

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	22WC003098
Case Name	Luke Paladin v. Cook County Sheriff's Department
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	25IWCC0482
Number of Pages of Decision	27
Decision Issued By	Frank Soto, Commissioner

Petitioner Attorney	Al Koritsaris
Respondent Attorney	Katrina Robinson

DATE FILED: 12/3/2025

/s/ Frank Soto, Commissioner

Signature

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: ☐ TTD ☐ PPD	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LUKE PALADIN,

Petitioner,

vs.

NO: 22 WC 3098

COOK COUNTY SHERIFF'S DEPARTMENT,
 DEPARTMENT OF CORRECTIONS,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses, temporary total disability benefits, prospective care, and 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 thereof.

Petitioner, a deputy sheriff correctional officer, sustained cervical and lumbar injuries when he was attacked by a combative detainee on December 19, 2021. The Commission hereby incorporates by reference the findings of fact contained in the Decision of the Arbitrator. However, following a careful review of the entire record, the Commission modifies the Decision of the Arbitrator to find that Petitioner sustained a 30% loss of use of the person as a whole based upon its analysis of the Illinois Workers' Compensation Act's §8.1b(b) statutory factors.

In reviewing permanent partial disability, the Commission must consider the §8.1b(b) enumerated criteria, including (i) the reported level of impairment pursuant to (a) [AMA "Guides to Evaluation of Permanent Impairment"]; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability as corroborated by treating medical records. 820 ILCS 305/8.1b(b). No single enumerated factor shall be the sole determinant of disability. *Id.*

Regarding criterion (i), Dr. Kern Singh provided AMA impairment ratings of 0% for

Petitioner's cervical and lumbar muscular strains. The Commission assigns some weight to this factor.

Regarding criterion (ii), Petitioner was a deputy sheriff correctional officer on the accident date. The job description of a correctional officer provided in Respondent's Exhibit 3 shows that it is a physically intensive position, specifically indicating that Petitioner was tasked with using appropriate physical force to control disruptive behavior. Petitioner eventually returned to his pre-accident full-time position, although his ongoing pain made him miss so much work that he now faced reprimand by Respondent for exceeding his allotted sick time. The Commission assigns great weight to this factor.

Regarding criterion (iii), Petitioner was 41 years old on the accident date. No testimony or direct evidence was presented specifically addressing how Petitioner's age affected his disability. Nevertheless, the Commission acknowledges that Petitioner was relatively young with a substantial work-life expectancy remaining. The Commission assigns moderate weight to this factor.

Regarding criterion (iv), Petitioner returned to his pre-accident position and presented no evidence to suggest that his future earning capacity had been adversely affected by the accident. The Commission thus assigns this factor no weight.

Regarding criterion (v), Petitioner treated his cervical and lumbar conditions with a C5-C6 discectomy with total disc arthroplasty, C6-C7 injection, L4-L5 injection, physical therapy, work conditioning, and pain medication. At that time of the hearing, Petitioner testified that he felt no improvement in his neck or low back symptoms. He continued to manage his ongoing pain with over-the-counter medications. The Commission assigns substantial weight to this factor.

In consideration of the above factors, the Commission increases the permanency award to 30% loss of use of the person as a whole for Petitioner's cervical and lumbar injuries, given that he required surgery, continues to miss work due to persistent symptoms, and has several decades remaining in the workforce. The Commission otherwise finds that the Arbitrator appropriately declined to award permanent partial disability for Petitioner's initial diagnosis of a concussion, as there was no evidence of ongoing symptoms related to the concussion beyond the first two treatment visits.

The Commission further affirms and adopts the Arbitrator's finding that Petitioner had reached MMI for his causally related cervical and lumbar injuries as of December 12, 2023, the date Petitioner was initially discharged from Dr. Chintan Sampat's care at MMI. Pursuant to this finding, the award of temporary total disability benefits after the MMI date of December 12, 2023 is hereby stricken. The Commission