of motion with pain when moving above horizontal plane and with resisted motions. He also demonstrated tenderness at the rotator cuff and tested positive for impingement. X-rays of the left shoulder were negative. Dr Cox diagnosed Petitioner with possible internal derangement of the shoulder and recommended a MRI of the left shoulder. Petitioner was allowed to return to work without restrictions.

Petitioner's first post-operative with Dr Cox was on May 22, 2014. During examination, Petitioner reported that his pain was decreasing from pre-surgery levels. Dr Cox recommended that he begin physical therapy to recover range of motion and strength in his shoulder. (PX2).

Petitioner began his post-surgery course of physical therapy on June 2, 2014. He complained of pain in the left anterior shoulder region and increased point sensitivity along the left anterior deltoid. The therapist noted that Petitioner also had decreased left shoulder range of motion due to pain. (PX3).

Dr Cox re-examined the Petitioner on June 17, 2014. During the appointment, Petitioner noted that he had a significant increase in pain in the anterolateral area after feeling a pop in his left shoulder. Dr Cox recommended that he continue therapy and restricted Petitioner to no work with the left arm. (PX2).

Petitioner testified that he was off work from the date of surgery, May 15, 2014, through July 30, 2014, at which point Respondent was able to accommodate his light duty work restrictions.

Petitioner was re-examined by Dr Cox on August 21, 2014. Petitioner had increased range of movement and motor strength in the left shoulder. Dr Cox recommended that he continue physical therapy and returned Petitioner to work full duty work. (PX2).

Petitioner's last physical therapy session took place on September 16, 2014. He attended a total of 58 sessions. The final chart notes from his therapist indicate Petitioner continued to experience pain and soreness in the left shoulder. Although Petitioner made significant progress with his shoulder and scapular strength, he still suffered from increased difficulty with shoulder rotation and was unable to lift heavier objects overhead long periods of time. (PX3).

Petitioner was discharged by Dr Cox on September 23, 2014. (PX2).

Petitioner attended a Section 12 Independent Medical Examination and AMA impairment rating at the request of Respondent on February 24, 2015. Dr Monaco found 0% impairment rating.

The causal connection between Petitioner's work accident and his current condition of ill-being is not stipulated to between the parties and is in dispute.

Petitioner testified that before the accident on February 4, 2014, he was not having any issues with his left shoulder. Petitioner testified that he felt pain immediately after falling and saw Dr Cox on February 11, 2014 after the pain persisted. Petitioner was diagnosed with left shoulder rotator cuff tendinosis and underwent a diagnostic arthroscopy with subacromial bursectomy and debridement. (PX2).

The Arbitrator has reviewed the medical evidence and the testimony of the Petitioner and finds Petitioner to be a credible witness. There is a causal connection between Petitioner's present condition of ill-being and the work accident of February 4, 2014.

L. What is the nature and extent of the injury?

Pursuant to Section 8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability ("PPD"), for accidental injuries occurring on or after September 1, 2011:

(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;
- (ii) The occupation of the injured employee;
- (iii) The age of the employee at the time of injury;
- (iv) The employee's future earning capacity; and
- (v) Evidence of disability corroborated by medical records.

significantly, resulting in increased soreness and stiffness. Petitioner testified that his life has been significantly affected by the injury, affecting his relationship with his daughter and diminishing his ability to participate in hobbies such as golf, basketball, and riding motorcycles.

The determination of PPD is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of PPD, consideration is not given to any single enumerated factor as the sole determinant. Therefore, after applying section 8.1(b) of the Act, 820 ILCS 305/8.1(b) and considering the relevance and weight of all these factors, including the AMA impairment rating of Dr Monaco, the Arbitrator concludes that the Petitioner has sustained a 12.5% permanent loss to the person as a whole, or 62.5 weeks of PPD benefits.

14 WC 24172

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Trevor McLaughlin,
Petitioner,

vs.

NO: 14 WC 24172
consol. 13 WC 22758
14 WC 24173

TJ's Maintenance and Remodeling, LLC,
Respondent.

16IWCC0180

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical care, and temporary total disability benefits, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on May 7, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under Section 19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 14 2016
MJB:ell
O-01/12/16
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

McLAUGHLIN, TREVOR
Employee/Petitioner

Case# **14WC024172**

13WC022758
14WC024173

TJ'S MAINTENANCE AND REMODELING LLC
Employer/Respondent

16IWCC0180

On 5/7/2015, 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 0.07% 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:

4392 LAW OFFICES OF HELEN BLOCH
33 N LASALLE ST
SUITE 3200
CHICAGO, IL 60602

0210 GANAN & SHAPIRO PC
MELISSA McENDRE
210 W ILLINOIS ST
CHICAGO, IL 60654

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

☐ 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
19(b)

Trevor McLaughlin
Employee/Petitioner

v.

T.J.'s Maintenance and Remodeling, LLC
Employer/Respondent

Case # **14WC 24172**

Consolidated cases: **14WC 24173 and 13 WC 22758**

16IWCC0180

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 **Gerald Granada**, Arbitrator of the Commission, in the city of **New Lenox**, on **April 7, 2015**. 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **7/25/13**, 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 not*** 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**51,584.00**; the average weekly wage was $**992.00**

On the date of accident, Petitioner was **46** years of age, ***married*** with **2** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**24,139.86** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**24,139.86**.

Respondent is entitled to a credit of $**1,553.90** under Section 8(j) of the Act.

ORDER

Petitioner failed to meet his burden of proof on the issue of accident. Claim denied.

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.

Signature of Arbitrator

5/5/15
Date

MAY 7 - 2015

FINDINGS OF FACT

16IWCC0180

At the time of the arbitration hearing, Petitioner presented three consolidated claims. Each claim will be addressed in separate decisions. This decision relates to Petitioner's claim stemming from an alleged work injury which manifested on July 25, 2013, in which Petitioner's claimed accident stems from repetitive trauma. In this case, the issues in dispute are as follows: 1) accident; 2) causation; 3) medical expenses; 4) TTD; and 5) prospective medical care.

On July 25, 2013, Petitioner was 46 years old and employed as a working supervisor for Respondent, which was a company owned by Petitioner's brother Tim McLaughlin. Petitioner's sister Tammy worked in the Respondent's office and assigned work orders. Neither Tim nor Tammy testified at the arbitration hearing.

Petitioner's job duties consisted of monitoring projects, making bids to potential clients, performing constructions jobs and working on maintenance projects for regular customers. He also performed tasks of a carpenter and was required to lift product, climb ladders and used tools of the trade including hammers. Petitioner also testified that he used vibratory tools. In 2013 he was assigned to resurfacing the pavement and replacing steel doors at a trucking company. He also worked in an attic removing mold and installing new vents to prevent mold in the future. On June 3, 2013, Petitioner injured his left arm when he caught himself from falling off a ladder – which is the subject matter of companion case13 WC 22758.

Petitioner provided a written statement to his employer dated June 28, 2013. (RX 9) The statement documents Petitioner's understanding of the chronology of events between June 2, 2013 and June 28, 2013. Petitioner further testified that he prepared the written statement as he needed to be covered for the shoulder injury. Petitioner submitted his carpal tunnel treatment through his group carrier. He testified he requested a form from Respondent but they gave him the wrong form, so he wrote the statement. The statement does not indicate he advised anyone at Respondent of the accident. The statement documents the accident consistent with the history provided to Dr. Chhadia on June 28, 2013. The statement indicates he told the office he had a doctor's appointment on June 6, 2013. (RX 9, p.3) According to the statement, Petitioner did not have an off work note until June 28, 2013. (RX 9, p.5) The statement documents Petitioner worked June 3, 2013 through June 19, 2013. He went on vacation from June 20, 2013 through June 24, 2013. (RX 9, p.4) He then returned to work for June 25, 2013 through June 28, 2013. (RX 9, p.4) The statement documents his insurance would not authorize the MRI until June 16, 2013. (RX 9,p.4). He does not distinguish whether the MRI is for the back or the shoulder.

Petitioner testified he had a doctor's appointment on June 6, 2013 with Dr. McNally for numbness to his hand and feet that was prescheduled. Dr. McNally's office notes document the history of the arm and feet numbness, but for the left shoulder, the records only state that something happened on Monday, and do not provide a history of accident. Dr. McNally's record states "last Monday, he did something to his left shoulder. " He does not state that "something" occurred at work. He states he was having pain and limited range of motion. He also states that he had a previous rotator cuff tear and biceps tear and the left shoulder "feels different." (PX A) The note states his primary doctor told him to wait and see if it clears up. The only notes from his primary doctor is from January and February 2013. (RX 6) Petitioner advised Dr. Bare that his bicep was "black and blue" after the accident. (RX 5, p.1) Dr. McNally made no note of any bruising during his examination.

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Petitioner had presented to his family doctor, Dr. Bailey, in January and February 2013. On January 23, 2013 he described left shoulder discomfort for the past two weeks. (RX 6, p.11) He also complained of a stiff neck. Dr. Bailey recommended medication, range of motion exercises and to have an MRI if no improvement. Petitioner returned to Dr. Bailey on February 1, 2013. He describes his left shoulder pain as feeling like someone hit him with a sledgehammer and the Hydrocodone seemed to help. (RX 6, p.14) The doctor recommended Alleve and potentially Meloxicam, and indicates Petitioner will be seeing an orthopedic soon. (R6, 15)

Dr. McNally's June 6, 2013 examination for the left shoulder notes a positive impingement sign. (PX A) There is no indication Petitioner has any bruising on his bicep. The diagnosis is low back pain, radiulopathy, rotator cuff syndrome, and carpal tunnel syndrome. The recommendations are closed MRI of the lumbar spine, EMG of the lower extremities, night splints for CTS, physical therapy for the left shoulder, Meloxicam, and follow up after tests and response to PT. The assessment also does not mention the accident and states the shoulder is not related to the carpal tunnel syndrome. It diagnoses the shoulder as a strain. He makes no recommendation for a shoulder MRI and no recommendation for a shoulder specialist.

Petitioner filed out a "Patient Registration" Form on June 6, 2013. (RX 10) Petitioner left blank the question regarding whether the visit is related to a work incident or an accident and notes "not sure." (RX 10, p.2) He notes he has aches and pain and left shoulder stiffness. He also filled out a "Patient Medical History" Form on June 6, 2013 wherein he notes stiffness in left shoulder, June 2, 2013; and mentions "shoulder at work," but, does not indicate how the accident occurred. The only check is for gradual onset. (RX 11, p.1)

Following the June 6, 2013 appointment, Petitioner testified he continued to work full duty. He then took a pre planned vacation to Door County on June 20, 2013 through June 24, 2013. He testified he did not treat with a doctor or hospital while on vacation.

He noted the work incident when he presented for the MRI on June 25, 2013. (RX 7, p. 41) The notes states "left shoulder pain, caught himself with left arm falling off extension ladder." This is the first documentation of the specific work accident.

Following the MRI, Petitioner had a follow up appointment with Dr. Chhadia, a shoulder specialist at the same facility as Dr. McNally on June 28, 2013. His history includes mention of an accident on June 3, 2013. Dr. Chhadia placed Petitioner off work. Petitioner advised Dr. Chhadia he has no prior complaints or treatment to his left shoulder. (PX A) However, Petitioner treated with Dr. Bailey, his primary care doctor, for shoulder pain on January 23, 2013, and February 1, 2013 approximately five months before the alleged accident. (RX 6, p.11).

The phone records document Petitioner attempted to direct his care and the work history. On August 15, 2013 and August 16, 2014, the notes document that Dr. McNally only indicated his left shoulder was hurt at work, and that the Petitioner was concerned that his back needs to be documented. (RX 7, p.16) Following the June 28, 2014 examination with Dr. Chhadia, Petitioner saw Dr. McNally again on July 11, 2013, which does not mention any work accident. Dr. McNally referred Petitioner to Dr. Novoselstsky, a pain doctor in their office. Dr. McNally did not see him again until March 25, 2014. He

16IWCC0180

recommended Petitioner continue with his treatment with Dr. Novoselstsky and did not recommend any treatment for the neck or the back.

Dr. Chhadia performed surgery for Petitioner's torn rotator cuff on October 3, 2013. He also had left shoulder carpal tunnel release during that surgery. He continued to have complaints to his left shoulder and hands. Dr. Chhadia performed a right carpal tunnel release on December 19, 2013. Petitioner returned to physical therapy. He began work conditioning on May 13, 2014. His initial evaluation found he could work at the medium demand level. His release on June 12, 2014 found he could work at the medium to heavy demand level. The records indicated his job as a working construction supervisor called for the heavy demand level. Even though Petitioner could work at the medium to heavy demand level, Dr. Chhadia placed him off work rather than provide light duty restrictions. (PX A)

Petitioner first presented to Dr. Novoselstsky in July 2013. He treated for his neck. Petitioner had a cervical spine MRI on July 25, 2015 that showed degenerative disc disease. The diagnosis was degenerative disc disease and spondolysis. Petitioner had median blocks and a radiofrequency abalation. Dr. Novoselstsky's records do not reflect the treatment was related to a work injury or aggravated by the work accident.

Respondent scheduled an IME with Dr. Nicholson for September 25 2013. He was deposed on November 5, 2014. (RX 1) Dr. Nicholson opined that the Petitioner's left shoulder condition was causally related to his June 3, 2013 accident.

Petitioner testified on cross examination that he did not perform any side jobs or projects while he was off work. Petitioner testified that he "did what his body would allow him to do." Petitioner also testified that Dr. Chhaddia kept petitioner off work because Respondent had no light duty available. The Respondent presented surveillance video on varies days from February 2012 to October 2014. Petitioner performs various activities including driving, removing snow with a leaf blower, carrying items from the trunk of his car, filling a car with a gas from a plastic gas can, and shopping. (RX 13) On April 28, 2014 surveillance video documents Petitioner lifting multiple bags of potting soil into the trunk of his vehicle from a retail store. On April 29, 2014, surveillance video documents Petitioner removing bags from his trunk and beginning a landscaping project in his yard, lifting bags over his shoulder, bending down to dump the soil onto the ground and working with the soil from a bent and kneeling position. On May 2, 2014, surveillance video documents petitioner washing a full size van with a power washer and standing on the van's bumper to wash the roof of the van. On July 11, 2014, surveillance video documents petitioner riding a bike on a bike trail. (RX 13)

On May 1, 2014 Petitioner presented to Dr. Bernstein for a Respondent IME related to his neck and low back diagnosis. Dr. Bernste noted that Petitioner claimed his low back worked itself out and is improved. He reviewed the June 25, 2013, lumbar MRI showing very mild age related degenerative changes without disc herniation or nerve root compression. Dr. Bernstein reviewed the cervical MRI from July 25, 2013 describing multilevel degenerative change and the EMG from July 9, 2014 and July 16, 2013 which do not show cervical radiculopathy. (RX 3) Dr. Bernstein found petitioner, at most, suffered strains of the cervical and lumbar spine as a result of the work accident on June 3, 2013. He had no permanent injury to either the neck or low back. He recommended a conditioning and strengthening program and normal recreational activities on his own. He found petitioner was at MMI for the neck and low back injury, and that no injection therapy was indicated, necessary or causally related to the

16IWCC0180

work incident.

On May 13, 2014, Petitioner had an initial evaluation for work conditioning. (RX 8) He demonstrated the ability to work at the medium physical demand level. However, Dr. Chhadia continued him off work without restrictions.

On May 28, 2014 Petitioner returned to Dr. Nicholson for another IME. He opined Petitioner should continue with work conditioning. (RX 1) He saw nothing on examination for additional surgery or treatment beyond the work conditioning. He noted Petitioner had some pain and mild impingement signs. He recommended Petitioner's surgeon would evaluate him for MMI status after the treatment. He opined Petitioner was not a surgical candidate.

On June 18, 2014 Petitioner presented to Dr. Vender for Respondent's IME as it related to the bilateral carpal tunnel syndrome. Dr. Vender noted that Petitioner had complaints of numbness and tingling in his hands since January 2013 and that the Petitioner had an appointment scheduled with Dr. McNally for this condition prior to his June 3, 2013 accident. Petitioner advised that even after his carpal tunnel surgeries, he still had continued complaints to his hands. He noted diffused pain to his hands. Dr. Vender recommended an EMG that was conducted that day. Dr. Vender diagnosed Petitioner with status post bilateral carpal tunnel release and left ulnar neuropathy at the level of his elbow. He documented the neuropathy would not be related to his work injury and is not related to his carpal tunnel surgeries. Dr. Vender opined that Petitioner was at MMI for both carpal tunnel releases and did not require work restrictions. . He further opined that the diagnosis was not related to the June 3, 2013 work injury as the symptoms were present before then.

Petitioner returned to work with restrictions in July 2014. He testified he continues to work light duty and works as a bidder and a supervisor.

Petitioner presented Dr. Chhadia for testimony on September 22, 2014. (PX B) He provided a history of the first appointment testifying Petitioner indicated he had burning in the top of the shoulder and had pain at night. He documented Petitioner had no prior history of shoulder injury or pain before June 3, 2013. In regards to petitioner's carpal tunnel syndrome, he testified it was due to his repetitive overuse work. He did not testify to the type of work Petitioner performed, but indicated Petitioner used vibratory tools and repetitive lifting in awkward positions. He also was not aware Petitioner was a working supervisor. His opinion does not take into account Petitioner's actual job duties or the amount of time Petitioner uses tools on a routine basis. Dr. Chhadia testified that he found petitioner did not have cervical radiculopathy. He could not opine that the MRI of the neck showed degenerative changes that were caused by the work accident or by his work activities. He performed a second surgery on December 19, 2013 for the left hand carpal tunnel. Petitioner had a second shoulder MRI on April 2, 2014. Based on the MRI and petitioner's complaints, Dr. Chhadia recommended a second surgery indicating Petitioner had additional findings not present at the time of the surgery yet related to the original injury. (PX B, p.31) The subscapularis and infraspinatus had some changes that could be causing pain and surgery could improve. Later, he testified he could not opine that the current finding on the MRI were related to the work accident. (PX B, p.80),

On January 28, 2015 petitioner presented Dr. McNally for testimony (PX H). Dr. McNally could not recall a specific work accident but indicated Petitioner could have told him and he simply did not write it down. He admitted his record are not perfect and the history could have been left out. He could not recall

16IWCC0180

if he recommended the MRI or Dr. Chhadia's appointment or not, but both would have been reasonable based on his review the June 3, 2014 office note as Petitioner had an impingement. Dr. McNally testified that working in construction could exacerbate carpal tunnel. He did not indicate Petitioner's job duties. He found the shoulder and neck could have been the same injury. He testified the neck was related to the work accident. (PX H, p.17) He later testified he was not aware of the work accident (PX H,p.20)

Petitioner testified that he wants additional treatment for his left shoulder, including the recommended surgery, and indicated he wanted to treat with a different doctor.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has failed to meet his burden of proof. This finding is based on both the Petitioner's testimony and the medical evidence – both of which lack any basis to support an accident claim under a repetitive trauma theory. According to the Petitioner's Application for Adjustment of Claim (Arb.Exh.4), Petitioner is alleging an accident from "Overuse repetitive heavy load conditions in scope of employment" and indicates the body part affected as "Neck, man as a whole." However, there was no testimony offered showing the Petitioner involved in any repetitive heavy load activities. Furthermore, there was no medical evidence to suggest that there was any causal connection between the July 25, 2013 MRI findings revealing Petitioner's degenerative disc disease, and the Petitioner's employment for Respondent. As such, the Arbitrator concludes that the Petitioner failed to prove that he sustained and accident arising out of and in the course of his employment on July 25, 2013.

2. Based on the Arbitrator's findings with regard to the issue of accident, all other issues are rendered moot.

14 WC 24173

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Trevor McLaughlin,
Petitioner,

vs.

NO: 14 WC 24173
consol. 13 WC 22758
14 WC 24172

TJ's Maintenance and Remodeling, LLC,
Respondent.

16IWCC0181

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical care, and temporary total disability benefits, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on May 7, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under Section 19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

MAR 14 2016

DATED:
MJB:ell
O-01/12/16
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

McLAUGHLIN, TREVOR
Employee/Petitioner

Case# **14WC024173**

13WC022758
14WC024172

TJ'S MAINTENANCE AND REMODELING LLC
Employer/Respondent

16IWCC0181

On 5/7/2015, 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 0.07% 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:

4392 LAW OFFICES OF HELEN BLOCH
33 N LASALLE ST
SUITE 3200
CHICAGO, IL 60602

0210 GANAN & SHAPIRO PC
MELISSA McENDRE
210 W ILLINOIS ST
CHICAGO, IL 60654

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

☐ 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
19(b)

Trevor McLaughlin
Employee/Petitioner

v.

T.J.'s Maintenance and Remodeling, LLC
Employer/Respondent

Case # **14WC 24173**

Consolidated cases: **14WC 24172 and 13 WC 22758**

16IWCC0181

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 **Gerald Granada**, Arbitrator of the Commission, in the city of **New Lenox**, on **April 7, 2015**. 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **6/6/13**, 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 not*** 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**51,584.00**; the average weekly wage was $**992.00**

On the date of accident, Petitioner was **46** years of age, ***married*** with **2** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**24,139.86** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**24,139.86**.

Respondent is entitled to a credit of $**1,553.90** under Section 8(j) of the Act.

ORDER

Petitioner failed to meet his burden of proof on the issue of accident. Claim denied.

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.

Signature of Arbitrator — **5/5/15** Date

MAY 7 – 2015

16IWCC0181

FINDINGS OF FACT

At the time of the arbitration hearing, Petitioner presented three consolidated claims. Each claim will be addressed in separate decisions. This decision relates to Petitioner's claim stemming from an alleged work injury which manifested on June 6, 2013 due to repetitive trauma. In this case, the issues in dispute are as follows: 1) accident; 2) causation; 3) medical expenses; 4) TTD; and 5) prospective medical care.

On July 25, 2013, Petitioner was 46 years old and employed as a working supervisor for Respondent, which was a company owned by Petitioner's brother Tim McLaughlin. Petitioner's sister Tammy worked in the Respondent's office and assigned work orders. Neither Tim nor Tammy testified at the arbitration hearing.

Petitioner's job duties consisted of monitoring projects, making bids to potential clients, performing constructions jobs and working on maintenance projections for regular customers. He also performed tasks of a carpenter and was required to lift product, climb ladders and used tools of the trade including hammers. Petitioner also testified that he used vibratory tools. In 2013 he was assigned to resurfacing the pavement and replacing steel doors at a trucking company. He also worked in an attic removing mold and installing new vents to prevent mold in the future. On June 3, 2013, Petitioner injured his left arm when he caught himself from falling off a ladder – which is the subject matter of companion case13 WC 22758.

Petitioner provided a written statement to his employer ated June 28, 2013. (RX 9) The statement documents Petitioner's understanding of the chronology of events between June 2, 2013 and June 28, 2013. Petitioner further testified that he prepared the written statement as he needed to be covered for a shoulder injury. Petitioner submitted his carpal tunnel treatment through his group carrier. He testified he requested a form from Respondent but they gave him the wrong form, so he wrote the statement. The statement does not indicate he advised anyone at Respondent of the accident. The statement indicates he told the office he had a doctor's appointment on June 6, 2013. According to the statement Petitioner did not have an off work note until June 28, 2013. The statement documents Petitioner worked June 3, 2013 through June 19, 2013. He went on vacation from June 20, 2013 through June 24, 2013. He then returned to work for June 25, 2013 through June 28, 2013. The statement documents his insurance would not authorize the MRI until June 16, 2013. He does not distinguish whether the MRI is for his back or shoulder.

Petitioner testified he had a doctor's appointment on June 6, 2013 with Dr. McNally for numbness to his hand and feet that was prescheduled. Dr. McNally's office notes document the history of the arm and feet numbness. Regarding the left shoulder, the records only state that something happened on Monday, and there is no history of accident. Petitioner testified he explained the entire incident to Dr. McNally at the exam. Dr. McNally's record states "last Monday, he did something to his left shoulder. " He does not state that "something" occurred at work. He states he was having pain and limited range of motion. He also states that he had a previous rotator cuff tear and biceps tear and the left shoulder "feels different." The note states his primary doctor told him to wait and see if it clears up. The only notes from his primary doctor is from January and February 2013. (RX 6) Petitioner advised Dr. Bare that his bicep was "black and blue" after the accident. (RX 5, p.1) Dr. McNally made no note of any bruising during his examination.

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Petitioner had presented to his family doctor, Dr. Bailey, in January and February 2013. On January 23, 2013 he described left shoulder discomfort for the past two weeks. (RX 6) He also complained of a stiff neck. Dr. Bailey recommended medication, range of motion exercises and to have an MRI if no improvement. Petitioner returned to Dr. Bailey on February 1, 2013. He describes his left shoulder pain as feeling like someone hit him with a sledgehammer and that the Hydrocodone seemed to help. The doctor recommended Alleve and potentially Meloxicam, and indicates Petitioner will be seeing an orthopedic soon.

Dr. McNally's June 6, 2013 examination for the left shoulder notes a positive impingement sign. (PX A) There is no indication Petitioner has any bruising on his bicep. The diagnosis is low back pain, radiulopathy, rotator cuff syndrome, and carpal tunnel syndrome. The recommendations are closed MRI of the lumbar spine, EMG of the lower extremities, night splints for CTS, physical therapy for the left shoulder, Meloxicam, and follow up after tests and response to PT. The assessment also does not mention the accident and states the shoulder is not related to the carpal tunnel syndrome. It diagnoses the shoulder as a strain. He makes no recommendation for a shoulder MRI and no recommendation for a shoulder specialist. Petitioner testified that the prescription did not indicate a shoulder MRI.

Petitioner filed out a "Patient Registration" Form on June 6, 2013. (RX 10) Petitioner left blank the question regarding whether the visit is related to a work incident or a accident and notes "not sure." (RX 10, p.2) He notes he has aches and pain and left shoulder stiffness. (RX 10, p.2) He also filled out a "Patient Medical History" Form on June 6, 2013 wherein he notes stiffness in left shoulder, June 2, 2013; and mentions "shoulder at work," but, does not indicate how the accident occurred. The only check is for gradual onset. (RX 11, p.1)

Following the June 6, 2013 appointment, Petitioner testified he continued to work full duty. He then took a pre planned vacation to Door County on June 20, 2013 through June 24, 2013. He testified he did not treat with a doctor or hospital while on vacation.

He noted the work incident when he presented for the MRI on June 25, 2013. (RX 7, p. 41) The notes states "left shoulder pain, caught himself with left arm falling off extension ladder." (RX 7, p. 41) This is the first documentation of the specific work accident.

Following the MRI, Petitioner had a follow up appointment with Dr. Chhadia, a shoulder specialist at the same facility as Dr. McNally on June 28, 2013. The records include the history of an accident on June 3, 2013. Dr. Chhadia placed Petitioner off work. Petitioner advised Dr. Chhadia he has no prior complaints or treatment to his left shoulder. (PX A) However, Petitioner treated with Dr. Bailey, his primary care doctor, for shoulder pain on January 23, 2013, and February 1, 2013 approximately five months before the alleged accident. (RX 6, p.11)

Dr. Chhadia performed surgery for Petitioner's torn rotator cuff on October 3, 2013. He also had left shoulder carpal tunnel release during that surgery. He continued to have complaints to his left shoulder and hands. Dr. Chhadia performed a right carpal tunnel release on December 19, 2013. Petitioner returned to physical therapy. He began work conditioning on May 13, 2014. His initial evaluation found he could work at the medium demand level. His release on June 12, 2014 found he could work at the medium to heavy demand level. The records indicated his job was a working construction supervisor called for the heavy demand level. Even though Petitioner could work at the medium to heavy demand

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level, Dr. Chhadia placed him off work rather than provide light duty restrictions. (PX A)

Petitioner first presented to Dr. Novoselstsky in July 2013. He treated for his neck. Petitioner had a cervical spine MRI on July 25, 2015 that showed degenerative disc disease. The diagnosis was degenerative disc disease and spondolysis. Petitioner had median blocks and a radiofrequency abalation. The records do not reflect the treatment was related to a work injury or aggravated by the work accident.

Respondent scheduled an IME with Dr. Nicholson for September 25 2013. He was deposed on November 5, 2014. (RX 1) Dr. Nicholson opined that the Petitioner's left shoulder condition was causally related to his June 3, 2013 accident.

Petitioner testified on cross examination that he did not perform any side jobs or projects while he was off work. Petitioner testified that he "did what his body would allow him to do." Petitioner also testified that Dr. Chhaddia kept him off work because Respondent had no light duty available. The Respondent presented surveillance video on various days from February 2012 to October 2014. (See RX 13) Petitioner performs various activities including driving, removing snow with a leaf blower, carrying items from the trunk of his car, filling a car with a gas from a plastic gas can, and shopping. On April 28, 2014 surveillance video documents Petitioner lifting multiple bags of potting soil into the trunk of his vehicle from a retail store. On April 29, 2014, surveillance video documents Petitioner removing bags from his trunk and beginning a landscaping project in his yard lifting bags over his shoulder, bending down to dump the soil onto the ground and working with the soil from a bent and kneeling position. On May 2, 2014, surveillance video documents petitioner washing a full size van with a power washer and standing on the van's bumper to wash the roof of the van. On July 11, 2014, surveillance video documents petitioner riding a bike on a bike trail.

On May 1, 2014 Petitioner presented to Dr. Bernstein for a Respondent IME related to his neck and low back diagnosis. Petitioner told Dr. Bernstein his low back worked itself out and is improved. He reviewed the June 25, 2013, lumbar MRI showing very mild age related degenerative changes without disc herniation or nerve root compression. Dr. Bernstein reviewed the cervical MRI from July 25, 2013 describing multilevel degenerative change and the EMG from July 9, 2014 and July 16, 2013 which do not show cervical radiculopathy. (RX 3) Dr. Bernstein found petitioner, at most, suffered strains of the cervical and lumbar spine as a result of the work accident on June 3, 2013. He had no permanent injury to either the neck or low back. He recommended a conditioning and strengthening program and normal recreational activities on his own. He found petitioner was at MMI for the neck and low back injury, and that no injection therapy was indicated, necessary or causally related to the work incident.

On May 13, 2014, Petitioner had an initial evaluation for work conditioning. (RX 8) He demonstrated the ability to work at the medium physical demand level. However, Dr. Chhadia continued him off work without restrictions.

On May 28, 2014 Petitioner returned to Dr. Nicholson for another IME. He opined Petitioner should continue with work conditioning. (RX 1) He saw nothing on examination for additional surgery or treatment beyond the work conditioning. He noted Petitioner had some pain and mild impingement signs. He recommended Petitioner's surgeon would evaluate him for MMI status after the treatment. He opined Petitioner was not a surgical candidate.

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On June 18, 2014 Petitioner presented to Dr. Vender for Respondent's IME to address Petitioner's bilateral carpal tunnel syndrome. Dr. Vender noted that Petitioner had complaints of numbness and tingling in his hands since January 2013 and that the Petitioner had an appointment scheduled with Dr. McNally for this condition prior to his June 3, 2013 accident. Petitioner advised that even after his carpal tunnel surgeries, he still had continued complaints to his hands. He notes diffused pain to his hands. Dr. Vender recommended an EMG that was conducted that day. Dr. Vender diagnosed Petitioner with status post bilateral carpal tunnel release and left ulnar neuropathy at the level of his elbow. He documented the neruopathy would not be related to his work injury and is not related to his carpal tunnel surgeries. Dr. Vender opined that Petitioner was at MMI for both carpal tunnel releases and did not require work restrictions. . He further opined the diagnosis was not related to the June 3, 2013 work injury as the symptoms were present before then.

Petitioner returned to work with restrictions in July 2014. He testified he continues to work light duty and works as a bidder and a supervisor.

Dr. Chhadia testified via evidence deposition on September 22, 2014. (PX B) He provided a history of the first appointment testifying Petitioner indicated he had burning in the top of the shoulder and had pain at night. He documented Petitioner had no prior history of shoulder injury or pain before June 3, 2013. In regards to petitioner's carpal tunnel syndrome, he testified it was due to his repetitive overuse work. He did not testify to the type of work Petitioner performed, but indicated Petitioner used vibratory tools and repetitive lifting in awkward positions. He also was not aware Petitioner was a working supervisor. His opinion does not take into account Petitioner's actual job duties or the amount of time Petitioner uses tools on a routine basis. Dr. Chhadia testified that he found petitioner did not have cervical radiculopathy. He could not opine that the MRI of the neck showed degenerative changes that were caused by the work accident or by his work activities.

Petitioner had a second shoulder MRI on April 2, 2014. Based on the MRI and petitioner's complaints, Dr. Chhadia recommended a second surgery indicating Petitioner has additional findings not present at the time of the surgery yet related to the original injury. (PX B, p.31) The subscapularis and infraspinatus had some changes that could be causing pain and surgery could improve. Later, he testified he could not opine that the current finding on the MRI are related to the work accident. (PX B, p.80)

On January 28, 2015 petitioner presented Dr. McNally for testimony. (PX H) Dr. McNally could not recall a specific work accident but indicated Petitioner could have told him and he simply did not write it down. He admitted his records are not perfect and the history could have been left out. He could not recall if he recommended the MRI or Dr. Chhadia's appointment, but both would have been reasonable based on his review the June 3, 2014 office note as Petitioner had an impingement. Dr. McNally testified that working in construction could exacerbate carpal tunnel. He did not indicate Petitioner's job duties. He found the shoulder and neck could have been the same injury. He testified the neck was related to the work accident. He later testified he was not aware of the work accident. (PX H, p.20)

Petitioner testified that he wants additional treatment for his left shoulder, including the recommended surgery, and indicated he wanted to treat with a different doctor.

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CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has failed to meet his burden of proof. This finding is based on both the Petitioner's testimony and the medical evidence – both of which lack any basis to support an accident claim under a repetitive trauma theory. The evidence fails to show that the Petitioner's job was repetitive by any means. By Petitioner's own description of his job as a project manager or working supervisor, his job duties varied throughout the day and differed each day depending on the project. Although Petitioner testified that he used vibratory tools and other hand tools, there was no evidence as to the frequency, duration or force required in using those tools. Use of those tools seemed to be very minimal given the supervisory nature of Petitioner's job with Respondent. Furthermore, there was no evidence that the Petitioner had any complaints to his feet or his hands contemporaneous with any particular work activity. Although Dr. McNally and Dr. Chhadia opined that the Petitioner's work could cause carpal tunnel syndrome, they did not express an understanding of what Petitioner did in his work, nor what specific aspects of Petitioner's work caused the carpal tunnel – thus providing very little weight on their opinions regarding causation. Furthermore, there was essentially no medical evidence showing Petitioner had any treatment for his feet. Based on all these factors, the Arbitrator concludes that the Petitioner failed to prove that he sustained an accident that manifested on June 6, 2013.

2. Based on the Arbitrator's findings with regard to the issue of accident, all other issues are rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jama Guethle,

Petitioner,

16IWCC0146

vs.

NO: 14WC26608

Chester Rehabilitation & Nursing,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 2, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

16IWCC0146

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 - 2016
o2/9/16
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

16IWCC0146

GUETHLE, JAMA
Employee/Petitioner

Case# 14WC026608

CHESTER REHABILITATION & NURSING
Employer/Respondent

On 7/2/2015, 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 0.11% 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:

4075 FISHER KERKHOVER COFFEY ET AL
JASON ECOFFEY
PO BOX 191
CHESTER, IL 62233

2542 BRYCE DOWNEY & LENKOV
RICHARD LENKOV
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

16IWCC0146

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Jama Guethle
Employee/Petitioner

v.

Chester Rehabilitation & Nursing
Employer/Respondent

Case # 14 WC 26608

Consolidated cases: None

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 **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **May 14, 2015**. 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. [x] 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. [x] 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. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **03/22/14**, 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 $**29,084.12**; the average weekly wage was $**559.31**.

On the date of accident, Petitioner was **53** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**4,440.37** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**4,440.37**.

Respondent is entitled to a credit of $**0.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $4,977.75, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $369.14/week for 11 5/7 weeks, commencing May 31, 2014 through August 20, 2014, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $4,440.37 for temporary total disability benefits that have been paid.

Respondent shall further authorize and pay for the surgery as currently recommended by Dr. Tony Chien, Petitioner's treating physician.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

Signature of Arbitrator

6/20/15
Date

JUL 2 - 2015

FINDINGS OF FACT

The parties presented for hearing pursuant to Section 19(b) of the Illinois Workers' Compensation Act. The parties placed into dispute the following issues: causal connection, temporary total disability, medical bills, and prospective medical treatment. The Petitioner testified at the hearing on May 14, 2015.

The Petitioner testified she was a 53 year old licensed practical nurse at Chester Rehabilitation & Nursing, a position she has held for three years. The Petitioner's job duties generally involve passing out medication and taking care of elderly residents at the facility. On March 22, 2014, the Petitioner claimed to have suffered a work-related accident when there was an elderly patient attempting to get in his shower with his clothes on. The Petitioner went into the bathroom, reached to turn the shower off so the resident would not get wet and when she reached, she twisted her left knee. The Petitioner immediately reported the injury to her employer. She then sought medical treatment with her primary-care physician, Dr. Lisa Lowry, at the Chester Clinic.

The medical records received into evidence indicate the Petitioner initially saw Angela Albertini, P.A., at Chester Clinic on March 24, 2014 providing a history that she was at work and a resident was trying to shower with his clothes on and when Petitioner reached up to turn shower off and left knee turned the other way and has been swollen and painful (Px. 1, pg. 2). Petitioner was then scheduled for MRI examination.

The Petitioner underwent MRI examination on March 28, 2014. The radiologist held an impression the MRI revealed severe erosive chondromalacia and moderate joint effusion associated with large Baker's cyst, focal tear of the posterior horn of the medial meniscus, and possible low-grade tear of the anterior horn of the lateral meniscus (Px. 2, pg. 4). The Petitioner was referred to Dr. Tony Chien, an orthopedist, following the MRI.

The Petitioner presented for treatment with Dr. Chien on April 4, 2014. Dr. Chien noted the patient injured herself at work on March 22, 2014 when "reaching to turn off shower at work when her left knee buckled and give on her" (Px. 3, pg. 41). Dr. Chien confirmed the diagnosis as presented on MRI examination and referred the Petitioner for surgery (Px. 3, pg. 42).

Following this recommendation, the Petitioner was requested to undergo a Section 12 examination with Dr. August Ritter. Dr. Ritter felt Petitioner's left knee pain was exacerbated by her work injury and she should undergo an injection and physical therapy prior to surgery. Dr. Chien then performed an injection on August 21, 2014 and allowed to return to work on a restricted basis (Px. 3, pg. 59). The Petitioner also attempted to undergo physical therapy but was told workers' comp would not approve any physical therapy. The Petitioner testified the injection provided no relief and she has persistent left knee pain since the date of injury. The testimony was confirmed through a medical record entered into evidence from October 30, 2014 with Dr. Chien. At that time, Dr. Chien noted "the patient did not have any improvement in symptoms with mediations and steroid injections" (Px. 3, pg. 65). Dr. Chien, once again, recommended surgery (Px. 3, pg. 66). The Petitioner testified she wishes to undergo surgery as recommended by Dr. Chien at this time.

The Petitioner also testified she has never had any medical treatment or trauma to her left knee prior to March 22, 2014.

On cross-examination, the Petitioner confirmed she is still working light-duty at this time and has been since August 21, 2014. She is doing paperwork at this time for Chester Rehabilitation & Nursing.

Dr. Tony Chien also testified, via deposition, on February 12, 2015. Dr. Chien testified he is a board certified orthopedic surgeon who has treated Petitioner since April 4, 2014. Dr. Chien took a history from Petitioner, performed a physical examination, and reviewed the MRI films for Petitioner. Dr. Chien diagnosed Petitioner with medial and lateral meniscal tears of the left knee along with a Baker's cyst and effusion of the left knee (Px. 3, pg. 8). Dr. Chien did allow the Petitioner to return to work on a restricted basis and recommended surgery (Px. 3, pg. 9). Dr. Chien testified he had been waiting on approval from workers' comp. for surgery since the first visit (Px. 3, pg. 10). Dr. Chien also testified he then kept Petitioner off of work completely from May 30, 2014 through August 20, 2014 (Px. 3, pg. 10). Dr. Chien noted the injection he ultimately attempted did not provide any relief to the Petitioner (Px. 3, pg. 11). Dr. Chien stated he has simply been following-up with Petitioner ever since waiting on approval from workers' comp. for surgery (Px. 3, pg. 12).

Dr. Chien opined that the majority of Petitioner's knee problems are directly related to her work injury of March 22, 2014 (Px. 3, pg. 12-13). Dr. Chien noted Petitioner had pre-existing chondromalacia, as well as arthritis, "but the injury could also cause that aggravation of her arthritis and chondromalacia of her knee" (Px. 3, pg. 13).

The Section 12 examiner, Dr. August Ritter, III, also testified, via deposition, on May 7, 2015. Dr. Ritter testified he was board certified in orthopedic surgery. Dr. Ritter performed an evaluation of Petitioner on July 8, 2014 (Rx. 1, pg. 10). Dr. Ritter took a history and performed a physical examination on Petitioner and diagnosed Petitioner with an acute exacerbation of her degenerative arthritis with some superimposed psoriatic arthritis with evidence of a posterior horn medial meniscus tear (Rx. 1, pg. 12). Dr. Ritter felt the meniscus tear was caused by the work injury, but that her current complaints were primarily caused by her underlying arthritic change in her knee (Rx. 1, pg. 13). Dr. Ritter did not believe the underlying arthritis was related to Petitioner's work injury (Rx. 1, pg. 14).

On cross-examination, Dr. Ritter testified he never reviewed the actual MRI films for Petitioner, just the radiologist report. Dr. Ritter also admitted he did not review any other medical records prior to his evaluation on July 8, 2014 (Rx. 1, pg. 15). Dr. Ritter also testified an injury might have made Petitioner's arthritis "more bothersome" (Rx. 1, pg. 16).

CONCLUSIONS

The Petitioner's current condition of ill-being is causally-related to her work injury of March 22, 2014. The Petitioner's testimony was credible. The Petitioner's testimony correlates with the treatment records received into evidence. The Arbitrator finds the causation opinion of Dr. Chien to be more persuasive than that of Dr. Ritter, the Section 12 examiner. Dr. Chien reviewed the actual MRI films and has persistently recommended surgical intervention to correct Petitioner's knee pain. Dr. Ritter did not review

any medical records, or the MRI film, and even conceded, the work injury caused the meniscal tears and Petitioner's arthritis would be "more bothersome" following her work injury.

The Arbitrator further notes that Petitioner has never had any left knee injury or medical treatment prior to March 22, 2014. It is well-settled that if a pre-existing condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Rock Road Construction Co. v. Industrial Commission,* 37 Ill.2d 123. Even if Petitioner, in this case, had some degree of pre-existing chondromalacia and arthritis, she never had any problem with it prior to her work injury. Dr. Chien opined the chondromalacia and arthritis could have been aggravated by her injury. Dr. Ritter conceded the arthritis could be "more bothersome" following her injury. Accordingly, the Arbitrator concludes the Petitioner's condition of ill-being is causally-related to her work injury of March 22, 2014.

The Respondent disputed liability for TTD and medical bills based upon their dispute as to causal connection. Based upon the conclusion herein regarding causal connection, the Arbitrator hereby concludes the Respondent shall pay the medical bills submitted in Petitioner's Group Exhibit #4 pursuant to Section 8(a) and 8.2 of the Illinois Workers' Compensation Act. The Respondent shall also pay TTD benefits for the period of May 31, 2014 through August 20, 2014, a period of 11 5/7 weeks. The Respondent shall, however, be entitled to a credit of $4,440.37 for all TTD benefits paid to date.

The Respondent shall also authorize and pay for the surgery as recommended by Dr. Tony Chien at this time.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SANDRA JOHNSON-CLEMONS,

Petitioner,

vs. NO: 14 WC 29622

RUSH UNIVERSITY MEDICAL CENTER,

Respondent.

16IWCC0182

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, and temporary total disability (TTD), and being advised of the facts and applicable law, reverses the Decision of the Arbitrator as stated below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all of the testimony, exhibits, pleadings and arguments submitted by the parties. Based upon the evidence, the Commission finds that Sandra Johnson-Clemons sustained a work-related injury arising out of and in the course of her employment on July 24, 2014. The Commission finds petitioner reached maximum medical improvement (MMI) as of December 17, 2014. Therefore, petitioner is entitled to all reasonable and necessary medical expenses through December 17, 2014. The petitioner is further entitled to TTD benefits from July 25, 2014 through December 17, 2014.

16IWCC0182

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings:

1. Ms. Johnson-Clemons testified that she works in a customer service oriented job with respondent that was "not at all physical." She would clean the patient rooms, introduce herself to the patients, and stock the rooms. T.11. She denied prior back issues. *Id.* Beginning in April 2014, petitioner testified that her job became full-time and she started to clean the offices, dust, vacuum, and take out the trash. T.12. She had to work 8 hour days and do a lot more work. T.13. This caused her to become more sore as she was using muscles that she had not used before. T.14.

2. On July 24, 2014, Ms. Johnson-Clemons was asked by her supervisor to empty a recycle bin as the employee whose job it was to empty the bin was off that day. T.16. She grabbed the bag with both hands and lifted the bag. T.18. The bag was half filled with papers and files. T.20. She stated the bag was heavy, but she did not feel anything. T.21. Petitioner's exhibit 1 contains a picture of a recycle bin similar to the one petitioner emptied. PX.1.

3. Petitioner finished working her shift, or worked another 45 minutes to an hour. T.21. She testified that she really did not notice anything, and noticed a little tightness once she stopped working. She did not think anything of it. T.22. She mentioned to her supervisor that the recycle bin was heavy and she was a little tight. Again, she did not think anything of it. *Id.*

4. Ms. Johnson-Clemons got a ride home from her co-worker and mentioned that the recycle bin was heavy and her back was now tight. T.23. She arrived home and took a longer than usual hot shower and went to bed. She awoke around 3 to 4 in the morning with pain radiating from her lower back to her left leg. She testified that she had never had this feeling before. T.24. Her pain got worse so she took two Aleve and laid back down. *Id.* She took a hot bath the next morning and noticed that she started to develop muscle spasms. T.25. She had to crawl from her bathroom to her bedroom and lay on the floor. *Id.*

5. Petitioner presented to Rush University on July 25, 2014. Per the medical report, petitioner had lower back pain with spasms for two weeks. She had pain radiating down her left leg with tingling and numbness to her left big toe. She denied any trauma. She reported that her pain had been improving until she picked up a heavy "box" last night. X-ray revealed very small osteophytes adjacent disk margins. There was mild degenerative sclerosis of the lower lumbar facets and SI joints. Petitioner was able to sit and stand. She had pain with ambulation. Petitioner had left buttock and hip pain radiating down to her toes that had been worse today. She had milder symptoms over the last couple of weeks. She had a pulling sensation in her lower back while vacuuming as

part of her job duties. Examination of the left hip revealed decreased range of motion. There was no tenderness in the left hip or back. She had a negative straight leg raise. The diagnosis was "likely" lumbar radiculopathy. PX.3.

6. Petitioner testified that she did not tell the doctors she had spasms for two weeks as she did not have spasms. She told them that she had a twinge in her back. T.26.

7. Ms. Johnson-Clemons presented to Rush University on July 27, 2014 with continued lower back pain that had been present for a few weeks and felt like a "twinge." She reported that she picked up a heavy "box" and was now experiencing increased pain in her left buttock radiating down to her left leg. Her condition did not improve despite the muscle relaxers and pain medication. She had numbness and tingling along the medial aspect of her foot. PX.3.

8. According to the work status report dated July 29, 2014, petitioner's condition was not work related. She was, however, unfit for work on this day. PX.2.

9. Petitioner was seen at Rush on July 30, 2014. She recently went to the ER twice for lower back pain radiating to the left lower extremity. Her pain was 5 out of 10 and getting worse with movement. She could hardly walk and she had numbness and a tingling sensation in her left big toe and the arch. She had tightness on palpation bilaterally at the vertebrae lumbar level. She had a positive straight leg raise. The assessment was low back pain. An MRI was recommended. PX.3.

10. On July 30, 2014, the work status note indicated that Petitioner's condition was pending work-related. She was unable to work from July 25, 2014 through August 13, 2014 and was to be released to work on August 14, 2014. PX.2.

11. Petitioner underwent an MRI of the lumbar spine without IV contrast on July 31, 2014 at Rush University. At L4-L5, there was mild-to-moderate spinal canal, moderate-to-severe right and moderate left foraminal stenosis. At L5-S1, there was moderate left foraminal stenosis. There was bilateral facet arthropathy noted at multiple levels, most marked at L4-L5 and L5-S1. PX.2.

12. Petitioner provided a recorded statement on August 4, 2014. Petitioner reported that on July 24, 2014, she lifted a half full bag of recycle paper out of a bin. She did not feel pain when she pulled the bag. She reported to her supervisor at the end of her shift that the bag was heavy. She started to have muscle spasms at 3 in the morning. RX.2.

13. Petitioner underwent a lumbar evaluation at Rush on August 6, 2014. Petitioner reported left low back pain with constant numbness in the big toe and medial arch of the left foot with intermittent shooting pain throughout the left lower extremity. Petitioner reported she lifted a heavy "bag" of recycling paper on July 25, 2014. She did not experience pain;

however, she had an onset of symptoms later that night and her symptoms had since progressed. She had increased tenderness in her left low back, left quad, and left iliac crest. She had increased tightness of bilateral lumbar paraspinals. She was to continue physical therapy. PX.3.

14. Per the work status report of August 14, 2014, Petitioner was unfit for duty from August 14, 2014 through August 27, 2014. Then on August 27, 2014, petitioner's condition was again noted as not work related, but she was unfit for duty until cleared by PMD. PX.2.

15. Petitioner saw Dr. James Mok of University of Chicago on September 15, 2014. She had lower back pain and left lower extremity pain after lifting a heavy bag at work. Dr. Mok noted the MRI demonstrated L4-L5 degenerative spondylolisthesis and spinal stenosis. He recommended an epidural injection. Dr. Mok noted that petitioner's symptoms were likely secondary to L4-L5 spondylolisthesis and spinal stenosis. Her findings were likely present prior to the accident, but the twisting motion "may" have irritated the nerve roots, which was causing her current radiculopathy. PX.4.

16. Ms. Johnson-Clemons was seen by Dr. David Dickerson of University of Chicago on September 25, 2014 for pain control. Petitioner's pain began after lifting the bag from the recycling bin off the ground. She did not recall a specific motion that caused the injury, but noted that 5 to 6 hours later she had severe back pain that was shooting in nature. She no longer complained of radicular symptoms and felt that her pain was improving. The diagnosis was myofacial pain and spondylolisthesis of the lumbar region. PX.4.

17. On September 29, 2014, Dr. Joel Augustin kept petitioner off work from September 30, 2014 through October 28, 2014. PX.2.

18. Petitioner underwent a Section 12 examination with Dr. Andrew Zelby on October 31, 2014. It was noted that petitioner lifted a heavy recycle "back" (sic) that was half full of paper that she estimated weighed more than 50 pounds. Petitioner did not have pain at that time, but developed pain a few hours later. Dr. Zelby diagnosed petitioner with lumbosacral spondylosis, spondylolisthesis-acquired, and lumbar stenosis. He noted that the medical records indicated petitioner had the same symptoms that she currently ascribed to her work injury in the two weeks prior to her injury. He stated that, at most, her condition was a temporary exacerbation of a pre-existing already symptomatic condition that was not aggravated or accelerated beyond its normal progression. The fact that she did not feel an increase in symptoms when the incident occurred made a temporary exacerbation possible, but medically unlikely. She only needed physical therapy and had reached MMI for any component of her condition that might be related. The injections were for the ongoing pre-existing already symptomatic degenerative condition. Her absence from work was related to the degenerative condition. RX.3.

19. Petitioner underwent a lumbar epidural injection on November 5, 2014. PX.4.

20. Petitioner was seen by Dr. Mok on November 7, 2014. Dr. Mok noted Petitioner's condition was degenerative, and there was an exacerbation at work. Radiographically there was no apparent acute change. He discussed a fusion and laminectomy with her. They were going to discuss an FCE if she wanted permanent restrictions. PX.4.

21. Petitioner was seen by Dr. Mok on December 17, 2014. Petitioner reported that she had significant improvement with her lower back and left leg pain. The injection resolved her lower back spasms. She reported 100 percent relief of her low back pain and radicular symptoms. She still had an aching pain in her lower back, mainly on the left. She was able to ambulate without much difficulty. She had no left lower extremity symptoms. Examination of the left lower extremity revealed no tenderness to palpation about the spinous prostheses with minimal discomfort when palpating over the paraspinal musculature of the left side. The assessment was L4-L5 spondylolisthesis and spinal stenosis. Surgery was ruled out given her improvement. She was to follow-up on a per needed basis. PX.4. Petitioner testified that this was her last visit Dr. Mok as she was released and did not require surgery. T34.

22. Petitioner testified that she had problems walking from the time of the accident until two months later. She was having spasms down her leg. She could not walk upstairs and it was hard for her to get in and out of a car. T.31. She could not cook for herself as she could not stand for long periods of time. She had to have family members care for her. She could not use public transportation since she could not walk long enough to make it to the front door. *Id.* She walked with a limp as she could not straighten her leg.

23. Petitioner testified that she still experiences pain in her back with movement. It is hard for her to find a comfortable position. She does not have the leg pain, however. T.33. When she told the doctors she was 100 percent, she meant her leg pains were 100 percent. T.34. She can now walk upstairs. *Id.* She testified that she would like to try to work her job full-duty. T.43.

The Commission is not bound by the Arbitrator's findings, and may properly determine the credibility of witnesses, weigh their testimony and assess the weight to be given to the evidence. *R.A. Cullinan & Sons v. Industrial Comm'n*, 216 Ill. App. 3d 1048, 1054, 575 N.E.2d 1240, 159 Ill. Dec. 180 (1991). It is the province of the Commission to weigh the evidence and draw reasonable inferences therefrom. *Niles Police Department v. Industrial Comm'n*, 83 Ill. 2d 528, 533-34, 416 N.E.2d 243, 245, 48 Ill. Dec. 212 (1981). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Industrial Comm'n*, 51 Ill. 2d 533, 536-37, 283 N.E.2d 875, 877 (1972).

Whether a claimant's disability is attributable solely to a degenerative process of the pre-existing condition or to an aggravation or acceleration of a pre-existing condition because of an accident is a factual determination to be decided by the Industrial Commission. *Roberts v.*

Industrial Comm'n, 93 Ill. 2d 532, 538, 67 Ill. Dec. 836, 445 N.E.2d 316 (1983); *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d at 36-37.

The Commission finds that Petitioner sustained a work-related injury on July 24, 2014. The evidence establishes that Petitioner was asked to empty a large recycle bin as her co-worker was absent that day. She subsequently mentioned to her supervisor that the recycle bin was heavy and that she was now tight. The Commission notes that no evidence was offered to rebut petitioner's testimony. Thus, the Commission finds sufficient evidence in support that petitioner sustained an accident arising out of and in the course of her employment. Though the Arbitrator made mention of the discrepancy in the record relative to the lifting of a box or a bag, the Commission finds this to be of little significance. The Petitioner was lifting a heavy weight.

The Commission, however, finds that the work-related accident caused a temporary aggravation of her pre-existing condition, and that she reached MMI as of December 17, 2014. The petitioner testified that she began working longer hours and performing additional duties in the months leading up to July 24, 2014. She was performing more vacuuming and dusting, which, she testified, required her to use muscles that she had not used before. She experienced muscle soreness as a result.

The Commission notes that the initial ER record from July 25, 2014 revealed that Ms. Johnson-Clemons had low back pain with spasms for two weeks. She also reported a pulling sensation in her low back while vacuuming. The second ER record from July 27, 2014 revealed that petitioner reported that she had low back pain and a "twinge" like sensation in her back for the past few weeks. Additionally, the July 25, 2014 x-ray and the July 31, 2014 MRI both revealed degenerative conditions. Dr. Mok confirmed that the findings were likely present prior to the accident and that the twisting motion "may" have irritated the nerve root, which was causing her radiculopathy.

Petitioner then underwent an injection on November 5, 2014. During the follow-up examination with Dr. Mok on December 17, 2014, petitioner reported significant improvement with low back pain and left leg pain. Her lower back spasms were resolved. Petitioner reported 100% relief in her low back pain and radicular symptoms. She had a slight back ache only. Dr. Mok advised petitioner to follow-up on a p.r.n. basis.

As of December 17, 2014, petitioner had no back spasms, no radicular symptoms, and no lower back pain. The Commission finds that petitioner's complaints as of December 17, 2014 are similar to her complaints prior to the accident, and any complaints relative to the work accident had since resolved. Consequently, the Commission finds petitioner sustained a temporary aggravation of her low back that returned to its pre-existing state as of December 17, 2014. Thus, the Commission awards petitioner medical expenses through December 17, 2014. Petitioner is also entitled to TTD benefits from July 25, 2014 through December 17, 2014, representing 21 weeks of disability.

16IWCC0182

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on February 4, 2015, is hereby reversed for the reasons stated above.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $317.76 per week for a period of 21 weeks (July 25, 2014 through December 17, 2014), that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses through December 17, 2014 under §8(a) of the Act, and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 14 2016

Michael J. Brennan

MJB/tdm
O: 1-12-16
052

Thomas J. Tyrrell

16IWCC0182

Dissent

I respectfully dissent from the decision of the majority. Arbitrator Mason's findings are both thorough and well reasoned. This decision is correct and should be affirmed

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

JOHNSON-CLEMONS, SANDRA
Employee/Petitioner

Case# 14WC029622

RUSH UNIVERSITY MEDICAL CENTER
Employer/Respondent

16IWCC0182

On 2/4/2015, 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 0.06% 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:

0293 KATZ FRIEDMAN EAGLE ET AL
DAVID M BARISH
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602-2983

2965 KEEFE CAMPBELL BIERY & ASSOC
MATTHEW IGNOFFO
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ 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
19(b)

Sandra Johnson-Clemons
Employee/Petitioner

v.

Rush University Medical Center
Employer/Respondent

Case # 14 WC 29622

Consolidated cases: N/A

16IWCC0182

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 Molly Mason, Arbitrator of the Commission, in the city of Chicago, on January 23, 2015. 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. ☐ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **July 24, 2014**, 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 not*** sustain an accident that arose out of and in the course of employment.

Timely notice of the claimed accident *was* given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the claimed accident.

Based on the foregoing findings as to accident and causation, the Arbitrator views the remaining disputed issues as moot and makes no findings as to those issues.

In the year preceding the injury, Petitioner earned $**24,785.28**; the average weekly wage was $**476.64**.

On the date of accident, Petitioner was **56** years of age, ***single*** with **0** dependent children.

Respondent shall be given a credit of $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**2,401.10** for other benefits, for a total credit of $**2,401.10**.

Respondent is entitled to a credit for any amounts paid through its group medical plan under Section 8(j) of the Act.

ORDER

Petitioner lacked credibility and failed to sustain her burden of proof as to accident and causation. As such, no benefits are awarded.

Based on the foregoing findings, the Arbitrator omits the ordinary Section 19(b) remand order from this decision.

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.

Molly C Mason
Signature of Arbitrator

2/4/15
Date

ICArbDec p. 2

FEB 4 - 2015

Sandra Johnson-Clemons v. Rush University Medical Center
14 WC 29622

Arbitrator's Findings of Fact

Petitioner testified she began working for Respondent hospital in September 2012. She denied having any low back problems at that time. She was involved in an accident in the early 1970s but testified that that accident involved her neck, not her back.

Petitioner testified she initially performed a part-time "turndown" job for Respondent. This job involved "tidying up" patients' rooms, pulling trash and saying goodnight to patients. The job was not physically taxing. She denied experiencing any problems with her back while performing this job.

Petitioner testified that, in April 2014, she obtained a new, higher-paying full-time job in Respondent's housekeeping department. The job consisted of cleaning offices. Initially, she "floated," working where needed. After a while, she was assigned to clean a specific area. Her job involved dusting, vacuuming, cleaning bathrooms and removing garbage. She testified that the job covered a greater area and involved "a lot more work" than her previous "turndown" position. She felt as if she had started a new workout routine. She experienced some shoulder stiffness due to having to reach up to dust shelves that were overhead.

Petitioner claims a work accident of July 24, 2014. Petitioner denied reporting any injury or seeing any doctor between the time she started her new job duties in April 2014 and this accident. She testified she felt fine when she started her shift on July 24, 2014. Her shift started at 3 PM and ended at 11:30 PM. At about 9 PM, her supervisor, Ted, called her and asked her to dispose of any trash that might be inside a large recycling container. She testified that the photographs marked as PX 1 show this container. She typically had no responsibility for emptying this container. Another worker normally took care of it but he was out that night. Her regular job required her only to lift and empty smaller plastic waste baskets.

Petitioner testified that the recycling container was chest high. It had a plastic liner. The liner was half full of loose paper. She lifted her arms overhead and twisted while lifting the liner out of the container and placing it in the can that was in her wheeled cart. She moved quickly while doing this because she was afraid the liner might break due to its heavy contents.

Petitioner testified she "didn't really feel anything" when she lifted the liner and disposed of its contents. She proceeded to clean some bathrooms. By the end of her shift, she was experiencing a little tightness in her back. When she signed out for the night, she told Ted that the recycling trash was very heavy. She did not report any injury to Ted. A co-worker, who she did not identify by name, drove her home. She mentioned the weight of the recycling trash and her back tightness to this co-worker. After she got home, she took a hot shower. She lingered in the shower due to her back tightness and then went to bed. She slept until 3 or 4 AM, at which point she woke up due to low back pain and radiating left leg pain. The pain

worsened. She got up, took two Aleves, and went back to bed. She got up again not long thereafter and sat in a hot tub. She experienced muscle spasms while in the tub. She got out of the tub, put on her robe and "crawled" to her bedroom. She called her daughter. Her daughter came to her house and drove her to the Emergency Room at Respondent hospital.

The Emergency Room records of July 25, 2014 set forth two histories. The first states:

> "Lower back pain with spasms x 2 weeks. Pain radiates down left leg. Tingling and numbness to left big toe. Denies any trauma, bowel or bladder incontinence. Pt reports back pain was improving until she picked up a heavy box last night. Pt took an Aleve tablet at 330 this am. No improvement of pain with the Aleve."

The second states:

> "55 yo female with c/o left buttock/hip pain radiating down to her toes that has been worse today, also numbness and tingling. Milder symptoms over the last couple of weeks. Works as a housekeeper and has been feeling a 'pulling' in her lower back while vacuuming. No dysuria or incontinence or retention. No leg weakness. No h/o back injury otherwise. Took Aleve this morning with minimal improvement."

On examination, the Emergency Room physician, Dr. Ansari, noted a decreased range of left hip motion, slightly decreased sensation to light touch over the left great toe and negative straight leg raising. Dr. Ansari indicated it was "difficult to assess strength LLE due to pain." Dr. Ansari diagnosed "likely lumbar radiculopathy." Dr. Ansari administered ibuprofen and two doses of morphine IM, with Petitioner continuing to complain of difficulty walking after the first dose. Dr. Ansari also ordered lumbar spine X-rays, which demonstrated no fracture or subluxation and mild degenerative sclerosis of the lower facets and SI joints. Petitioner was discharged from the Emergency Room at about 7:24 PM with instructions to set up a follow-up appointment and return to the Emergency Room if her symptoms worsened. PX 2, PX 4.

Petitioner denied telling Emergency Room personnel that she had been experiencing back spasms for two weeks. She also denied telling anyone she injured her back by lifting a box. She does not handle boxes at work. She acknowledged saying she had been experiencing pulling in her back while vacuuming.

Petitioner did not testify to another Emergency Room visit but records in PX 3 show that she returned to the Emergency Room at Respondent hospital on the morning of July 27, 2014. A registered nurse recorded the following history:

> "Pt with mild lower back pain for the past few weeks like

> a 'twinge.' On Thursday pt picked up a heavy box and now having increased pain in left buttock area radiating down left leg. Pt seen on Friday here at Rush ER and was prescribed pain medicine and a muscle relaxer and states the pain has not improved. Pt with numbness and tingling along medial aspect of foot. Denies any urinary or bowel incontinence."

A different Emergency Room physician, Dr. Seitz, recorded the following history:

> "55 year old female presents to the emergency department complaining of left lower back pain. States that she's been having this pain for a few weeks – pain radiates from her left lower back down into her left buttock area. This past Thursday she picked up a heavy box and states that the pain has exacerbated. [sic] Seen this past Friday – states that she's still having pain. The patient denies any extremity numbness, weakness or tingling. The patient denies any urinary retention, denies any fecal or urinary incontinence."

After examining Petitioner, Dr. Seitz indicated Petitioner might require therapy. He recommended she continue her medication and follow up with her personal care provider. PX 3. RX 4.

Petitioner testified she went to Respondent's Employee Health department after being seen at the Emergency Room.

On July 29, 2014, a nurse affiliated with Respondent's Employee Health department issued a note indicating Petitioner could not work. The nurse described Petitioner's condition as "not work related." PX 2.

On July 30, 2014, Petitioner saw Dr. Augustin at Rush University Family Physicians. The doctor recorded the following history:

> "The patient is a 55 year old female who presents with hx of sleep apnea, not using the CPAP machine, went to the ER twice, last time was on Sunday for pain in her left lower back radiating to the left lower extremity. Pain started on Friday, 5-10/10, Getting worse with movement. Can hardly walk. Has numbness, tingling sensation in her left big toe and the arch."

On examination, Dr. Augustin noted no tenderness to palpation of the spinous process, tenderness to palpation of the paraspinous muscles and positive straight leg raising. He prescribed Norco, Flexeril and Neurontin, along with a lumbar spine MRI and physical therapy.

He issued a note indicating Petitioner was unable to work from July 25, 2014 to August 13, 2014 and could resume working on August 14, 2014. PX 3.

Also on July 30, 2014, an Employee Health nurse issued a note indicating Petitioner would be off work until August 14, 2014. The nurse described Petitioner's condition as "pending work related." PX 2.

The lumbar spine MRI, performed on July 31, 2014, showed moderate to severe right and moderate left foraminal stenosis at L4-L5, moderate left foraminal stenosis at L5-S1 and bilateral facet arthropathy at multiple levels, most marked at L4-L5 and L5-S1.

On August 1, 2014, Dr. Duvall of Respondent's Employee Health department issued a note indicating that Petitioner's condition was "pending" and that Petitioner's doctor had found her unfit for work until August 14, 2014. PX 2.

On August 4, 2014, Petitioner gave a recorded statement to Kathy Bennett [hereafter "Bennett"], an adjuster affiliated with Sedgwick, Respondent's workers' compensation carrier. During this statement, Petitioner identified Ted Lowery as her supervisor. She indicated she works from 3 PM to 11:30 PM, Monday through Friday. She informed Bennett she had been injured at work the preceding Thursday, July 24th. The account of the accident she provided to Bennett was consistent with her testimony. She indicated that, when she left work that night, she told Ted the bag of paper refuse was heavier than the garbage she usually handles but she did not make an incident report because she "didn't feel anything." She also stated: "well, I didn't hurt myself, I mean, I didn't feel it then, but about 3:00 in the morning is when I felt it and I started having muscle spasms." RX 2, pp. 4-5. She informed Bennett she had made two trips to the Emergency Room, two visits to Employee Health and one visit to Dr. Augustin. She also informed Bennett that she did not report to work on July 25th. She denied sustaining any prior back injuries. RX 2, p. 6.

On August 6, 2014, Petitioner underwent an initial evaluation at Respondent hospital's physical therapy department. The evaluating therapist, Rima Gana, recorded the following history:

> "Patient is a 55 year old female who presents with chief complaints of left LBP, with constant numbness in big toe/ medial arch of L foot and intermitting shooting pain throughout LLE. On 7/24, pt reports lifting heavy bag of recycling paper from tall trash bin when she was at work, without experiencing pain. However, onset of symptoms began later that night and have progressively gotten worse. Has visited ER twice since then and received pain medication which has only provided temporary relief of shooting pain down LLE. She is unable to FWB on LLE and has recently been experiencing loss of balance, with no episodes of falls.

> She reports that in the past, she used to experience discomfort in back after vacuuming/cleaning but would feel better after taking Aleve."

The therapist also noted that Petitioner was currently off work due to pain, was filing for workers' compensation and planned to return to work on August 14th, pending follow-up with her doctor. PX 3. RX 4.

Petitioner returned to Dr. Augustin on August 13, 2014 and complained of 10/10 pain in her left leg, along with difficulty walking and numbness in her left big toe. After reviewing the MRI, Dr. Augustin prescribed Lidoderm patches and recommended an orthopedic evaluation. He issued a slip indicating Petitioner needed to remain off work until August 27, 2014 and could return to work on August 28, 2014.

Petitioner testified that Dr. Augustin referred her to an orthopedic specialist affiliated with Respondent hospital. Through no choice of her own, she did not see this specialist.

On August 21, 2014, Bennett sent Petitioner a denial letter indicating that, "after careful consideration of all available information," Sedgwick had determined Petitioner's claim was not compensable. Petitioner acknowledged receiving this letter. RX 1.

On September 2, 2014, Petitioner filed an Application for Adjustment of Claim alleging an injury of July 24, 2014 involving her "back and body." PX 2.

On September 12, 2014, Petitioner saw Dr. Mok, an orthopedic surgeon affiliated with the University of Chicago. Dr. Mok's note of that date reflects that Petitioner complained of low back and left leg pain secondary to lifting garbage and twisting awkwardly at work on July 25, 2014. He noted that Petitioner did not begin experiencing pain until the day after this event.

Dr. Mok interpreted Petitioner's MRI as showing "L4-L5 degenerative spondylolisthesis and spinal stenosis." He noted Petitioner was participating in therapy and taking medication. He recommended an epidural steroid injection.

Dr. Mok indicated he told Petitioner her spondylolisthesis and stenosis likely pre-dated the lifting incident but that it was "possible" the incident irritated her nerve roots, causing radicular symptoms. PX 4.

Petitioner testified that, between late July 2014 and her first visit to Dr. Mok, she was experiencing spasms running down her leg and difficulty walking. She was unable to climb stairs or get into an SUV. She limped and could not put weight on her left leg.

At Dr. Mok's referral, Petitioner saw Dr. Dickerson on September 25, 2014. Dr. Dickerson decided to defer the previously recommended injection because Petitioner reported

significant improvement of her radicular symptoms. He prescribed medication and instructed Petitioner to follow up in four weeks. PX 4.

Petitioner followed up with Latanya Kennedy, C.N.S., on October 22, 2014. Kennedy noted that Petitioner was still experiencing intermittent low back pain rated 5/10. She also noted that Petitioner had self-discontinued the previously prescribed medication and expressed a desire to have an interventional procedure. PX 4.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Zelby on October 31, 2014. Dr. Zelby is a board certified neurosurgeon and an assistant professor of neurosurgery at Respondent hospital. RX 3.

Dr. Zelby's account of the July 24, 2014 work accident is consistent with Petitioner's testimony. He noted that Petitioner was currently undergoing therapy and awaiting a back injection. He indicated that Petitioner was still experiencing activity-related low back pain but that she denied any left leg symptoms. He also indicated that Petitioner denied any pre-accident back problems and had been off work since the accident.

Dr. Zelby described Petitioner's gait as "a little slow but otherwise normal." On examination, he noted positive lying straight leg raising on the left, only in the back. He described inconsistent behavioral responses as "positive for diminished pain on distraction."

Dr. Zelby interpreted the MRI as showing "mild degenerative disc disease, primarily at L1-L2, L2-L3 and L3-L4." He noted "no acute or post-traumatic abnormalities."

Dr. Zelby indicated he reviewed the Emergency Room records, Dr. Augustin's notes and Dr. Mok's note of September 12, 2014.

Dr. Zelby noted a variance between Petitioner's account of the accident and the histories set forth in the records. He addressed causation as follows: "At the most, her injury was a temporary exacerbation of a pre-existing and already symptomatic condition that was not aggravated or accelerated beyond its normal progression. The fact that she did not feel an increase in symptoms when the incident occurred makes a temporary exacerbation possible but medically unlikely."

On November 5, 2014, Dr. Dickerson administered a lumbar epidural steroid injection at L5-S1. Following the injection, he instructed Petitioner to resume the previously prescribed medication and return in eight weeks. PX 4.

Petitioner returned to Dr. Mok on November 7, 2014. The doctor indicated it was too early to tell whether the recent injection was providing much relief. He indicated Petitioner could perform light duty with no bending, twisting or lifting over 10 pounds and no prolonged sitting or standing without breaks. PX 5. He commented on causation as follows: "We discussed that this is a degenerative condition and, while there was an exacerbation at work,

radiographically there is no acute change apparent. The degree of stenosis and spondylolisthesis [is] advanced." He indicated Petitioner might benefit from a fusion and laminectomy. PX 4.

Petitioner testified she provided all of her doctors' notes and work status reports to both Employee Health and her immediate work area.

Petitioner offered into evidence a note dated November 12, 2014 authored by David Steinbach, Respondent's associate director of environmental services. The note states: "the Environmental Services Department requires you to be 'fit for duty' in order to be authorized to work. We cannot accommodate 'light duty.'" PX 5.

On December 17, 2014, a physician affiliated with the University of Chicago Medical Center wrote out a slip releasing Petitioner to "light duty x 4 weeks" as of the following day. The physician's signature is not legible. PX 5.

Petitioner returned to Dr. Mok on December 22, 2014. The doctor noted that Petitioner was still experiencing some left-sided lower back aching but that her lower back and leg pain was significantly improved. He informed Petitioner he did not view her as a surgical candidate, based on her current level of pain, and noted that Petitioner "readily agreed." He indicated Petitioner could return to the pain clinic on a PRN basis. Because Petitioner expressed a desire to continue therapy, he recommended she obtain a new therapy prescription from her personal care physician. He started Petitioner on Nortriptyline to help with sleep. PX 4.

Petitioner testified Dr. Mok released her from care on December 22, 2014, indicating she did not require surgery, but recommended she continue seeing Dr. Dickerson. She is scheduled to see Dr. Dickerson on January 28, 2015.

Petitioner testified that her group carrier paid most of her medical bills but that her group coverage "ran out" in the latter part of 2014.

Petitioner denied experiencing any new back or leg injury after her claimed work accident.

Petitioner testified her leg pain is gone but she is still experiencing lower back pain. If her most recent records reflect she used the phrase "100% better" to describe her symptoms, she intended that phrase to mean she is now able to walk and climb stairs.

Under cross-examination, Petitioner denied telling Emergency Room personnel on July 25, 2014 that she had been experiencing low back spasms for two weeks. She did say she had felt pulling in her lower back while vacuuming during the preceding two weeks. She did not begin vacuuming at work until June 2014. Prior to that, she "floated," working where needed. The Emergency Room records indicate she lifted a box but she does not deal with boxes at work. The bathrooms she cleaned after her claimed work accident were small. She did not

report any accident to Ted when she clocked out because she was "not really" feeling any pain at that point. She felt some discomfort in her back before she woke up in pain at 3 or 4 AM on July 25, 2014. Before she went to bed on July 24, 2014, the only activity she engaged in was a hot shower. When her group coverage ran out, she received information concerning COBRA. She has not seen Dr. Mok or Dr. Dickerson since December. She would like to try to return to full duty.

No witnesses testified on behalf of Respondent.

Arbitrator's Credibility Assessment

The Arbitrator had problems with Petitioner, credibility-wise.

Petitioner testified to making one visit to Respondent's Emergency Room on the morning after her claimed work accident of July 24, 2014. She took issue with aspects of the history recorded at that visit. She denied telling Emergency Room personnel she had been experiencing back spasms for two weeks. She acknowledged experiencing some soreness while performing her work duties before the accident but testified she experienced that soreness in her shoulders, while dusting overhead. She also denied saying that her back symptoms had increased the previous night after she lifted a heavy box.

Petitioner actually made two trips to Respondent's Emergency Room following the claimed accident. Both of these trips occurred within three days of the claimed accident. The Emergency Room records contain four histories recorded by different providers. All of these providers noted that Petitioner had been experiencing back symptoms for a couple of weeks. None of them indicated that Petitioner was injured at work, let alone that she was injured while lifting a heavy trash bag out of a recycling bin. They indicated Petitioner complained of increased back pain secondary to lifting a heavy box. Petitioner testified she does not deal with boxes at work. Dr. Augustin, who saw Petitioner in follow-up, also made no mention of work activity or a work accident. It was not until early August 2014, after the MRI, that any provider recorded a history of lifting a heavy trash bag at work on July 24, 2014.

Arbitrator's Conclusions of Law

Did Petitioner sustain an accident on July 24, 2014 arising out of and in the course of her employment? Did Petitioner establish causation?

Based on the foregoing assessment, the Arbitrator finds that Petitioner lacked credibility and failed to prove a work accident of July 24, 2014. If Petitioner injured her back in the manner she testified to, why would two sets of Emergency Room records at her place of employment not mention a work-related injury? The records do mention a lifting event involving a heavy box but Petitioner adamantly testified she does not have to deal with boxes at work.

Even if Petitioner's account of the lifting incident is given full weight, the record as a whole does not support a finding of causation. Petitioner acknowledged experiencing some symptoms, akin to post-workout soreness, while performing her duties before the lifting incident but she denied experiencing radicular symptoms or spasms. The Emergency Room records call this denial into question. Even more significantly, Petitioner consistently denied experiencing any symptoms when she lifted the bag of recycling trash. Her MRI shows degenerative rather than acute pathology. Dr. Mok described this pathology as "advanced." Dr. Mok indicated it was "possible" that the lifting/twisting Petitioner described could have irritated her nerve roots but there is no indication he reviewed the Emergency Room records. Dr. Zelby, who did review those records, and was thus aware of the conflicting histories, found it unlikely that the described incident could have exacerbated Petitioner's underlying condition.

Based on the foregoing, the Arbitrator denies this claim and awards no benefits.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Bernice Charles-Hoover,
Petitioner,
vs.

NO: 14WC 30500

Pace Bus,
Respondent,

16IWCC0185

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, medical, prospective medical, penalties, fees and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 7, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

MAR 14 2016

DATED:
o022516
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

CHARLES-HOOVER, BERNICE
Employee/Petitioner

Case# **14WC030500**

PACE BUS
Employer/Respondent

16IWCC0185

On 7/30/2015, 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 0.14% 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:

1067 ANKIN LAW OFFICE LLC
JOSHUA E RUDOLFI
162 W GRAND AVE
CHICAGO, IL 60654

1505 SLAVIN & SLAVIN
PATRICK SHIFLEY
20 S CLARK ST SUITE 510
CHICAGO, IL 60603

16IWCC0185

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

☐ 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
19(b)

Bernice Charles-Hoover
Employee/Petitioner

v.

Pace Bus
Employer/Respondent

Case # **14** WC **030500**

Consolidated cases: _____

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 **Arbitrator Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago, Illinois**, on **05/07/2015**. 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☒ TPD ☐ Maintenance ☐ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **July 8, 2014**, 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 not*** 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**53,215.24**; the average weekly wage was $**1,023.37**.

On the date of accident, Petitioner was **48** years of age, ***single*** with **0** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**14,182.84** for TTD, $ **0** for TPD, $ **0** for maintenance, and $ **0** for other benefits, for a total credit of $ **0** .

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

ORDER

Because the accident did not arise out of work, and was not causally connected to said employment, benefits are denied.

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.

Deborah L. Simpson
Signature of Arbitrator

July 30, 2015
Date

ICArbDec19(b)

JUL 30 2015

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Bernice Charles,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 14 WC 30500**
	)	
Pace Bus,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on July 8, 2014, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that the Petitioner gave the Respondent notice of the accident which is the subject matter of the dispute within the time limits stated in the Act. They further agree that in the year preceding the injuries, the Petitioner earned $53,215.24, and that her average weekly wage was $1,023.37.

At issue in this hearing is as follows: (1) Did the Petitioner sustain accidental injuries that arose out of and in the course of employment; (2) Is the Petitioner's current condition of ill-being causally connected to this injury; (3) Were the medical services that were provided to Petitioner reasonable and necessary and has the Respondent paid all appropriate charges for all reasonable and necessary medical services; (4) Is Petitioner entitled to TTD; (5) Is the Petitioner entitled to any prospective medical care; and (6) Should penalties or fees be imposed upon Respondent.

STATEMENT OF FACTS

Petitioner testified that she is employed by Respondent as a bus operator for 21 years. She is responsible for transporting passengers and interacting with them. (TR. P. 14) Petitioner testified that she had been involved in violent incidents on Pace buses during the course of her employment. (TR. P. 40; RX 1) Petitioner testified that during previous incidents she had responded by calling Pace dispatch. (TR. P. 43, 45, 46, 47, 48, 49; RX 1) Petitioner testified that she was aware of Pace's procedures concerning violent incidents. (TR. P. 52) Petitioner testified that Pace's procedure for violent incidents was for the operator to call dispatch. (TR. P. 52) Petitioner testified that she had made it a habit of following the procedure of calling dispatch in the past. (TR. P. 52; RX 1)

Petitioner testified that on July 8, 2014, while in said employment, she was on a break with her vehicle parked at a bus terminal. (Tr. P. 15-16) While parked at a bus terminal she was

approached by a 24-25 year old woman with a question about which route she would be driving. (TR. P. 16) Petitioner then responded to the question, and the woman walked away. (TR. P. 17) According to Petitioner, the woman then returned, began an argument with the Petitioner, and eventually doused the Petitioner with the liquid contents of a bottle which had been in the woman's hand. (TR. P. 17-19)

After the Petitioner was doused with the liquid, the young woman walked away from the bus without further comment to the Petitioner. (TR. P. 19, 38) Petitioner testified that at the time, there were no other passengers on the bus. (TR. P. 39) Petitioner testified, on both direct and cross examination, that after the woman left, she had an opportunity to close the door and remain on the bus. (TR. P. 19, 40, 62) Petitioner testified that instead, she got off the bus to go look for security personnel. (TR. P. 19) Petitioner testified that she was then involved in another altercation with the woman, in which she was struck in the eye and head, had her hair pulled, and was brought to the ground. (TR. P. 19-20) Petitioner testified that the woman hit her in the eye and her glasses flew off, and Petitioner grabbed her eye. (TR. P. 20) When Petitioner grabbed her eye the woman struck her upside the head with the bottle. (TR. P. 20) The Petitioner did not know what the bottle was made of; she said it was hard, she did not remember the bottle breaking. (TR.P. 20) According to the Petitioner during the altercation the woman started pulling Petitioner's hair from her scalp. (TR.P. 20)

Petitioner testified that she received treatment at Ingalls Memorial Hospital. (TR. P. 22) At Ingalls, Petitioner gave a history of an eye injury and denied any head injury. (PX 2 P 12) Petitioner was diagnosed with a corneal abrasion, facial contusion, and skin avulsion. (PX 2 P 12) Petitioner was noted to have no musculoskeletal symptoms. (PX 2 P 16) Petitioner was noted to have a normal range of motion in her neck. (PX 2 P 17) Petitioner was noted to have a normal lower extremity exam, including strength, range of motion, and sensation. (PX 2 P 17) There is no indication that hair was pulled from Petitioner's scalp in the medical records from Ingalls Memorial. (PX 2)

Petitioner testified that she received follow up care for a mugging from Dr. Rochelle Hawkins on July 15, 2014. (PX 4 P 12) At that time, Petitioner reported that she was suffering from body-aches as a result of being jumped on. (PX 4 P 12) Petitioner was noted to have a full range of motion in her extremities. No other issues were noted with her extremities. (PX 4 P 12) Petitioner was noted to have minimal tenderness in her upper back and shoulders. No other issues were noted with her back. (PX 4 P 12) Petitioner was diagnosed with contusions and myalgia and prescribed naprosyn and Flexeril. (PX 4 P 12) There is no indication that Petitioner was missing any hair from her scalp at the time of this examination.

Petitioner testified that she received follow up treatment from Midwest Eye Center by Dr. Weisberg, and was seen on July 15, 2014. (PX 3 P8) At that time, she reported sensitivity to light. (PX 3 P 10) Dr. Weisberg noted that there was no ocular abrasion and that her eye looked healthy. (PX 3 P 10) The External Eye Exam, Anterior Segment Exam, and Fundus Exam were all identical between the right and uninjured left eye with the exception of a slight ecchymosis of the inferior orbital rim found on the external eye exam. (PX 3 P 9) Dr. Weisberg prescribed a short course of topical steroid drops. (PX 3 P 10). Petitioner was placed off work due to sensitivity to light, and directed to follow up in one week. (PX 3 P 10)

A copy of a letter from Dr. Weisberg to Dr. Hawkins was included in Dr. Hawkins records. (PX 4 P 9) That letter bears a fax transmission stamp dating it to July 15, 2014. (PX 4 P 9) Dr. Weisberg's letter notes that there was no abrasion, that there was photosensitivity, and that no other cause of pain was identified. (PX 4 P 9)

Petitioner was seen for treatment by Dr. Rochelle Hawkins on July 24, 2014. (PX 4 P 13) Dr. Hawkins noted for the first time that treatment was for a Worker's Compensation claim. (PX 4 P 13) At that time, Petitioner made complaints of headache, right leg pain, left arm pain, and right eye pain. (PX 4 P 13) Petitioner additionally complained of interrupted sleep. (PX 4 P 13) Petitioner was noted to have a full range of motion in her extremities. (PX 4 P 13) Dr. Hawkins noted a previously unmentioned bruising on Petitioner's right leg. (PX 4 P 13) Petitioner was noted to have mild tenderness in her lower back and buttocks. (PX 4 P 13) Petitioner was diagnosed with Myalgia post mugging and posttraumatic stress disorder. (PX 4 P 13) Petitioner was instructed to continue with counseling. (PX 4 P 13)

Petitioner was seen for treatment by Dr. Rochelle Hawkins on July 31, 2014 for follow up on a mugging. (PX 4 P 14) Petitioner's complaints included right eye pain, headache, right leg pain, and left arm pain. (PX 4 P 14) Petitioner made a new complaint of buttock pain. (PX 4 P 14) Petitioner was instructed to continue counseling. (PX 4 P 14)

Petitioner was seen for treatment by Dr. Rochelle Hawkins on August 7, 2014. (PX 4 P 15) This is the first time the notes include a detailed recitation of Petitioner's claimed history. (PX 4 P 15) Petitioner complained of intermittent headaches, left wrist stiffness, and throbbing eyes. (PX 4 P 15) Dr. Hawkins makes the first note of a bald spot on this date. (PX 4 P 15) Dr. Hawkins also noted that Petitioner had a corneal abrasion at this time. (PX 4 P 15) Petitioner was noted to have a full range of motion in her extremities. (PX 4 P 15) Petitioner was instructed to follow up with Midwest Eye Center and to continue taking medication. (PX 4 P 15)

Petitioner was seen for follow up treatment by Dr. Hawkins on August 14, 2014. (PX 4 P 16) At that time, Petitioner's subjective complaints included neck and back strain, neck pain and difficulties with approval of workers compensation checks. (PX 4 P 16) Petitioner was noted to have a full range of motion in her extremities. (PX 4 P 16) Petitioner was instructed to continue treating with pain medication. (PX 4 P 16)

Petitioner was seen at Midwest Eye Center again on August 18, 2014. (PX 3 P 5) At that time, she was complaining of pain in her right eye with an onset of that day. (PX 3 P 5) Dr. Weisberg's impression was that Petitioner had acute pain in the right eye and senile nuclear sclerosis, both marked as new. (PX 3 P 6) Dr. Weisberg noted that Petitioner was suffering a sinus infection relevant to her eye condition, and diagnosed her as having two dry spots on right eye. (PX 3 P 5, 6)

Petitioner was seen for follow up treatment by Dr. Hawkins on August 28, 2014. (PX 4 P 17) Petitioner makes a subjective complaint of difficulty walking due to back pain. (PX 4 P 17) Petitioner was noted to have clear lungs with no other chest symptoms noted. (PX 4 P 17) Petitioner was noted to have a full range of motion in her extremities. (PX 4 P 17) At this time, Dr. Hawkins plan includes the notation "litigation likely". (PX 4 P 17)

Petitioner was seen for an initial visit at Elmwood Park Same Day Surgery Center on September 2, 2014. (PX 5 P 17) Petitioner received pain treatment from Dr. Mehta, an anesthesiologist. (PX 5 P 17) Petitioner related a history which included being doused with soda twice, and a new report of a loss of consciousness. (PX 5 P 17) Petitioner reported a history of immediate pain in her back, right leg, and right eye. (PX 5 P 17) Petitioner claimed to be experiencing blurred vision and back pain with radiation into the right leg. (PX 5 P 17) Petitioner made an initial complaint of scalp tenderness. (PX 5 P 17) Petitioner had a normal straight leg test. (PX 5 P 17) Petitioner was diagnosed with myofascial pain, lumbar radiculitis, head contusion, and right eye abrasion. (PX 5 P 17) Petitioner was instructed to initiate physical therapy three times a week for four weeks. (PX 5 P 18) Petitioner was referred to an ophthalmologist for a right eye examination for an abrasion, and to a neurologist for her headaches. (PX 5 P 18)

The Petitioner presented to Dr. Edward Herba, a neurologist, on September 10, 2014. (PX 5 P 26) At that time, the Petitioner reported not having lost consciousness at the time of the altercation. (PX 5 P 26) Petitioner reported ongoing confusion while navigating a bus route. (PX 5 P 26) Petitioner reported experiencing depression, and sleeplessness. (PX 5 P 26) Petitioner reported headaches, but reported that those headaches were primarily limited to the period immediately after the injury. (PX 5 P 26) Dr. Herba diagnosed post-concussion syndrome and prescribed an MRI. (PX 5 P 27).

Petitioner was seen for follow up treatment by Dr. Hawkins on September 11, 2014. (PX 4 P 18) Petitioner complained of lower back pain, pain to the right leg, intermittent headaches, pain to right eye, and forgetfulness. (PX 4 P 18) Petitioner denied having photophobia. (PX 4 P 18) Petitioner was noted to have clear lungs with no other chest symptoms noted. (PX 4 P 18) Petitioner had a full range of motion in her extremities. (PX 4 P 18) Her neck was supple with no noted phenomena. (PX 4 P 18) Dr. Hawkins made a diagnosis of acute low back pain, and instructed the Petitioner to continue Naproxen and Flexeril. (PX 4 P 18)

Petitioner was seen for an initial evaluation at Athletico on September 11, 2015. (PX 5 P 29) At that time, Petitioner presented with decreased lumbar range of motion, guarded ambulation, and decreased lower extremity flexibility. (PX 5 P 29)

Petitioner was seen for an initial examination at Family Eye Physicians on September 15, 2014. (PX 5 P 31) At that time, she reported seeing floaters only in her left eye. (PX 5 P 33) Petitioner was diagnosed with a small corneal abrasion, blepharitis, a pinguecula, and a senile nuclear cataract. (PX 5 P 34) Petitioner was prescribed a hygiene regimen and e-mycin ointment for two days.

On September 16, 2015, an X-Ray of the Petitioner's spine was performed. (PX 5 P 36) There were no spondylolistheses, subluxations or swelling seen. No abnormalities were noted. (PX 5 P 36)

Petitioner was seen for an examination at Family Eye Physicians on September 17, 2014. (PX 5 P 31) At that time the corneal abrasion was deemed resolved. (PX 5 P 31, 32)

On September 19, 2014, an MRI of the Petitioner's brain was performed. (PX 5 P 39) The MRI was deemed unremarkable. (PX 5 P 39)

Petitioner was seen for further treatment by Dr. Mehta on September 23, 2014. (PX 5 P 40) Petitioner was noted to have range of motion within normal limits, normal gait, normal mood, memory, and affect. (PX 5 P 40) No objective symptoms of injury were noted. (PX 5 P 40)

Petitioner was seen for follow up treatment by Dr. Hawkins on September 25, 2014. (PX 4 P 19) Petitioner made no subjective complaint of pain at that time. (PX 4 P 19) Petitioner was noted to have clear lungs with no other chest symptoms noted. (PX 4 P 19) Petitioner was noted to have a full range of motion in her extremities. (PX 4 P 19) At that time, Dr. Hawkins stated that Petitioner could return to work pending neurological evaluation. (PX 4 P 19)

Petitioner was seen at Athletico for further physical therapy on October 6, 2014. (PX 5 P 45) Petitioner was noted to have poor body mechanics and improving lower extremity flexibility. (PX 5 P 45) Petitioner's strength was noted to be 4/5, 4+5, or 5/5 in all categories, and equally between each of the lower extremities. (PX 5 P 46)

Petitioner was seen by Dr. Mehta on October 7, 2014. (PX 5 P 48) No report of headaches is made. (PX 5 P 48) At that time she reported that her back pain was mostly muscular in nature. (PX 5 P 48) She had no objective symptoms, a normal gait, normal mood, memory and affect. (PX 5 P 48)

Petitioner was seen for a Section 12 exam on October 22, 2014 with Dr. David Spencer. (RX 4) Petitioner reported pain in her body and head. (RX 4 P 1) Objectively, she was noted to sit comfortably, walk without a limp, and to have full flexion and extension of her spine. (RX 4 P 1) Dr. Spencer diagnosed Petitioner with resolved body pain following an altercation on July 8, 2014, with no residual impairment. (RX 4 P 2) Dr. Spencer made no comment on the reasonableness of prior treatment. (RX 4)

Petitioner was seen by Dr. Mehta on October 28, 2014. (PX 5 P 53) At that time it was noted her pain had reduced to a 1-2/10 and diffused through her body. (PX 5 P 53) No report of headaches was made. (PX 5 P 54) No objective symptoms were noted, and Petitioner was noted to have normal range of motion, and normal mood, memory and affect. (PX 5 P 53) At this point Dr. Mehta placed her at MMI for her lumbar strain and cervicalgia. (PX 5 P54) She was given a return to work date of November 10, 2014. (PX 5 P 54)

Petitioner was seen by Dr. Herba on October 29, 2014. (PX 5 P 57) At that time Petitioner reported that her headaches had resolved. (PX 5 P 57) She reported intermittent right eye pain, and corneal scarring with 90% improvement in the right eye. (PX 5 P 57) The Petitioner reported to Dr. Herba that she periodically encountered the woman who attacked her on the buses in her area. (PX 5 P 57) The Petitioner expressed to Dr. Herba that she was anxious about encounters with the woman and would want to change which bus routes she drove. (PX 5 P 57) Dr. Herba diagnosed the Petitioner as needing psychological examination for posttraumatic stress based upon this anxiety. (PX 5 P 57)

Petitioner testified that she was released to return to work full duty, in relation to her back complaints, on October 29, 2014. (TR. P. 32)

On November 7, 2014, the Petitioner was seen at Athletico. (PX 5 P 59) At that time, she was deemed to be appropriate for discharge, having met or nearly met all goals. (PX 5 P 59)

Dr. Herba drafted a letter on November 16, 2014 to Elmwood Park Clinic (Dr. Mehta's practice). (PX 5 P 58) According to that letter Petitioner reported damage to her right cornea. (PX 5 P 58) Petitioner also reported reduced headaches. (PX 5 P 58) Petitioner reported feelings of depression and anger due to post injury contact with the woman who attacked her. (PX 5 P 58) Petitioner reported encountering that woman on her former bus route. (PX 5 P 58) Petitioner reported knowing that the woman was "still going to work, etc., and is in apparently good health", and anger. (PX 5 P 58) Petitioner reported fear based upon those encounters, fear relating to returning to her position. (PX 5 P 58) Dr. Herba then prescribed a psychology interview. (PX 5 P 58) Dr. Herba placed her off work at that time. (PX 5 P 58)

On November 22, 2014, the Petitioner was seen by Dr. Daniel Kelley of Integrated Behavioral Medicine. (PX 6 P 4) At that examination, the Petitioner again reported a loss of consciousness during her assault. (PX 6 P 4) Petitioner reported that she had been diagnosed with a concussion by the emergency room doctor. (PX 6 P 4) Petitioner is noted to have specifically denied a past psychiatric history. (PX 6 P 4) The Petitioner was noted to be fully alert and oriented, and socially appropriate. (PX 6 P 4) However, Petitioner was also noted to have an altered affect, and disorganized thought patterns. (PX 6 P 4)

At the November 22, 2014 examination, Petitioner was examined with the Minnesota Multiphasic Personality Inventory – 2 – Restructured Form. It was noted by Dr. Kelley that her responses showed evidence of invalidity. (PX 6 P 5) Elements of her testing were unable to be interpreted, and other elements were to be interpreted with caution due to invalid responses. (PX 6 P 5)

Dr. Kelley diagnosed Petitioner with post-traumatic stress disorder and placed her off work based upon that diagnosis. (PX 6 P 6, 7)

Petitioner testified that she received benefits from her employer's workers compensation insurance company through November of 2014. (TR. P. 34) Petitioner introduced evidence that Respondent had made payment of medical bills. (PX 5 P 4)

Pursuant to the records of Integrated Behavioral Medicine, the Petitioner was treated by Dr. Kelley through April 1, 2015. (PX 6 P 41) Petitioner was to remain off work based upon her reported symptoms to Dr. Kelley. (PX 6 P 42)

At the hearing, Petitioner testified that she had previously seen a family counselor in group counseling with her family. (TR. P. 35) Petitioner testified that her counseling was not one on one. (TR. P. 36) When confronted with records of attendance of those sessions on cross examination, Petitioner admitted that she only attended one session with her family. (TR. P. 55) Petitioner admitted that she had seen the counselor alone for many sessions. (TR. P. 55)

Petitioner initially testified that there had been no other instances of mental health issues in her past. (TR. P. 58) However, on cross examination, Petitioner admitted that she had previously been diagnosed with PTSD, and that she had submitted a disability claim form to Pace in 2002 for the PTSD. (TR. P. 61)

Petitioner initially testified that she had never had any issues performing her job duties. (TR. P. 36) Upon cross examination, Petitioner testified that she had previously submitted

FMLA paperwork with a diagnosis of PTSD in 2002, and for a need for family counseling in 2010. (TR. P. 55, 59)

Respondent introduced a copy of the 2010 FMLA paperwork, submitted by Petitioner and completed by Sabita Nandy, Ed.S., showing that Petitioner's treater had requested leave for Petitioner from September 25, 2010 through December 25, 2010 so that "she does not endanger her passengers at work while driving her bus". (RX 2 P1, 4) The Petitioner was noted to suffer from anxiety, depression, feelings of worthlessness, fatigue, insomnia, inability to concentrate, and impaired cognitive abilities. (RX 2 P 4) Petitioner was to attend psychotherapy every week. (RX 2 P4)

Petitioner also testified that she had never seen the woman who attacked her before the incident. (TR. P. 53) Petitioner testified that she had not seen the woman other than at criminal court hearings. (TR. P. 53) Petitioner testified that the woman had not previously ridden her route. (TR. P. 53) Petitioner testified that she had no knowledge of the woman at the time of hearing. (TR. P. 53)

Petitioner testified that she had never told any of her doctors that she had seen the woman before the assault. (TR. P. 64) Petitioner testified that she had never told any of her doctors that she knew the work status of the woman. (TR. P. 65) Petitioner testified that she had never told any of her doctors that she was upset that the woman had returned to work. (TR. P. 65)

Petitioner testified that her symptoms at this time included nightmares, anxiety, irritation, loss of concentration, and inability to sleep. (TR. P.72) Petitioner admitted that these symptoms were identical to the symptoms she experienced when she was receiving counseling in 2010. (TR. P. 73)

Petitioner gave no evidence of confusion during her testimony. Petitioner was able to understand and answer all questions appropriately and to follow the change in subject matter without difficulty or confusion. Petitioner gave no evidence of agitation, anxiety or inability to concentrate during the hearing.

CONCLUSIONS OF LAW

For an injury to "arise out of" employment, it must have its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 58 (1989).

Petitioner must show, through a preponderance of the evidence, that the injury was caused or aggravated by the work accident, and not simply a result of a normal daily activity. *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193, 214 (2003).

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987).

In Illinois, fights arising out of disputes concerning the employer's work are risks incidental to the employment, and resulting injuries are compensable. *Fischer v. Industrial Comm'n*, 408 Ill. 115, 119, 96 N.E.2d 478 (1951).

However, injuries to the aggressor in such a fight are not compensable. *Container Corp. of America v. Industrial Comm'n*, 401 Ill. 129, 133, 81 N.E.2d 571 (1948).

When a fight is interrupted and an aggressor completely withdraws from an altercation, and the victim pursues the aggressor, a second aggression is instigated by the victim of the first. *People v. Armstrong*, 273 Ill.App.3d 531, 534, 210 Ill.Dec. 430, 653 N.E.2d 17 (1995).

Who made the first physical contact, while important in identifying the aggressor, is not decisive. Rather, the parties' conduct must be examined in light of the totality of circumstances. *Ford Motor Co. v. Industrial Comm'n,* 78 Ill 2d. 260, 399 N.E. 2d 1280, 35 Ill. Dec. 752 (1980)

The right to defend ones' self does not permit the pursuit and injuring of an aggressor after the aggressor has abandoned the quarrel. *People v. Shappert,* 34 Ill. App. 3d 683, 340 N.E.2d 282 (1975)

Where the initial aggressor completely withdraws from an altercation, the victim's subsequent actions constitute a separate aggression. *People v. Armstrong,* 273 Ill. App. 3d 531, 653 N.E. 2d 17, 210 Ill. Dec. 430 (1995)

Internal inconsistencies in a claimant's testimony, as well as conflicts between the claimant's testimony and medical records, may be taken to indicate unreliability. *Gilbert v. Martin & Bayley/Hucks*, 08 IL.W.C. 004187 (Ill. Indus. Comm'n 2010).

Credibility is the quality of a witness which renders his evidence worthy of belief. The Arbitrator, whose province it is to evaluate witness credibility, evaluates the witness' demeanor and any external inconsistencies with testimony. Where a claimant's testimony is inconsistent with his actual behavior and conduct, the Commission has held that an award cannot stand. *McDonald v. Industrial Commission*, 39 Ill. 2d 396 (1968); *Swift v. Industrial Commission*, 52 Ill. 2d 490 (1972).

In support of the Arbitrator's decision with regard to whether Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent, the Arbitrator makes the following conclusions of law:

Based upon the testimony of the Petitioner, there was an intervening opportunity when the Petitioner was not in danger from her assailant. Petitioner testified that after the woman left the bus she was not in danger, and that no passengers were in danger. The Petitioner's testimony was that her assailant had left the bus and walked away. The Arbitrator finds that the original altercation had terminated. The Petitioner then chose to exit the bus and "find security," rather than follow the procedures established by the Respondent which the Petitioner admitted that she was familiar with and had followed in the past on multiple occasions. The Petitioner testified that she was aware of the procedures of her employer. She testified that the procedure was to call dispatch for assistance. The Petitioner testified that she had a habit of following that

procedure. Petitioner testified, and Respondent introduced evidence showing, the habit of the Petitioner was to respond to a threat to her safety by making a telephone call to dispatch. Petitioner specifically admitted to a prior incident where she called dispatch five times in response to a present threat of violence. Under Rule 406 of the Illinois Rules of Evidence the Petitioner's habit of calling dispatch when desiring assistance is evidence that she would have called dispatch had she desired assistance.

The Petitioner's testimony that she left the bus intending to seek a security guard is not credible. The Petitioner testified that after the assailant got off the bus she moved away from the bus, and that is when Petitioner exited the bus. The Petitioner continued her description of the incident by indicating that after she got off the bus when she looked straight ahead but she did not see a security guard, she then turned to her right, which would have been an area along the side of the bus, and did not see security. When Petitioner turned to her left, which would have been the front of the bus, which is the windowed area, the woman hit her in the eyes, implying that Petitioner was face to face with her assailant. (TR. P. 19-20) The Petitioner had to be aware that the woman had not yet left the vicinity of the bus as the woman had to have been visible through the window. Petitioner's testimony that she had no idea whether the woman who poured liquid on her was still in the terminal is not credible. Petitioner was aware that the company policy was to stay in the bus and call dispatch, which Petitioner could have done.

Also, in assessing the credibility of the Petitioner, the medical records contradict the testimony of the Petitioner. Internal inconsistencies in a claimant's testimony, as well as conflicts between the claimant's testimony and medical records, may be taken to indicate unreliability. *Gilbert v. Martin & Bayley/Hucks*, 08 IL.W.C. 004187 (Ill. Indus. Comm'n 2010). The Petitioner testified inconsistently with the history of symptoms given to her treaters. The history provided by the Petitioner to her different treaters was inconsistent. At the Ingalls Memorial Hospital Emergency Room, right after the incident, the Petitioner reported no musculoskeletal symptoms, no loss of consciousness, had a normal range of motion in her neck, and had a normal lower extremity exam. The Petitioner later reported to her treaters that she had immediately manifested symptoms, that she had lost consciousness at the scene, and that she had been diagnosed with a concussion. She told two of the doctors she lost consciousness, after denying it at the emergency room and when she saw her primary care physician. She repeatedly told doctors that she had a corneal abrasion when the first eye doctor she saw denied the existence of a corneal abrasion immediately after the incident. She was diagnosed with a small corneal abrasion in September of 2014, six months after the incident. Petitioner also reported to Dr. Herba that she had corneal scarring as result of this incident. The letter from Dr. Weisberg to Dr. Hawkins in July of 2014, notes that there was no abrasion, that there was photosensitivity, and that no other cause of pain was identified. Petitioner denied a prior mental health history and only admitted to her prior mental health history upon confrontation with records during cross examination. Petitioner denied having PTSD in the past. When confronted with paperwork she filled out requesting a leave of absence from work due to PTSD in 2002 and again in 2010, Petitioner admitted that she did have PTSD in the past, and that the symptoms she was describing now were the exact same symptoms she experienced in the past.

Petitioner's credibility is also challenged by her conflicting statements regarding her knowledge of her assailant. Petitioner denied knowing or seeing her assailant, other than at court for court proceedings after the woman was arrested. However, Petitioner reported to her doctors

that she had seen her around, had seen her on the route going to work and was fearful that she would have problems with the woman when she returned to work. Petitioner told at least one of her doctors that she thought she was going to have to change her route when she returned to work because she was afraid of having contact with the woman.

When a fight is interrupted and an aggressor completely withdraws from an altercation, and the victim pursues the aggressor, a second aggression is instigated by the victim of the first. *People v. Armstrong*, 273 Ill.App.3d 531, 534, 210 Ill.Dec. 430, 653 N.E.2d 17 (1995). Who made the first physical contact, while important in identifying the aggressor, is not decisive. Rather, the parties' conduct must be examined in light of the totality of circumstances. *Ford Motor Co. v. Industrial Comm'n,* 78 Ill 2d. 260, 399 N.E. 2d 1280, 35 Ill. Dec. 752 (1980) In this particular case it is clear that the altercation was over when the woman left the bus after pouring liquid on the Petitioner. Why the Petitioner left the bus rather than call dispatch is not clear. Her actions could be interpreted as instigating a second aggression. By Petitioner's account, the only version we have, Petitioner did not know where the woman was after she left the area and once Petitioner was off the bus the woman attacked her again when Petitioner turned to face the direction that the aggressor had gone in. It was from the account of the Petitioner instantaneous. Petitioner did not indicate that she took a step in any direction yet when she turned to her left the woman was close enough to strike Petitioner in the face. Petitioner's testimony describing the incident is not credible, based upon all the inconsistencies listed above.

Petitioner has failed to meet her burden of proof by a preponderance of the evidence that an injury occurred on July 8, 2014 which arose out of and in the course of her employment with Respondent.

Is the Petitioner's current condition of ill-being causally connected to this injury? Were the medical services that were provided to Petitioner reasonable and necessary and has the Respondent paid all appropriate charges for all reasonable and necessary medical services? Is Petitioner entitled to TTD? Is the Petitioner entitled to any prospective medical care? and Should penalties or fees be imposed upon Respondent?

Petitioner has failed to prove a compensable accident. The remaining issues are moot.

ORDER OF THE ARBITRATOR

Petitioner has failed to prove a compensable accident. Benefits pursuant to Section 8 of the Act are denied.

Richard L. Simpson
Signature of Arbitrator

July 30, 2015
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jerry Haling,

Petitioner,

vs. NO. 14WC033071

16IWCC0177

Patriot Pools,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, employee relationship, temporary disability, permanent disability, medical expenses, wage calculations, benefit rates, penalties and attorney fees, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 20, 2015 is hereby affirmed and adopted.

No bond is required for the removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 11 2016
SJM/sj
o-2/25/2016
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HALING, JERRY
Employee/Petitioner

Case# **14WC033071**

PATRIOT POOLS
Employer/Respondent

16IWCC0177

On 4/20/2015, 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 0.10% 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:

0013 DUDLEY & SCHLAX LLC
PETER SCHLAX
325 N MILWAUKEE AVE SUITE 202
LIBERTYVILLE, IL 60048

0560 WIEDNER McAULIFFE LTD
MICHAEL E DOERRIES
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

16IWCC0177

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JERRY HALING
Employee/Petitioner

Case # 14 WC 33071

v.

Consolidated cases: N/A

PATRIOT POOLS
Employer/Respondent

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 Lynette Thompson-Smith, Arbitrator of the Commission, in the city of Chicago, on March 18, 2015. 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. [x] Was there an employee-employer relationship?
C. [x] 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [x] 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. [x] 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. [x] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other

FINDINGS

On 8/7/14, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent.

On this date, Petitioner ***did not*** 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 not causally related to the accident..

In the year preceding the injury, Petitioner earned $1,995.00 in 2014; the average weekly wage was $332.50.

On the date of accident, Petitioner was 49 years of age, ***single*** with no dependent children.

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

Respondent is not liable for charges of Petitioner's medical services.

Respondent shall be given a credit of $00.00 for TTD, $00.00 for TPD, $00.00 for maintenance, and $00.00 for other benefits, for a total credit of $00.00.

Respondent is entitled to a credit of $00.00 under Section 8(j) of the Act.

ORDER

The Petitioner has failed to prove, by a preponderance of the evidence, that there was an employer/employee relationship, between him and the Respondent on August 7, 2014; therefore, his injuries did not arise out of and in the course of employment and no benefits will be awarded, pursuant to 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.

16IWCC0177

FINDINGS OF FACT

The disputed issues in this matter are: 1) employee/employer relationship; 2) accident; 3) causal connection; 4) earnings; 5) average weekly wage; 6) medical bills; 7) temporary total disability; 8) penalties; 9) attorney's fees; and 10) the nature and extent of Petitioner's injuries. *See,* AX1.

Mr. Jerry Haling, ("Petitioner"), a carpenter, performed carpentry tasks for Patriot Pools ("Respondent"), which installs in-ground pools for private residences. Petitioner is the cousin of Charles Haling, the owner of Respondent.

Petitioner's testimony

Petitioner testified that he performed carpentry tasks for his cousin's business. He did carpentry work under Mr. Charles Haling's direction, who was always present when Petitioner worked a job. He generally fabricated cover boxes after concrete had been poured or decking laid around the outside of the pool. He used some of his own tools to perform this task with materials always supplied by Respondent. Petitioner also worked for Tim Pearson, an owner of several properties, performing maintenance, light repairs, and shoveling. He worked one to two days a week, up to a week straight, and evenings or weekends for Mr. Pearson. Additionally, he occasionally mowed the yard and supervised service calls at his father's hotel, which was a two minute walk from Petitioner's home.

Petitioner testified that he worked at the Glenview job site in late March and early April, 2014, and erected a silt fence with Mr. Haling at a Lake Villa project on August 4, 2014. He believed that Mr. Haling expected him to be ready to go to work the next day, but could not recall going to work. He did not recall receiving a message from his father on August 5, 2014, regarding Mr. Haling asking about his whereabouts. He did not recall telephoning Mr. Haling on August 6, 2014, asking for work, learning that he did not have work, and that the owner needed to talk about his behavior before there could be any future offers of employment. He did not recall Mr. Haling telling him he could ride to a job site to discuss his concerns.

Petitioner stated Mr. Haling picked him up on August 7, 2014 and they conversed while driving to Glenview. He denied telling Mr. Haling that he had gone to an AA meeting because he was struggling with alcohol and that he needed an AA sponsor in an effort to get his life together. Instead, he claims Mr. Haling stated he was going to the site to pump water out of the pool.

Petitioner testified that upon arrival in Glenview, he exited the vehicle and walked to the back of the property. A pump was in the very back or middle of the pool. He further testified that if the pump was plugged in, it would work provided the float was not "tied down low." If the float was "tied down low," someone would have to access the pump and adjust the float. He testified that Mr. Haling told him to pick up a piece of wood to access the pump. Petitioner was going to grab a plank and lay it on top of the wood so he would not be standing in water while accessing the pump. Petitioner claims he

placed a log in the pool and picked up a second piece and walked to the edge of the pool where he dropped in the first log. He tried to lean over and put it down when he lost his balance and fell into the pool, striking his head.

Petitioner regained consciousness at Lutheran General Hospital. He did not recall telling physicians in the emergency room (ER) that he had gone to an AA meeting on August 6, 2014. Concerning an AA coin found in his pocket, he stated it probably belonged to a friend. He did not recall stating that he had been drinking alcohol and had gone on a "bender recently." Further, he did not recall stating that he drinks alcohol daily, anywhere from six to twelve (6-12) beers, and that for the past six (6) months he had been consuming six (6) beers a day. In addition, he could not recall stating that he used cocaine on and off and claims he was never told that he had tested positive for cocaine. Further, he denied using cocaine in the days preceding his admission. Finally, he could not recall meeting with a physician or detoxification counselor, regarding alcohol consumption and drug use.

Petitioner remained a patient at Lutheran General Hospital, until August 10, 2014, when he was discharged. Per the ER records of August 7, 2014, Petitioner had been sober for eight years but over the past week, began drinking. He believes he stopped drinking two days ago after "a long bender." In an attempt to retain sobriety, he attended an AA meeting the preceding day. On this day, he was working around an in-ground pool when he had a syncopal episode or seizure. An AA recovery coin was found in his pants pocket. The ER physician suspected Petitioner suffered a "withdrawal seizure." Diagnostic studies showed a fractured right fourth proximal phalanx, while the studies of the head, face, neck, chest, and abdomen were negative. Petitioner was diagnosed with delirium tremens and a closed hand fracture. He was admitted because of "alcohol ingestion." PX1, pp. 50-53, 66 & 109.

During his admission, Petitioner's records state that he was consuming six to twelve (6-12) beers daily, the last two days ago or August 5, 2014. During an infectious disease consultation, he stated he has smoked a pack a day for 30 years, drinks six to twelve (6-12) beers daily, and has been drinking since his 20s, with eight (8) years of sobriety. On August 7, 2014, he woke up, had coffee, went to a job site, leaned forward to pick something up, felt dizzy and lightheaded and fell forward. PX1 pp. 97 & 105.

During a consultation for loss of consciousness, Petitioner stated he had been drinking six to twelve (6-12) beers a day for the last ten (10) years with "significant recidivism" for alcoholism, despite attending AA. He drank two (2) days before his fall. He stated he was working in a swimming pool but could not recall whether in the bottom or outside the pool. He lifted a "6 by 6 concrete block," felt lightheaded and fell forward. A syncopal episode was the suspected etiology with a work-up prescribed accordingly. PX1, pg. 111.

He tested positive for cocaine on a drug screen and underwent a substance abuse consultation.

Petitioner described his alcohol abuse and incarceration two (2) years earlier. He began drinking alcohol at 17, initially four to six (4-6) beers each occasion, and started attending AA around 1984. He reported ten years of sobriety, though the past six (6) months he had been drinking six (6) beers a day. In addition, he used cocaine "on and off." Notably, he admitted "blowing off" work most recently, because of his drinking. He was encouraged to enroll in an intensive outpatient addiction program. PX1, pp. 147 & 121.

Dr. Ferlit rendered care from August 7, 2014 through November 18, 2014. He recorded a history of Petitioner "standing [on] a board" and having a seizure. He continued taping and splinting the right finger and hand. Later, he released Petitioner to modified duty on September 22, 2014 and ordered hand therapy. He ordered an MRI of the cervical spine, which was performed on October 1, 2014 and read to show a small, herniated disc at C6-7. He referred him to Dr. Herman, who released Petitioner to return to work on October 8, 2014. After released to return to work, Petitioner testified that he assisted his parents and resumed working for Tim Pearson. PX4.

Testimony on behalf of Respondent

Charles Haling testified that his company has been in business since 2011, designing and constructing residential pools within sixty (60) miles of its Antioch office location and his home. He further testified that his wife assists him on a part-time basis, and Respondent does not employ any full-time workers. All pool designs, excavations, concrete, tile and deck work, is performed by contractors. These contractors provide their own equipment, materials and proof of insurance; and were paid when their contracted tasks were completed. The work is seasonal and weather dependent.

Mr. Haling sets the schedule for each phase of a project. He has, on occasion, retained Petitioner's services to perform carpentry work. The two are relatives and neighbors and because Petitioner lacks a driver's license, Mr. Haling transports him to and from a job site and is always present at the job site, on those occasions when he retains Petitioner's services.

Mr. Haling testified that at the commencement of each workday, he would meet with Petitioner for ten to fifteen (10-15) minutes, to discuss the tasks to be performed, how to proceed and the goal to be achieved. Petitioner did not do any excavating, electrical, venting or other mechanical work. Instead, he primarily constructed wooden boxes to house the pool's motor and might assist in building the frames for a concrete pour. The two agreed on an hourly rate of $15.00.

Mr. Haling testified that in 2014, the petitioner worked for him approximately twelve to fourteen (12-14) days during a five-month period. The longest continuous cycle of employment might have been three (3) days. He was paid by checks totaling $1,995.00, over six periods.

Mr. Haling further testified that Petitioner worked on a pool project in Glenview in April 2014, several days in May 2014, and on August 1, 2014. On the August date, Petitioner and Mr. Haling fastened a 1

x 4 rail along the side of a pool, in preparation for tile work. Three days later, on August 4, 2014, Petitioner and Mr. Haling erected 80 feet of silt fence and strung yellow ribbon at a Lake Villa job site. The task was completed in three to four hours that day. Mr. Charles Haling was not expecting the petitioner at any job sites after the silt fence was erected on August 4, 2014.

Mr. Haling testified that he had a telephone conversation with Petitioner's father, his uncle, on August 5, 2014, stating he had work coming up and was unable to get a hold of Petitioner. He inquired as to his whereabouts. On the following day, August 6, 2014, Mr. Haling received a call from Petitioner in the afternoon. Petitioner stated he wanted and needed to work. In response, Mr. Haling advised the petitioner "no work would be scheduled" until they had a discussion as to "what was going on and where he was headed" because the petitioner had disappointed him at work sites, on a few occasions in the past. Mr. Haling stated that he had "performance issues" with Petitioner in June and July 2014. Specifically, work was scheduled and Petitioner had not shown up. He thought that they needed to talk. According to Mr. Haling, the petitioner stated he really wanted and needed to work. He advised Petitioner that he had a meeting the next day, August 7, 2014, at the Glenview job site and that Petitioner was welcome to ride along with him to discuss his future. Petitioner agreed and Mr. Haling stated he would pick him up.

Mr. Haling arrived at Petitioner's residence the next morning and picked him up. He testified that he did not see Petitioner put any tools in the back of his truck, nor was he wearing his tool belt when he climbed into the truck. The two chatted while driving to the meeting in Glenview.

During the drive, Mr. Haling told Petitioner that his performance and been slipshod and he had been unreliable. According to Mr. Haling, Petitioner responded that he was attending AA and was "going to get his life back in order and just needed a break." He wanted a sponsor for AA and they discussed contacting a mutual acquaintance who had previously assisted Petitioner with substance abuse issues. According to Mr. Hailing, there were no discussions as to any service or tasks Petitioner would perform that day; and no discussion of any payment for services that Petitioner might render. There were no contractors scheduled to work that day and no work scheduled that could utilize Petitioner's services. The reason that Mr. Haling was going to the site was to discuss elevations with the tile contractor, Jose.

Mr. Haling testified that the tile contractor had approximately three (3) days of work to perform and once completed, the next phase was stone coping, then equipment installation, followed by decking. He estimated approximately three (3) weeks of work had to be performed before fabricating a cover box, the task petitioner could perform. Mr. Haling stated that the petitioner was only at the site because he took a ride to discuss what work, if anything, he would do in the future. Mr. Haling stated that the goal that day was to meet the tile contractor and discuss elevations, as there was no other work to be done.

According to Mr. Haling, he and Petitioner arrived at the job site and did not remove any items from the truck. They did not conduct a pre-activity meeting that is held at the start of each of Petitioner's workdays. Instead, the two walked toward the back of the residence, greeted an employee of the property owner and entered the back yard. Mr. Haling noticed eight to ten (8-10) inches of water in the pool. Per Mr. Haling's contractual obligation, a pump had been set in the pool, to be available for contractors, during the course of the project. Commonly, the float on the pump is manually activated when removing the remaining two (2) inches of water from the pool that cannot be removed with the usual operation of the pump. Contractors will place lumber in the pool to access the pump to remove these remaining two inches. There was a piece of lumber left in the pool that had been used by contractors, who had gone into the pool to drain the remaining few inches.

After standing and talking to the petitioner and waiting for the tile contractor for approximately ten (10) minutes, Mr. Haling decided to plug in the pump. He testified that he turned away from the petitioner, walked toward the home, to plug in the cord and activate the pump. As he turned, he heard a grunt and turned back to see the petitioner with a piece of lumber in his hands, a remnant from a pergola the owner was building. He did not know why petitioner had the lumber in his hand as he did not direct Petitioner to pick up anything, nor had he directed him to climb into the pool to access the pump. He saw Petitioner take a few steps toward the edge of the pool and fall over the edge. Mr. Haling went in after him and found Petitioner on his hands and knees with his eyes rolled back into his head, as though he was having a seizure. He picked him up, pulled him to the shallow end to get him to a dry area. He climbed out, retrieved his phone and called 911. Petitioner asked him what happened and was non-responsive to inquiries from ambulance personnel who arrived on the scene. Mr. Haling called Petitioner's father to obtain medical information and the petitioner left in the ambulance.
After the ambulance left the job site, Mr. Haling plugged in the pump and reset a breaker in the house. The pump began working negating the necessity to climb into the pool to access it. Mr. Haling testified that the area around the rim of the pool was dirt, as the concrete deck had yet to be poured. The dirt was not muddy that day and he did not see a skid mark or anything near the edge of the pool where Petitioner fell in.

CONCLUSIONS OF LAW

B. Was there an employee-employer relationship?

The burden is on the petitioner to prove by a preponderance of the evidence, each and every element of his claim, including the existence of an employer-employee relationship. "Preponderance" is evidence which is of greater weight and more convincing than the evidence offered in opposition to it; that is, evidence, which as a whole, shows that the fact to be proved is more probable than not; that which best accords with reason and probability; something more than "weight"; it denotes a superiority of weight or outweighing. *Black's Law Dictionary, West Publishing Company, Fifth*

Edition, 1979. The Arbitrator shall weigh the credibility of the witnesses, including witness demeanor, interest or motivation of the witness, improbability or probability of the witness' version, internal inconsistencies in witness testimony and/or conduct; and external inconsistencies when the witness testimony is compared to other evidence, both testimonial and documentary. *Beattie v. Industrial Commission,* 276 Ill.App.3d 446 (1995).

Section 1(b) of the Illinois Workers' Compensation Act defines an employee as every person in the service of another under any contract of hire, express or implied, oral or written. 820 ILCS 305.1(b) The relationship is contractual and is the product of mutual assent, that is, a meeting of minds expressed by some offer on the part of one to work for the other and acceptance on the part of the other. The manifestation of mutual assent, the gist of contract formation, is ascertained objectively, by considering the conduct of the parties and not simply the subjective understanding of one party. Contracts, Farnsworth, 4th Ed.pg. 114 (2004); *Bd. of Education v. IWCC,* 53 Ill.2d 167 (1988); *Crepps v. IWCC,* 402 Ill. 606 (1949). Further, an employer-employee relationship does not exist in the absence of payment or expected payment of consideration in some form by the employer to the employee. *Board of Education v. Industrial Commission,* 53 Ill.2d 167 (1972). Thus, in the absence of a mutual assent to enter a contract of hire, a gratuitous or voluntary undertaking does not give rise to a legally enforceable claim for payment of services arising from an implied contract or otherwise. *Wolverine Insurance Company v. Jockish,* 83 Ill.App.3d 411 (1980).

Because of the laws of contract formation, Workers' Compensation Acts have been uniformly construed to exclude from coverage, volunteers and gratuitous workers who neither receive nor expect to receive pay or other remuneration for services. A volunteer is one who introduces himself into matters which do not concern him and undertakes to do something that he is not bound to do or which is not in pursuance or protection of any interest of the employer and which is undertaken in the absence of any peril requiring him to act as on an emergency. *Kensington Steel v. Industrial Commission,* 385 Ill. 504 (1944); *Houston v. Quincy Post 5129* (1989). An injury from a risk not incident to the employment, but rather from a volitional act of one's own choosing, that is outside of any reasonable exercise of the employment, does not arise out of the employment, and the employer is not liable to an employee who so voluntarily exposes himself to such danger. *Peoples Gas Light and Coke Co. v. Industrial Commission,* 405 Ill. 73 (1950).

In finding that the petitioner failed to establish an employer-employee relationship on August 7, 2014, the Arbitrator finds Charles Haling's testimony to be more credible. Mr. Charles Haling had concerns about Petitioner's reliability, as he was unavailable when needed. Petitioner admitted to medical personnel his poor performance and excessive drinking was causing him to "blow off" work, which corroborates Mr. Haling's testimony. On August 6, 2014, Charles Haling received a telephone call from Petitioner offering his services. Charles Haling declined this offer, responding he had no immediate work for Petitioner to perform and they would have to discuss his performance issues before he could be retained in the future. He invited the petitioner to ride along with him to discuss

these concerns. Charles Haling's rejection of Petitioner's offer and Petitioner's understanding of this rejection is supported by Petitioner's failure to bring his tool belt to the site that day. In fact, carpentry tasks that Petitioner could perform would not be needed for several weeks.

In addition, while Charles Haling picked up the petitioner the morning of August 7, 2014, as he had on days when Petitioner rendered services, he and petitioner did not conduct the usual ten to fifteen (10-15) minute pre-activity meeting to address the task to be performed, how it was going to be performed, and the desired goal to be achieved. Likewise, there were no discussions about the rate of pay, the services to be performed, or hours to be worked. The Arbitrator finds Charles Haling's assertion that there were no assigned tasks to be performed that day other than his meeting with a tile contractor, to be credible; and the only reason the petitioner was at the job site was because he rode with him to discuss his future well-being and employment. These objective facts and conduct by the parties indicate that there was no mutual assent or meeting of the minds that Petitioner's offer of service had been accepted. The employer-employee relationship was not created.

The Arbitrator notes that Petitioner's denial of consuming alcohol and using cocaine in the days before August 7, 2014; his denial of attending an AA meeting and possessing his own AA coin contradicts the numerous histories he gave to medical personnel. The records reference chronic alcohol abuse, drug use and failed efforts at sobriety. Such histories constitute admissions against interest and impeached his credibility.

The Arbitrator finds that any activities undertaken by Petitioner after exiting the vehicle on August 7, 2014, were not at the directive of Mr. Haling, but were of his own volition. Petitioner undertook a task, which did not concern him, that is, attempting to access the pump. Moreover, it was not in the pursuance or protection of Respondent's interest.

Additionally, there was no peril that required of Petitioner to act, such as an emergency. There was no need to toss lumber in the pool to gain access to the pump to activate it. Consequently, Petitioner's injuries were due to a risk not incidental to his employment, i.e., carpentry tasks, but from an act of his own choosing, outside any reasonable exercise of his carpentry skills. Respondent is not liable for injuries which occurred when Petitioner voluntarily exposed himself to a danger outside his bailiwick.

The Arbitrator finds that the Petitioner has not proven, by a preponderance of the evidence, that there was an employer-employee relationship between Petitioner and Respondent, on August 7, 2014. Therefore, Petitioner did not sustain an accident arising out of and in the course of his employment. Having found that the petitioner has not proven an employee-employer relationship, all other disputed issues are moot and will not be addressed.

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ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
14WC33071
SIGNATURE PAGE

Signature of Arbitrator

April 20, 2015
Date of Decision

APR 20 2015

STATE OF ILLINOIS)
) SS.
COUNTY OF ST. CLAIR)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Causation	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify:	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JEFFREY HOWARD III,

Petitioner,

16IWCC0187

vs.

NO: 14 WC 39000

ST. CLAIR HIGHWAY DEPARTMENT,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation and medical expenses both current and prospective, and being advised of the facts and law, reverses the Decision of the Arbitrator and finds that Petitioner sustained his burden of proving his stipulated compensable accident caused a current condition of ill being of his left knee. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Findings of Fact and Conclusions of Law

1. Petitioner testified he was a truck driver/laborer for Respondent since December 31, 2013. His job entailed heavy labor and he did not need any assistance in performing his work activities. He had not lost any work for injuries or had any workers' compensation claims prior to the current claim.

2. On September 18, 2014, he was pulling big tree limbs up an incline to a chipper when he stepped into a hole, twisted, and fell. His coworkers "almost had to call the crane to come help," because they could not pick him up. Petitioner injured his left knee in the accident. Petitioner sought treatment and eventually came under the care of Dr. Mall.

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3. Petitioner testified he had previous injuries/surgeries to his left knee. However, at the time of the instant accident he was working full duty and was not under the care of any doctor for his left knee. The last time he previously treated for his left knee was probably at an emergency room three to four years prior to the accident. His left knee was "doing great" prior to this injury.

4. Petitioner testified that currently he had a lot of pain that shoots down his leg and up his hamstring. He can't sleep at night. The pain becomes unbearable after walking 15 to 20 minutes. Total knee replacement has been recommended and Petitioner wants to proceed with the surgery.

5. On cross examination, Petitioner agreed that he had six previous knee surgeries, the first when he was in junior high. He had four surgeries through high school and two more while playing football at the University of Miami starting in 1985. He did not have any surgeries after he left college and has not sought any medical treatment for his knee in the St. Louis area.

6. Petitioner agreed that he treated with Dr. Feldner, his general practitioner, from time to time for his knee between 2002 and 2009. Petitioner had four aspirations and injections of his left knee and was prescribed anti-inflammatories. However, Dr. Feldner advised Petitioner to discontinue them because of concerns about his kidneys. Dr. Feldner also discussed with Petitioner the possibility of a Synvisc injection.

7. Petitioner agreed he has visited the emergency room ("ER") at St. Elizabeth on several occasions, some of which concerned pain or inflammation of his left knee. He did not dispute that one such visit was in July of 2013. At that time he complained of 8/10 pain and asked that his knee be drained.

8. Petitioner also testified that when he presented to the ER after the instant accident, he told the doctors that he was taking Norco which was prescribed in July of 2013. He had not refilled the prescription in the interim. Somebody at the ER mentioned that he might need a replacement.

9. Petitioner returned to the ER on September 28, prior to an October 1, 2014 appointment already scheduled with Dr. Bassman. Dr. Bassman took Petitioner off work and told him to return in three weeks. Apparently, instead of returning to Dr. Bassman, Petitioner saw Dr. Mall who was referred by his lawyer. Dr. Mall administered an injection and began physical therapy. That treatment did not improve his condition.

10. Currently, Petitioner does not take any medication, even over-the-counter medication, and does not use any assistive devices for walking. He used a knee brace years previously. Petitioner agreed that at the ER on September 19, 2014 he told the providers that he had a brace and would use it. Petitioner then testified that Dr. Feldner refilled the prescription for Tylenol 3 that he initially received at the ER. He was still currently taking the medication. Petitioner was able to drive to the arbitration hearing, but had to get out of the car twice.

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11. On redirect examination, Petitioner testified at the ER on July 2, 2013 he mentioned chronic knee pain with swelling once or twice a year and denied any new injury. He did not lose any time at work because of that episode. He played in the NFL for two years but had no real playing time. His last knee surgery was in 1986.

12. The medical records indicate that on August 16, 2002, Petitioner presented to his general practitioner, Dr. Feldner, and complained of left knee pain and swelling. It was noted that he worked construction, which exacerbated his symptoms. Petitioner returned on September 26th and continued to complain of left knee pain, effusion and crepitus.

13. On December 22, 2004, Dr. Feldner wrote a letter noting that Petitioner was a hard worker and worked in a physically demanding job in construction despite advanced arthritis and his continued difficulties with his knee related to the original and subsequent injuries. On April 4, 2006 and May 1, 2007, Dr. Feldner drained Petitioner's knee and administered injections.

14. On April 8, 2008, Petitioner reported gradual onset of left knee, right calf, and right hamstring pain with no specific trauma. Dr. Feldner prescribed medication and physical therapy. On May 30, 2008, physical therapy noted that Petitioner had a total of four visits, cancelled three, and failed to show up for three sessions. A woman answered his phone and hung up on several occasions. Petitioner had not made progress due to noncompliance and was discharged.

15. X-rays taken on June 16, 2008 showed moderate tricompartmental osteoarthritis, multiple calcified joint bodies, and joint effusion. On June 23, 2008, Petitioner presented to the ER with leg swelling. He stepped off a truck "the wrong way." Petitioner was referred for a Doppler to exclude a blood clot. The test showed no thrombosis but did show fluid collection representing either a ruptured Baker's cyst or hematoma.

16. An MRI taken June 27, 2008 showed extensive pathology in the left knee including evidence apparently confirming a ruptured Baker's cyst.

17. On December 3, 2008, Petitioner presented to the ER with right leg pain after turning his knee. Chronic left knee pain was also mentioned. On June 2, 2013, Petitioner returned to the ER with chronic left knee pain, which he rated as 8/10. He stated that he had six arthroscopic surgeries and every year in around June or July he has problems. He had swelling and limited range of motion. Later there was a notation that once or twice a year his knee flares up and he has swelling. It swelled to this extent two years previously and it was drained. X-rays of the left knee compared to December 3, 2008 x-rays showed stable tricompartmental arthritis, with multiple joint bodies with bodies with interval enlargement, and interval increase in knee joint effusion.

18. Petitioner presented to the ER on September 19, 2014 with left knee and hip pain which became inflamed after dragging tree limbs up a hill the previous day at work. Petitioner reported 7/10 pain. He denied falling. A history of left knee problems was noted. X-

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rays of the left knee compared to July 3, 2013 x-rays showed severe degenerative osteoarthritic changes in three compartments of the knee with numerous loose bodies and possible developing synovial osteochondromatosis. Petitioner was taken off work for two days.

19. Petitioner returned to the ER of September 28, 2014 reporting 8/10 pain and decreased range of motion. He reported the knee felt loose. New x-rays showed no change since the previous study. He had an appointment to see an orthopedist. The treatment notes indicated he needed a replacement.

20. On October 1, 2014, Petitioner presented to Dr. Bassman for evaluation of his left knee complaining of 3-4/10 pain. He reported a past football injury but was able to work without difficulty until he stepped in a hole pulling a tree/log up a hill. He stated he was denied workers' compensation benefits because the length of his employment. Dr. Bassman's examination appears to have been normal.

21. On October 22, 2014, Petitioner presented to Dr. Mall for evaluation of his left knee pain. He reported six previous left knee surgeries dating from 1979. However, he was able to work full duty as a truck driver/laborer for nine months until he twisted his left knee stepping into a gopher hole while pulling some tree limbs at work. He reported no treatment for his left knee for three to four years. X-rays showed severe arthritis of the left knee. Dr. Mall noted that because of the severe nature of the arthritis it was a preexisting long-standing condition. Nevertheless, he indicated Petitioner suffered an acute twisting injury, evidenced by moderate effusion, which he opined aggravated the arthritis. He administered a cortisone injection and prescribed physical therapy and anti-inflammatories.

22. On October 24, 2014, Petitioner presented to Dr. Woods, D.C. for evaluation and treatment of his left knee on referral from Dr. Mall. He reported a work injury on September 19, 2014 when he twisted his knee when stepping into a hole while pulling tree limbs. Dr. Woods began treatment to decrease pain and increase range of motion.

23. Petitioner returned to Dr. Mall on November 19, 2014 for follow up for his left knee arthritis and work-related aggravation. He reported no change in his condition. The injection provided short-lived relief and while the PT increased his strength, he still had substantial pain. At this point, Dr. Mall recommended left knee arthroplasty.

24. The last treatment note from Dr. Woods is dated March 6, 2015, and there appears to be a total of 44 sessions. Petitioner reported no real improvement at every visit. For the last 30 or so, Dr. Woods noted that Petitioner had not yet reached maximum medical improvement and was undergoing necessary therapeutic treatment.

25. Dr. Mall testified by deposition on February 11, 2015 that he is board certified in orthopedic surgery. He has a "fellowship in sports medicine, sort of complicated shoulder and knee surgery, shoulder replacements, knee replacements, that sort of thing."

26. Dr. Mall first saw Petitioner on October 22, 2014. He reported pulling tree limbs when he twisted his left knee stepping into a gopher hole. He had immediate swelling and felt pain ever since. He reported several left knee surgeries since 1979 but he had not had treatment for his left knee for three to four years and was able to work full duty for Respondent for 9-10 months. He was currently unable to work full duty.

27. On examination, Dr. Mall noted moderate swelling despite his icing and trying to elevate the leg since the injury. X-rays showed fairly severe osteoarthritis. Dr. Mall testified that Petitioner clearly had arthritis for a while which was probably related to his earlier injuries. However, according to his history he had not recently had problems or treatment. Dr. Mall opined that it was "pretty clear" that Petitioner's current accident was "an aggravation of a preexisting condition" which caused his arthritis to become symptomatic.

28. Dr. Mall initially prescribed conservative treatment of injections, physical therapy, and anti-inflammatories. Petitioner did not significantly improve with the conservative treatment and Dr. Mall eventually recommended a total knee arthroplasty. From his review of previous medical records, he did not see any prior recommendation for an arthroplasty. Dr. Mall opined that the instant accident made his preexisting condition more symptomatic and accelerated the need for arthroplasty. People can have extensive arthritis with absolutely no pain.

29. On cross examination, Dr. Mall testified he reviewed ER records relating to Petitioner's injury, Dr. Ritchie's Section 12 examination report, and Dr. Bassman's records. He did not have other records from St. Elizabeth or previous surgeons. Petitioner's lawyer had probably referred him about five patients in the last six months. Petitioner was 6'4" and 335 pounds. He advised Petitioner to lose weight but it was difficult to increase his activity because of his weight and his knee condition. Dr. Mall was provided an MRI report. He testified it simply confirmed the x-ray findings that Petitioner had end-stage arthritis and did not offer any additional information. For a person in Petitioner's condition an MRI is a needless expense. Dr. Mall agreed that the accident probably did not change the structure of his knee but it caused it to be symptomatic. He also agreed that if Petitioner sought treatment in June of 2013 that would inconsistent with the history Petitioner provided to him.

30. Dr. Mall thought the notation in the ER report that Petitioner needed a knee replacement was probably included by an ER doctor after seeing the x-ray, but he was not sure. He did not know whether Petitioner had been told that he needed such surgery previously by another orthopedic surgeon. He discussed possible arthroplasty with Petitioner at their first visit, but he thought it was appropriate to try conservative treatment first. Dr. Mall could not explain Dr. Bassman's basically benign examination, which was different from his. However, there was no way he had full range of motion; that was "just not possible."

31. Dr. Mall disagreed with Dr. Ritchie's conclusion that the real reason Petitioner needed a knee replacement was the underlying arthritis; it was because of Petitioner's pain. However, he agreed that there were any number of potential causes that could aggravate

his arthritis. Exacerbation is common in patients with arthritis. When they cannot get the patient back to the pre-exacerbation condition then more aggressive treatment is required. The aggravation did not need to be a twisting, "just some sort of tweak of the knee can aggravate those symptoms." People can also have exacerbation without anything really occurring. But natural progression "is more of a slower process."

32. Dr. Ritchie testified by deposition on February 23, 2015. He is a board certified orthopedic surgeon who basically treats everything but the spine. Knee surgery probably accounts for 60% of his practice and he performs about 200 to 210 knee replacements a year. He examined Petitioner on November 21, 2014 at the request of Respondent's lawyer and issued a report. Petitioner reported working for Respondent as a truck driver for about nine months when on September 19, 2014 he was pulling a tree, stepped into a hole, and twisted his left knee. Petitioner reported having about six prior knee arthroscopies dating back to college where he played football. He had a chronic knee problem which was better or worse day to day. He had not worked since the accident.

33. On examination, Petitioner could not fully extend his left knee, had about 85% flexion, marked deformity, palpable osteophytes, and low-grade effusion. The effusion was normal for a person with a knee of this condition. Dr. Ritchie thought his prior injuries and weight were probably the two biggest factors in the degeneration of his knee. X-rays were "pretty bad," showing "a tremendously arthritic knee."

34. Dr. Ritchie opined that the work accident did not cause any additional alteration or damage to the knee but he thought "it created the subjective symptoms that he had sought treatment for." He thought the treatment he received to the date of his examination was reasonable. However, any prospective treatment would be necessary "because of the severity of the preexisting disease." His knee was "pretty much destroyed prior to this" accident. The mechanism Petitioner reported would not cause additional damage to the knee. He thought Petitioner could drive a truck with his condition, but may not be able to do a lot of walking. Petitioner was not taking medication, which supported Dr. Ritchie's impression that his complaint of 9/10 pain was exaggerated.

35. On cross examination, Dr. Ritchie testified Petitioner only disclosed his prior surgeries after he was questioned specifically about it. He believed Petitioner's report was consistent with the history he gave to Dr. Mall. He did not see any records indicting Petitioner was unable to perform his work prior to the accident. Dr. Ritchie thought the accident caused him some pain, but did not aggravate his condition. He distinguished between exacerbation, from which the patient can return to baseline, and aggravation, in which the condition is permanently worsened. He had previously mistakenly used the terms interchangeably. Even if Petitioner suffered a meniscus tear in the instant accident that would be inconsequential and would not affect his treatment.

36. Dr. Ritchie would not opine about whether Petitioner could return to work in his regular job. If Petitioner were his patient he would probably get a functional capacity evaluation to determine his work abilities. However, if was not able to return to work that would be because of his arthritis and not the work accident.

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37. On redirect examination, Dr. Ritchie testified he would recommend treatment to minimize symptoms including anti-inflammatories, injections, and weight loss. He would delay a replacement for as long as possible because with Petitioner's size it may wear out within five years. However, the only surgical alternative would be arthroplasty.

In finding Petitioner did not prove causation, the Arbitrator questioned Petitioner's credibility because of his incorrect statement that he had not received medical treatment for his knee for three to four years prior to the accident and his misstatement on direct examination that his pain medications were not refilled after his July 2013 ER visit. She also stressed that there was no evidence that the accident caused any structural change in Petitioner's knee.

In his brief, Petitioner quotes extensively from *Clutterbuck v. UPS*, 15 I.W.C.C. 46 (2015), in which the Commission framed the issue as "whether the accident *** aggravated or accelerated the preexisting condition, or whether the preexisting condition alone was the cause of the injury and the need for total knee replacement surgery." The Commission reasoned that the employer finds the employee as it finds him/her. In *Clutterbuck*, the Commission found the accident caused the need for replacement surgery even though it had been recommended five months prior to the accident. The Commission notes that although the Commission decision in *Clutterbuck* is not precedential, it is informative and we find the Commission's framing of the issue in *Clutterbuck* appropriate here. The Commission finds the causation opinion of Dr. Mall persuasive. Dr. Mall's opinion that the accident caused additional pain which accelerated his need for surgery appears reasonable. Even Dr. Ritchie agreed that the accident caused pain which resulted in Petitioner's seeking medical treatment, even though he believed he had returned to his pre-accident baseline at the time of his examination.

While it is clear that Petitioner had an extensive preexisting arthritic condition of his left knee requiring six previous arthroscopies, the last surgery was apparently in 1986, 28 years prior to the instant stipulated accident. Despite his condition and seeking relatively recent treatment for his left knee arthritis before the accident, it appears that Petitioner was able to perform his relatively heavy labor job prior to the accident. Therefore, the Commission concludes that Petitioner sustained his burden of proving causal connection between his stipulated work accident, his current condition of ill-being, and his need for treatment.

The Arbitrator awarded temporary total disability benefits to the date of Dr. Ritchie's Section 12 medical report, November 21, 2014. Petitioner argues that the Commission should award temporary total disability benefits to the date of arbitration, because he "remains incapacitated from work."

While we reverse the Arbitrator on the issue of causal connection to the current condition of ill-being to his left knee, the Commission affirms the Arbitrator's award of temporary total disability. Petitioner did not specifically testify that he could not return to work, and there do not appear to be any ongoing off work notes. Therefore, the Commission concludes that Petitioner did not sustain his burden of proving he is entitled to temporary total disability benefits beyond that awarded by the Arbitrator.

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Similarly, the Arbitrator awarded medical expenses incurred up to the date of Dr. Ritchie's Section 12 medical report. The Commission finds that some of the conservative treatment provided to Petitioner was neither necessary nor reasonable. Throughout the physical therapy/chiropractic treatment provided by Dr. Woods, Petitioner reported little or no improvement. There seemed no reason to continue such treatment for approximately 44 sessions.

Dr. Mall recommended knee replacement surgery on November 19, 2014, based at least on part because of the ineffectiveness of conservative treatment. Additional physical therapy/chiropractic treatment after that date appears excessive especially considering the ineffectiveness of such treatment to date. Therefore, the Commission finds that the denial of current medical expenses incurred after November 21, 2014, as ordered by the Arbitrator, was reasonable and we affirm that portion of the decision.

However, the Commission finds that prospective knee replacement surgery is necessary, reasonable, and related to Petitioner's work accident. It is clear that conservative treatment was not effective in alleviating his condition. Even Dr. Ritchie acknowledged that arthroplasty was the only surgical treatment that was currently available. Therefore, the Commission reverses the Arbitrator and orders Respondent to authorize and pay for knee replacement surgery recommended by Dr. Mall as well as other associated medical treatment.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $386.21 per week for a period of 7&5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner medical expenses incurred through November 21, 2014 under §8(a) of the Act pursuant to the applicable medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay for prospective treatment prescribed by Dr. Mall including left knee arthroplasty and related treatment.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

16IWCC0187

The party commencing the proceeding for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: MAR 14 2016

Charles J. DeVriendt

RWW/dw
O-2/10/16
46

Joshua D. Luskin

Dissent

I respectively dissent from the majority Decision of the Commission. I would have found that Petitioner did not sustain his burden of proving that the current condition of ill-being of his left knee and the possible need for prospective knee replacement was causally connected to his work accident. Therefore, I would have affirmed the Decision of the Arbitrator in its entirety.

It is clear that Petitioner had severe arthritis in his left knee and would likely need replacement even absent any trauma. Even Dr. Mall testified that any "tweak" Petitioner could have sustained in normal activities of daily living could have aggravated his condition requiring more aggressive treatment. In addition, the causation opinion testimony of Dr. Ritchie was persuasive and reasonable including his opinion that the mechanism of injury Petitioner described would not likely cause permanent aggravation of the underlying arthritis. Even Dr. Mall conceded that the accident most likely did not result in any change of the structural condition of Petitioner's knee.

The Arbitrator was correct that Petitioner seems to have been less than forthright about his previous treatment, not only in his testimony, but also in his histories to Dr. Mall and Dr. Ritchie. That omission was particularly relevant with regard to the testimony of Dr. Mall. He based his causation opinion substantially, if not predominantly, on his assumption that Petitioner did not have treatment or symptoms for an extended period of time prior to the accident, an assumption that was basically incorrect.

For the reasons stated above, I would have affirmed and adopted the Decision of the Arbitrator and respectively dissent from the majority.

Ruth W. White

STATE OF ILLINOIS)
) SS.
COUNTY OF)
KANKAKEE

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jorge A. Ortega,
Petitioner,
vs.
Railway & Industrial Services, Inc.,
Respondent,

NO: 14WC 42418

16IWCC0183

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Petitioner, herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary total disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 2, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 14 2016
MJB/bm
o-3/7/16
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

ORTEGA, JORGE A
Employee/Petitioner

Case# 14WC042418

RAILWAY & INDUSTRIAL SERVICES INC
Employer/Respondent

16IWCC0183

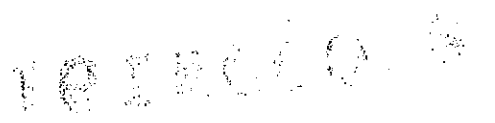
On 7/2/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% 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:

1067 ANKIN LAW OFFICE LLC
SCOTT GOLDSTEIN
162 W GRAND AVE
CHICAGO, IL 60654

2337 INMAN & FITZGIBBONS LTD
TERRENCE DONOHUE
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602



STATE OF ILLINOIS)
)SS.
COUNTY OF KANKAKEE)

☐ 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
19(b) & 8(a)

Jorge A. Ortega
Employee/Petitioner

v.

Railway & Industrial Services, Inc.
Employer/Respondent

Case # 14 WC 42418

Consolidated cases: N/A

16IWCC0183

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 **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Kankakee**, on **May 11, 2015** and **June 3, 2015**. 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Prospective TKA surgery as prescribed by Dr. Chudik**

16IWCC0193

FINDINGS

On the date of accident, **November 21, 2014**, 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 not*** sustain an accident that arose out of and in the course of employment as explained *infra.*

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

Petitioner's current condition of ill-being ***is not*** causally related to the accident as explained *infra.*

In the year preceding the injury, Petitioner earned $**30,843.20**; the average weekly wage was $**593.14**.

On the date of accident, Petitioner was **36** years of age, ***married*** with **1** dependent child.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services as explained *infra.*

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

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

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner failed to establish that he sustained a compensable accident at work. By extension, all remaining issues are rendered moot and all requested benefits and compensation are denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

Signature of Arbitrator

June 29, 2015
Date

ICArbDec19(b) p.2

JUL 2 - 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*
19(b) & 8(a)

Jorge A. Ortega
Employee/Petitioner

v.

Case # 14 WC 42418

Consolidated cases: N/A

Railway & Industrial Services, Inc.
Employer/Respondent

16IWCC0183

FINDINGS OF FACT

The issues in dispute in this case include accident, causal connection, Respondent's liability for certain unpaid medical bills, Petitioner's entitlement to temporary total disability benefits from November 23, 2014 through May 11, 2015, as well as Petitioner's entitlement to prospective medical treatment in the form of injections as recommended by Dr. Glaser. Arbitrator's Exhibit[1] ("AX") 1. AX1. The parties have stipulated to all other issues. *Id.*

Background

Petitioner testified that he was employed by Respondent for approximately 1½ years, initially as a welder, and later as an inspector on November 21, 2014. He explained that Respondent repairs freight trains and his duties were to inspect freight trains, box cars, and side frames looking for dents, cracks, and manufacturer information.

Respondent offered into evidence subpoenaed copies of medical records from Presence St. Joseph Medical Center and from Petitioner's treating physician, Dr. Masood, regarding Petitioner's prior medical treatment. RX3(a) & (b).

Those records reflect that Petitioner was hit by a car on or about September 20, 2009 and he underwent x-rays of his left femur left hip, left knee, left lower leg, and left shoulder. RX3(b) at 262-264. He also underwent x-rays of the chest, abdomen, and pelvis. RX3(b) at 265-266. Additionally, from this trauma Petitioner underwent a CT of his cervical spine with normal or mild findings, where possible. RX3(b) at 269-270. The interpreting radiologist noted "[a]ttenuation artifacts are presumably related to face and neck structures that obscures details about the upper cervical spine...." Id.

Petitioner also underwent x-rays of the thoracic spine on March 4, 2013 showing no acute fracture. RX3(b) at 281. Additionally, Petitioner underwent a CT scan of the head based on a clinical history of intoxication, trauma, and being hit by a car. RX3(b) at 283. The results obtainable were relatively normal. Id. Petitioner further underwent a CT scan of the cervical spine, which was negative. RX3(b) at 285.

Respondent also offered into evidence certain employment records in its Group Exhibit No. 1. Included is a Last Chance Agreement executed by Respondent's representative, a union representative, and Petitioner on October 10, 2014. RX1. The agreement indicates that Petitioner was discharged on October 3, 2014 for failure to call into work or show up for work for two consecutive scheduled work shifts. Id. It also indicates that any

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party.

violation of the agreement or Respondent's rules relating to attendance and absenteeism would result in immediate discharge. Id.

Petitioner acknowledged that he signed a last chance agreement for attendance-related issues at work prior to his alleged accident occurring six weeks later on November 21, 2014. He also acknowledged that Respondent has certain mandatory overtime work days, which included Saturday, November 22, 2014, the day after his alleged accident at work. Petitioner further acknowledged that if he had any type of attendance violation he would be automatically terminated after entering into the last chance agreement of October 10, 2014.

Petitioner explained that he did not call his absence into work for Saturday, November 22, 2014 because his cell phone was turned off by Sprint for lack of payment. On cross examination, Petitioner reiterated that he did not call or show up to work because his cell phone was shut off. He also testified that there was no other phone that he could have used.

November 21, 2014

Petitioner testified that he was performing his normal job duties as an inspector on November 21, 2014. He explained that he was inspecting a side frame and went to stand it upright and felt pain in his back. Petitioner described a side frame to be the bottom of the cart that holds the wheels and that side frames weigh from 70-100 tons. The particular side frames that he was handling on the date of accident weighed approximately 70 tons each. Petitioner explained that, in order to stand the side frame up, he had to push on it. Petitioner testified that he was engaged in this activity about 15 minutes before the end of his shift on November 21, 2014 and that he completed his shift at approximately 3:30 p.m.

On cross examination, Petitioner testified that the accident was observed by Mr. Chavez who was standing right behind him. Petitioner testified that Mr. Chavez told him that he should not be moving the side frames the way that he was. Petitioner acknowledged that he did not tell Mr. Chavez that he was hurt. Petitioner also testified on cross examination that Dave, a supervisor, may have witnessed the incident. He explained that Dave was in the middle of the side frames approximately 10 feet from him.

Petitioner testified that he did not report the injury because he thought it was a small pain that would go away. He testified that he went home after his shift and he had a ride home that day. Petitioner testified that he went to bed around 4:30 p.m. and woke up around 3:30 a.m. and could not get out of bed. He testified that he reported the back pain to his parents and two younger brothers and did nothing on Saturday except stay in bed the whole day.

Petitioner further testified on cross examination that he did not tell anyone that he was hurt on November 21, 22 or 23, 2014. On Monday, November 24, 2014, Petitioner testified that he was supposed to work and he did call in and leave messages. Petitioner testified that he left a voicemail, but he could not recall if he spoke with anyone on that Monday. He also could not recall what he said in that voicemail, but he believed that the voicemail indicated that he was hurt at work either on Monday or Tuesday. Petitioner testified that he decided to seek medical care at St. Joseph's emergency room.

Emergency Room Treatment

The Presence St. Joseph Medical Center records reflect that Petitioner arrived in the emergency room at 3:28 p.m. on Sunday, November 23, 2014 reported pain at a level of 10/10. PX2. The triage nurse noted Petitioner's

report that "he was lifting 70lbs frames at work Friday and c/o lower back pain." Id. A physician's assistant, John Marogol, P.A., in the emergency room noted the following history:

> 36 Yr old male states he has low back pain x 2 days. While at work on Friday he lifted a side panel which is very heavy and a little later in the day he began to feel pain in his lower back. The pain progressively became worse and states a 10/10 sharp pain that is exacerbated by movement and palpation. He states that his legs feel week at times during ambulation. He has had no changes in bowel habits, no new numbness, no SOB or CP and in NAD.

Id. Petitioner was given Norco, 60 mg of Toradol, and 5 mg of Valium and discharged home with a diagnosis of low back pain. Id. The emergency room physician, Dr. Ian Cole, noted his concurrence with the physician's assistant's plan. Id. Petitioner was discharged on November 23, 2014 with prescriptions for Norco, Valium, and Motrin 600 mg and instructions to follow up with a primary care physician. Id. Petitioner filled out a form indicating that he did not have his own primary care physician at the time and was referred to either Dr. Shahid Masood or Dr. Chintan Sampat for follow up in one day. Id.

Communications with Respondent

On Monday, November 24, 2014, Petitioner testified that he called in to his job and told them what was going on. After some voicemails, he explained that he eventually spoke with Matt Hagberg at about 10:35 a.m. Petitioner testified that he had to fill out an incident report because he was injured at work on Friday, November 21, 2014 and later went to Respondent's facility to fill out an incident report.

Petitioner testified that Mr. Hagberg told him to get medical care at the old Joliet facility, but he could not be seen soon so he went to see his own physician and Mr. Hagberg told him he could go there. Petitioner also testified that he spoke with Mr. Hagberg sometime in the morning on Tuesday, November 25, 2014 and told him about the work injury.

Petitioner testified that he was terminated from Respondent's employment in a letter dated November 25, 2014 for violating the last chance agreement. *See* RX1. He testified that on cross examination that he received notice of the termination on that day. Petitioner also testified that he filed a grievance, which is still pending and no final decision has yet been made. *See* RX1.

On re-direct examination, Petitioner testified that he got his phone turned back on between date of accident and when he reported the accident. He explained that he paid part of the bill and got his phone turned back on by calling the toll-free number.

Continued Medical Treatment

The medical records reflect that Petitioner saw Dr. Masood on December 3, 2014. PX3. Dr. Masood noted the following history from Petitioner:

> works at railway – got hurt inspecting site frames/injured his back, lower back on 11/21/14 – pain 10/10, not sleeping, having difficulty with adls, had went to er – reports no xrays done, is having numbness and tingling to rle, no loss of incontinence, medication minimally effective

Id. Dr. Masood diagnosed Petitioner with back pain, injury and paresthesias. Id. He ordered physical therapy, follow up in two weeks, and made a referral to a pain clinic if Petitioner's pain persisted. Id. Dr. Masood

provided Petitioner with a lumbar back brace prescription and placed him off work for an "undetermined" period of time. Id.

Petitioner testified that he then followed up with Dr. Glaser as referred by a friend. Petitioner understood that Dr. Glaser would see him without insurance, which he did not have at the time.

The medical records of Pain Specialists of Greater Chicago show that Petitioner saw Dr. Scott Glaser for the first time on December 15, 2014. PX4. Dr. Glaser noted the following history:

> The patient is a 36 Years Old male who presents with left lower back pain and left buttock & leg pain. The onset was sudden. The precipitating event was a work-related accident. The pain began 1 months ago. Patient is right handed. The pain presents patient from work. The patient describes the pain and frequently associated symptoms with the following adjectives: aching, burning. The pain is improved by heat, ice, lying on the right side. Pain is made worse by physical activity, sitting. The patient reports frequent numbness, constant weakness as associated symptoms. The patient was working on his job 11.21 when he tried to push side frames weighing 70 tons and had the immediate onset of lower back pain on the left and left leg numbness. He is also noting neck pain and numbness in his left arm. He has developed thoracic spinal pain. He cannot sleep, he can hardly bathe himself. He went to the ER. He was given Oxycodone with minimal benefit. He is also on a NSAID and oral steroids which is gone. Additionally, Valium and a muscle relaxant. He has trouble even driving as a passenger in a car. He cannot sit for more than a few minutes.
>
> The patient also complains of neck/ mid back pain and left hand/wrist pain. The onset was sudden. precipitating event was a work-related accident. The patient describes the pain and frequently associated symptoms with the following adjectives: aching, burning. The pain is improved by heat, ice, lying on the right side. Pain is made worse by physical activity, walking. The patient reports constant numbness as associated symptoms.

Id. Dr. Glaser diagnosed Petitioner with cervical radiculopathy, lumbar radiculopathy, and cervical, thoracic and lumbar facet syndrome without myelopathy. Id.

Petitioner had an initial physical therapy evaluation on December 18, 2014. PX4; PX6. He reported that on November 21, 204 he "pushed material between wheels and sideframes. Felt heat on left side of your back. Went home and a few hours later, had a lot of pain. No xrays or MRIs yet. Went to ER and they said I was too young for an xray on my back. Gave me a shot and sent me home. Headaches are bad. Ihave a hard time swallowing. Not sure if it's the medicine I'm taking. I get up for 15 minutes then have to lay down. Thats all I do all day." Id.

On January 5, 2014 Petitioner saw Dr. Glaser reporting that his left lower back, left buttock, and leg pain have remained the same. PX4. He also reported no relief of his neck pain or right upper extremity or right lower extremity pain. Id. Petitioner reported that "He has trouble taking care of himself and his parents have had to move in. He cannot even stand long enought to cook dinner. He also has thoracic spinal pain." Id. Dr. Glaser ordered cervical and lumbar MRIs.

Petitioner underwent the recommended cervical MRI on January 8, 2015. PX4. The interpreting radiologist noted subligamentous posterior disk protrusions at C5-C6 and C6-C7 measuring approximately 2-3 mm which elevated the posterior longitudinal ligaments and indent the thecal sac as well as mild left lateral recess narrowing at C5-C6 and mild bilateral neuroforaminal narrowing at C6-C7. Id. Petitioner's lumbar MRI of the

same date showed subligamentous posterior disk herniations at L2-L3, L3-L4 and L4-L5 measuring approximately 2-3 mm, 2-3 mm, and 3-4 mm respectively which elevated the posterior longitudinal ligaments and indent the thecal sac as well as mild spinal stenosis and bilateral neuroforaminal narrowing.

Petitioner testified that he underwent physical therapy, but it did not help him. *See* PX6. Petitioner also testified that Dr. Glaser prescribed pain medications and pulled him off of physical therapy because the elliptical exercises were hurting him. He explained that the medications only help him somewhat.

Petitioner returned to Dr. Glaser on January 14, 2015 reporting no improvement in his pain. PX4. Dr. Glaser reviewed Petitioner's MRIs and noted "acutely injured discs caused by the work accident that effected the facet joints in those areas. He continued to have severe pain and a low quality of life. He continues to have thoracic pain as well." Id. Dr. Glaser ordered bilateral facet joint injections at L3-L4, L4-L5, and L5-S1. Id.

Petitioner returned to Dr. Glaser on February 16, 2015, March 18, 2015 and April 27, 2015 reporting no improvement in his symptoms. PX5. He continued to recommend bilateral facet joint injections at L3-L4, L4-L5, and L5-S1, and he released Petitioner back to light duty work effective February 17, 2015. Id. In the interim, Respondent requested that Petitioner undergo a medical evaluation pursuant to Section 12 of the Act.

Section 12 Examination – Dr. Graf

On March 16, 2015, Petitioner underwent a medical evaluation with Dr. Carl Graf at Respondent's request. RX2. Dr. Graf reviewed various treating medical records, examined Petitioner, took a history from Petitioner about the alleged injury, and he rendered various opinions. Id. Dr. Graf noted the following history from Petitioner:

> Mr. Jorge Ortega is a 36-year-old male who works for Railway and Industrial Services. He states this is a railroad company which repairs freight train cars. Mr. Ortega states he works as an "inspector and welder." He states he inspects parts including side frames, wheels, etc. He states he inspects the bottom of the trains and checks manufactures dates, cracks, rusted parts and broken springs. Mr. Ortega states that he also needs to help on the line. He indicates this is a heavy job though it depended. He states if they could not find the manufacturer information on the "side frame" this had to be moved. He states that this is 70 tons in weight. Mr. Ortega noted that his boss kicked the side frame over and it leaned on the wheels of the train. He states that he had to push this back and he had a "hot burst" of pain in his low back. Mr. Ortega states he went home and took a nap and had severe pain. He states he went to the emergency room and was sent to Physicians Immediate Care. An examination was provided and he was sent for an MRI scan through he states this was not approved by his workers compensation insurance. Mr. Ortega states he waited approximately a month and called an attorney. He states he was sent for an MRI and sent to see Dr. Glaser. He was given medications including oxycodone 10 mg and placed in physical therapy. He states that after a month he had increased back pain and he was recommended an epidural steroid injection. He states that this was again denied by insurance. He has had no treatment recently. Mr. Ortega states he saw Dr. Glaser and gets medications every month and was given a 15 pound weight lifting restriction. He indicates further he was terminated from his company.

Id. Dr. Graf performed a physical examination noting that Petitioner had an antalgic gait that improved upon leaving the examination room and no problem standing on his tiptoes though he stated he could not place weight on his left heel. Id. Dr. Graf also noted that Petitioner's straight leg raise in the distracted scenario was negative, unlike in informed scenario, and that Petitioner's supine straight leg raise was equivocal with

Petitioner complaining of severe back pain at 10 degrees; which was inconsistent with the sitting straight leg raise to 90 degrees. Id.

In his review of medical records, Dr. Graf noted Dr. Masood's note of January 30, 2015 after Petitioner's admission to the emergency room for treatment of a worsening sore throat and tachycardia. Id. Dr. Graf noted Dr. Masood's understanding that Petitioner was involved in a motor vehicle accident "a long time ago" and "a history of chronic backache" for which Dr. Masood was going to continue with the same treatment plan. Id. Dr. Graf also noted a consultation note from Dr. Maen Martini who noted Petitioner's report that he was not taking any pain medications and a history of "some back pain issues in the past but otherwise healthy." Id. Dr. Graf also reviewed Petitioner's lumbar MRI of January 8, 2015 which he found showed tiny disc bulging from L2-L5 and no significant nerve root compression. Id.

Dr. Graf diagnosed Petitioner with unsubstantiated subjective complaints of low back pain and thoracic pain. Id. He indicated that Petitioner's subjective complaints were not correlated by objective findings and that he demonstrated myriad inconsistencies and non-organic pain signs on evaluation. Id. He further noted that Petitioner's lumbar MRI showed mild degenerative changes, which did not substantiate his subjective complaints of severe low back pain. Id.

Dr. Graf noted that Petitioner showed signs of malingering during his examination and that, while the initial course of physical therapy was reasonable, the use of strong narcotics such as OxyContin, was not reasonable. Id. Ultimately, he opined that Petitioner was at maximum medical improvement, he did not need any further medical care and that he could return to work full duty. Id.

Matt Hagberg

Respondent called Matt Hagberg ("Mr. Hagberg") as a witness. He is testified that has been employed by Respondent as the Manager of Facility Safety and Standards for approximately two years. He explained that he is the safety coordinator and ensures that employees are following OSHA and safety regulations. He also oversees investigations of alleged work accidents.

Mr. Hagberg testified that he knows Petitioner, who was employed by Respondent. He testified that he investigated Petitioner's alleged accident at work and was aware of the last chance agreement, but not the date it was executed. He also testified that he did not know when he spoke with Petitioner on November 25, 2014 whether Petitioner had been terminated or if there was any disciplinary action going on at that time.

Mr. Hagberg testified that he took notes during his investigation and testified about these notes. RX1. Mr. Hagberg testified that the receptionist left him a voicemail or told him when he was in the office that Petitioner had called in and that he needed to report an injury or fill out an accident report. Id.

Mr. Hagberg noted Petitioner voicemail of November 24, 2014 at 4:32 a.m. that he would not be into work for "next few days[.]" RX1. He testified that Petitioner did not report a work-related accident in that message and that they did not speak on this day.

On November 25, 2014 at 5:17 a.m. Mr. Hagberg testified that Petitioner left a voicemail in the general mailbox. He noted "same as above" and "wont be in dr on Monday[.]" RX1. Mr. Hagberg also made the following notation: "1st time he indicates any type of injury[.]" Id. On cross examination, he was questioned about this notation and the difference in ink and darker imprint than his other handwritten notes. The Arbitrator

18IWCC0183

notes that this notation is a darker imprint than Mr. Hagberg's other notations indicating that it was made with a different pen or at a different time than the other notes. Mr. Hagberg also noted Petitioner's second voicemail on November 25, 2014 at 5:32 a.m. that "sister to pick up[.]" Id.

Mr. Hagberg also testified relative to an accident investigation that he conducted beginning November 25, 2014. *See* RX1. He testified that at 9:01 a.m. he left a voicemail for Petitioner to call him because he understood that he needed to report an injury and they needed to start the paperwork process. He testified that he did not speak with Petitioner on November 25, 2014.

Mr. Hagberg testified that the next time he spoke to Petitioner was on December 1, 2014. RX1. He received a voicemail at approximately 7:58 a.m. and he picked up the message at 8:50 a.m. Id. Mr. Hagberg testified that he left Petitioner a message to call him. Id.

Mr. Hagberg testified that he spoke with Petitioner around 9:45 a.m. on December 1, 2014. RX1. He testified that Petitioner told him that he hurt his back. Mr. Hagberg testified that he asked Petitioner specific questions listed in the report (i.e., what was the employee's job at the time of the incident, were any special tools or processes involved, etc.). Id.

Mr. Hagberg testified that he asked Petitioner what he was doing at the time and that Petitioner reported that he was inspecting side frames. The investigation report notes Petitioner's report that he was "inspecting sideframes." Id.

Mr. Hagberg testified that he asked Petitioner how he got injured inspecting side frames. He explained that Petitioner responded that he was looking for a number on the sideframes and Mr. Holroyd pushed the sideframes over on his foot and they leaned up against some wheels and he tried to physically right them on his own, which is how he suspected he injured himself. Mr. Hagberg's investigation report reflects the following statement given by Petitioner:

> Try to locate AAR ID# on sideframes. Employee could no locate asked David Holroyd for help Mr Holroyd kicked over sideframe which leaned against wheels. Side frames did not fall over. Mr. Ortega tried to stand then back upright. Employee relized he was not going to move sideframes. Gathered clipboard & headed to west office. Clocked out went home. Went to sleep for few hours. Woke up with pain in back. Lower back left side. Saturday morning still feeling pain. Went to ER (St. Joes) on Sunday AM (11/23/2014). Discharged from ER with referral to DR @ Meridian. Appt is set for Wed 12/3/2014 @ 2:00 PM."

RX1. The investigation report also reflect Mr. Hagberg's note that "employee took it upon himself to visit e/r without notifying co of injury @ time of incident. Employee was seen and reffered to Family Medical Group Follow Up." Id.

Mr. Hagberg testified that he inquired with others about the incident on December 1, 2014. His report notes that he spoke with Heriberto Chavez ("Mr. Chavez") who "said he did not talk to Mr. Ortega.]" Id. He also noted that he spoke with David Holroyd ("Mr. Holroyd") who stated "did not see anything to indicate any type of injury." Id. On cross examination, Mr. Hagberg testified that Mr. Hoylroyd told him that he (Mr. Hoylrod) kicked the side frame over because they were looking for a number and Petitioner attempted to right it.

Mr. Hagberg testified that side frames have been weighed in other circumstances to ensure that lifting devices can do what they are supposed to do, and he does not know of anything that weighs 70 tons other than a freight car. He explained that side frames are carried by a large forklift or bobcat able to lift that capacity. On cross examination, Mr. Hagberg testified that the side frames weigh approximately 900-1100 pounds.

Heriberto Chavez

Respondent called Heriberto Chavez ("Mr. Chavez") as a witness. Mr. Chavez testified that he works for Respondent as a welder and was working in this capacity on November 21, 2014. He testified that he is familiar with Petitioner who worked for Respondent during that period of time.

Mr. Chavez testified that he did not see Petitioner injure his back at any time on that date. Mr. Chavez also testified that Petitioner did not tell him that he injured his back on that day and that Petitioner did not indicate in any way that he injured his back.

Additional Information

Regarding his current condition, Petitioner testified that his lower left side back hurts. Petitioner testified that he had pain in his neck, but it still hurts here and there. Petitioner's primary complaint relates to the low back.

Petitioner testified that he had no prior low back injury or medical treatment and that Respondent has not paid any benefits for him. On cross examination, Petitioner testified that he could not recall being in a motor vehicle accident. He testified that he did not receive any medical treatment for head, neck or back injuries.

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ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

In support of the Arbitrator's decision relating to Issue (C), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

An employee's injury is compensable under the Act only if it arises out of and in the course of the employment. 820 ILCS 305/2 (LEXIS 2011). The "in the course of employment" element refers to "[i]njuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work...." *Metropolitan Water Reclamation District of Greater Chicago v. IWCC*, 407 Ill. App. 3d 1010, 1013-14 (1st Dist. 2011). The "'arising out of' component refers to the origin or cause of the claimant's injury and requires that the risk be connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Metropolitan Water Reclamation District*, 407 Ill. App. 3d at 1013-14 (*citing Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58 (Ill. Sup. Ct. 1989)). A claimant must prove both elements were present (i.e., that an injury arose out of and occurred in the course of her employment) to establish that her injury is compensable. *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 910 (1st Dist. 2006).

The Arbitrator finds that Petitioner failed to establish by a preponderance of credible evidence that he sustained a compensable accident at work on November 21, 2014 as claimed. In so concluding, the Arbitrator addresses Petitioner's testimony and reports in contemporaneous treating medical records in light of the testimony and written statements of Mr. Hagberg and the opinions of Respondent's Section 12 examiner, Dr. Graf.

Petitioner testified at trial that he injured his low back while engaged in inspecting side frames at work. The investigation of Mr. Hagberg and testimony of Petitioner's co-worker, Mr. Chavez, confirm that Petitioner was at work on the afternoon of November 21, 2014. Their testimony also confirms that Petitioner was engaged in inspecting side frames around that time. The medical records from the emergency room beginning Sunday, November 23, 2014 and the records of Dr. Masood beginning on December 3, 2014 further reflect a consistently reported mechanism of injury to the low back while lifting or moving side frames at work that weighed tons. However, the consistency of Petitioner's testimony and his reports of injury, given the entirety of this record, is questionable.

Petitioner asserts that he felt something in his back at the time he was working with the side frame on the afternoon of November 21, 2014. He testified that he thought it was a small pain that would go away, but did not. Petitioner explained that he began experiencing pain after going to bed that Friday evening and woke up around 3:30 a.m., but was then unable to get out of bed. He testified that he reported the back pain to his parents and two younger brothers and did nothing on Saturday except stay in bed the whole day.

At the same time, Petitioner knew that Saturday was a mandatory work day. He understood that his employment was at risk given the last chance agreement entered into just six weeks earlier. But, he testified that he did not call in to work on Saturday morning because he had no cellular phone service.

Petitioner did not seek medical attention for his back until Sunday afternoon and he did not call into work until Monday, November 24, 2014, another day he was supposed to work. Petitioner testified that he left voicemails,

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and Mr. Hagberg's testimony confirms as much. Petitioner's first voicemail was left quite early in the morning on November 24, 2014 at 4:32 a.m. According to Mr. Hagberg, Petitioner indicated in that voicemail that he would not be into work for the "next few days[.]"

If Petitioner's testimony is to be believed, his phone service was disconnected on some unknown date for lack of payment. No records showing the disconnected cellular service were offered into evidence. Petitioner's phone service continued to be disconnected over the weekend after his witnessed, but allegedly then-unknown, injury at work. Additionally, Petitioner had no cellular phone service the following day, Saturday, which happened to be a mandatory day of work. Despite knowing that he could be terminated for violating the last chance agreement he signed a month and a half earlier, he made no other attempts to call Respondent using any land line or borrowing someone else's cellular phone.

Petitioner also sought no medical treatment on Saturday. He allegedly did nothing that day due to his intense pain. Petitioner did not go to the emergency room until Sunday afternoon. But in the interim—somehow, at some point, despite pain at a reported level of 10/10 prohibiting him from doing anything from the time he woke up on Saturday until he went to the emergency room on Sunday afternoon—Petitioner was able to pay part of his bill reinstating his cellular service by calling the toll-free number. No records reflecting Petitioner's payment to reinstate the disconnected cellular phone service between Friday afternoon and the early morning hours on Monday morning were offered into evidence.

Again, if Petitioner's testimony is to be believed, all of these events occurred after his alleged accident just minutes before the end of his shift on Friday afternoon, extending over a mandatory work day the absence of which would likely lead to his termination from work, but before making the first call into work at the early hour of 4:32 a.m. on Monday morning. Petitioner's testimony, and specifically the consistency of his reported injury at work to medical providers, is simply not credible in light of the record as a whole.

Based on the foregoing, the Arbitrator finds that Petitioner failed to establish by a preponderance of credible evidence that he sustained a compensable accident at work on November 21, 2014 as claimed. By extension, all other issues are rendered moot and all requested compensation and benefits are denied.

STATE OF ILLINOIS)	☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF DUPAGE)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Bruce Morrick,

Petitioner,

vs. NO: 15WC 04945

Packey Webb Ford,

16IWCC0186

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of accident and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 7, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 14 2016
o022516
DLG/mw
045

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MORRICK, BRUCE
Employee/Petitioner

Case# 15WC004945

16IWCC0186

PACKEY WEBB FORD
Employer/Respondent

On 8/7/2015, 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 0.16% 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:

2208 CAPRON & AVGERINOS PC
DANIEL F CAPRON
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

2027 WIEDNER & McAULIFFE LTD
JEFFREY L SALISBURY
2990 N PERRYVILLE RD STE 4300
ROCKFORD, IL 61107

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STATE OF ILLINOIS)
)SS.
COUNTY OF DUPAGE)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Bruce Morrick
Employee/Petitioner

v.

Packey Webb Ford
Employer/Respondent

Case # **15 WC 04945**

Consolidated cases:

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 **Jessica A. Hegarty**, Arbitrator of the Commission, in the city of **Wheaton**, on **May 27, 2015**. 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. [x] 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. [x] 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. [x] 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 **August 1, 2014**, 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 not*** sustain an accident that arose out of and in the course of employment. See attached.

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

Petitioner's current condition of ill-being ***is not*** causally related to the accident. See attached. (No accident.)

In the year preceding the injury, Petitioner earned **$47,552.44**; the average weekly wage was **$914.47**

On the date of accident, Petitioner was **59** years of age, **married** with **0** dependent children.

ORDER

The Arbitrator finds that Petitioner failed to prove he suffered an injury arising out of and in the course of employment on August 1, 2014. All benefits are denied. See attached.

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.

Signature of Arbitrator

Date: 8/4/15

AUG 7 - 2015

16IWCC0186

STATE OF ILLINOIS)
COUNTY OF DUPAGE) SS
)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRUCE MORRICK,
Petitioner,
vs.
PACKEY WEBB FORD,
Respondent.

Case No. 15 WC 04945

ADDENDUM TO ARBITRATOR'S DECISION

This matter proceeded to hearing on May 27, 2014,pursuant to Section 19(b) of the Illinois Workers' Compensation Act (the "Act") before Arbitrator Jessica A. Hegarty in Wheaton, Illinois.

The disputed issues are:

- Accident;
- Causal connection; and
- Prospective medical

FINDINGS OF FACT

Petitioner testified to working for Respondent in the body shop since 1978. His duties included repairing damaged vehicles before they were sent to the paint shop. Petitioner described no history of problems with his right knee prior to the alleged injury on August 1, 2014.

Petitioner alleges that on Friday, August 1, 2014, he was replacing a front bumper which weighed approximately 75 pounds. According to his testimony, while kneeling down on a carpet, his knee came into contact with a hard object. Petitioner testified he immediately looked down and determined that he knelt on a bolt or chunk of bolt followed by immediate pain and bruising. He did not seek immediate medical treatment. He was off of work over the weekend and when he returned to work on Monday, he experienced more pain while kneeling. On Tuesday, August 5, 2014, he advised his supervisor, James Reynolds, that he would need to see a physician. He testified that he advised Mr. Reynolds that he had knelt down on a bolt the previous week.

James Reynolds, the respondent's body shop manager for the past 38 years, testified on behalf of the Respondent. According his testimony, he first learned of the Petitioner's knee problem on the day of, or shortly before, the Petitioner's initial medical treatment.

At that time, the Petitioner reported that he needed to see a doctor for knee pain because he had knelt down on a bolt at work.

Records of Dreyer Medical Clinic offered into evidence as Petitioner's Exhibit 1 show that Petitioner called in and spoke with Kathleen Soto at 9:14 a.m. on Tuesday, August 5, 2014. The message recorded by Ms. Soto indicates that the Petitioner said his knee hurts, "feels swollen – has been going on for about two weeks." The Petitioner asked to speak with a clinical assistant and was advised that one would return his call. A subsequent telephone conversation with Tina Appel, R.N., took place at 9:42 a.m. The notes of that conversation indicate that the Petitioner complained of feeling as if he had a sprain of the right knee. Nurse Appel noted the following: "Patient is an umpire but was off and returned and feels like maybe he injured [the knee]. The patient was scheduled to be evaluated by Dr. Houlahan at 5:00 p.m. that day."

Petitioner presented to Dr. Houlahan who noted a history of acute right knee pain for the past week. The doctor noted Petitioner:

> "states that he kneeled down approx one week ago and must have kneeled on something as he had a sharp pain on his patella. Since then he has had pain on his kneecap especially when kneeling. He denies any swelling of his knee joint or any locking or catching. He has no twisting injuries."

On examination of the right knee, the physician recorded positive tenderness of the patella, negative varus valgus stress test, no effusions, negative McMurray. The assessment was a contusion of the right knee. Petitioner was prescribed Norco to help with knee pain, and advised to rest the knee as much as possible. Dr. Houlahan reassured the Petitioner that there no signs consistent with any internal damage.

Petitioner testified that he did not recollect the substance of the histories provided in the two telephone conversations when he first contacted Dreyer Clinic to schedule the appointment. However, he states the conversations were approximately five minutes long.

Petitioner testified that he continued working, but his symptoms did not abate. On August 21, 2015, he was directed by Maggie Morroni to see a physician at Cadence Convenient Care in Wheaton. A progress note from that provider offered as Petitioner's Exhibit 2 contains a history of Petitioner kneeling down onto a bolt or screw with his right knee, directly onto the right kneecap, but not breaking the skin. He had been limping the last two to three weeks, and also had been umpiring baseball games. The Petitioner denied twisting his knee or spraining it. On examination of the knee there was no effusion, no ecchymosis, no deformity, no laceration, no erythema, no LCL laxity, normal patellar mobility, no bony tenderness, normal meniscus and no MCL laxity. There was tenderness at the patellar tendon. There was no medial joint line, no lateral joint line, no MCL and no LCL tenderness. There was crepitus to the right patella and mild swelling of the infrapatellar tendon/bursa. Petitioner was diagnosed with a contusion of the knee, infrapatellar bursitis and a muscle strain of the right thigh.

X-rays revealed mild degenerative changes and osteophyte formation at the medial tibial plateau. Petitioner was instructed to follow up with Cadence Occupational Health Clinic.

On August 25, 2014, Petitioner was evaluated at Cadence Occupational Health Clinic by Dr. Robinson who noted a history of coming down "hard" with his weight and a 75-pound bumper onto his right knee on rolled-up carpet and not seeing a one-inch screw head. There was no abrasion or bruising present. He was diagnosed with a probable suprapatellar bursitis and patella contusion with infrapatella tendinitis.

On September 3, 2014, Petitioner was evaluated by Dr. McCarthy at Cadence Occupational Health Clinic who noted a history of right knee pain since kneeling on a bolt or screw while working on a car about August 1.

On September 15, 2014, Petitioner presented to Dr. Aaron Bare at Cadence Physicians Group who noted a history of kneeling down and striking a bolt with his knee. On X-ray imaging there was 50% narrowing of the medial joint line. Petitioner was diagnosed with pain, osteoarthritis and patellar tendinitis. Dr. Bare suggested treatment of the arthritis with an intra-articular cortisone injection. He also recommended ultrasound treatment for the patellar tendon from the blunt trauma sustained to that area. He concluded the degenerative osteoarthritis was pre-existing, but aggravated by the acute injury.

Further conservative care by Dr. Bare did not relieve Petitioner's symptoms and after an MRI study on October 28, 2014, revealing a horizontal cleavage tear of the medial meniscus, severe thinning of articular cartilage throughout the medial compartment and bone marrow edema which may be degenerative, Dr. Bare recommended either a uni-compartmental arthroplasty or total knee arthroplasty. Petitioner sought a second opinion from Dr. Mark Schinsky, who agreed with the need for surgery. Dr. Schinsky also offered an opinion that the Petitioner's work accident aggravated or exacerbated a pre-existing degenerative arthritis.

On April 29, 2015, Petitioner attended an independent medical examination with Dr. Lawrence Lieber who reviewed MRI films and treatment records, concluding that the Petitioner's current condition was unrelated to the accident of August 1, 2014. Dr. Lieber stated the work accident involved only a "minor contusion" which neither caused nor aggravated the pre-existing degenerative arthritis.

CONCLUSIONS OF LAW

In support of the Arbitrator's Decision as to whether the Petitioner sustained an accident which arose out of and in the course of his employment, the Arbitrator concludes as follows:

Petitioner testified that immediately after kneeling down onto the bolt on August 1, 2014, he looked down and identified what he struck with his knee. His testimony is contradictory to notes recorded in the Dreyer Medical Clinic from Kathleen Soto and Tina Appel. In notes of the telephone conversations each individual had with Petitioner, there is no indication that he injured himself in the manner or at the time described by Petitioner. The first message from Ms. Soto simply indicates that Petitioner stated his knee hurt and felt swollen, and had been "going on for about two weeks." The second note from Tina Appel similarly fails to note a history of any trauma, referencing only umpiring and that Petitioner "feels like maybe he injured [the knee]." Furthermore, contrary to the Petitioner's testimony that he knew exactly what happened to him on August 1, 2014, the progress note of Dr. Houlahan taken later that day indicates that Petitioner "must have kneeled on something" due to the sharp pain he felt on his patella. The note does not identify the bolt or screw referenced in the later histories provided by Petitioner to other treating physicians. The Arbitrator also notes that there is no specific finding of bruising or ecchymosis, also inconsistent with the Petitioner's testimony. The alleged injury occurred only four days previously. Had Petitioner actually suffered bruising, one can reasonably assume it would have been apparent to a physician. The absence of such a finding begs the question whether the incident event occurred as alleged.

Petitioner acknowledges that he did not tell James Reynolds of the incident until after he decided he needed to see a physician. Although he may have told James Reynolds that he knelt on a bolt, the testimony is unclear exactly when that conversation took place on August 5, 2014. If Petitioner had identified the exact mechanism of alleged injury to James Reynolds, there is no reason for him not to have so stated to Kathleen Soto, Tina Appel or Dr. Houlahan.

The Arbitrator also notes that the progress note from Dr. Houlahan fails to mention anything about working with or replacing a bumper, and traces the incident to one week previously, not four days. On August 21, 2014, Petitioner told Dr. Hockett at Cadence Convenient Care that he knelt down on a bolt or screw, while Petitioner testified that it was definitely a bolt when he looked down into the piece of carpet immediately after the incident. There is also no reference in that progress note of dealing with a heavy bumper. That further explanation was first provided to Dr. Robinson on August 25, 2014 the third medical provider and fifth person to whom Petitioner described the onset of symptoms. That note indicates Petitioner did not see a one-inch screw head, although Petitioner testified he did not so specifically describe the screw head to the physician.

Based on the admitted delay in reporting the alleged injury, and the inconsistent histories of onset of symptoms noted above in the Dreyer Medical Clinic records, the Arbitrator finds that Petitioner failed to prove that he suffered an accidental injury arising out of and in the course of employment on August 1, 2014. Had the mechanism of injury been so clear to the Petitioner immediately, it is inconceivable that three different individuals at Dreyer Medical Clinic would not have recorded the incident more in keeping with Petitioner's testimony.

Having found the Petitioner failed to prove he suffered an accidental injury arising out of and in the course of employment on August 1, 2014, the Arbitrator need not address the other disputed issues. However, the Arbitrator would note that all of the diagnostic studies and findings of Dr. Bare, Dr. Schinsky and Dr. Lieber point to a significant pre-existing condition of osteoarthritis which would have invariably become symptomatic. That is more consistent with the lack of any stated history of trauma noted in the records of Dreyer Medical Clinic, along with the inconsistently reported timing of the onset of symptoms. The treatment recommendations of Dr. Bare and Dr. Schinsky relate to the pre-existing condition, not to a minor contusion causing no identified bruising or internal derangement of the knee.

All benefits are therefore denied.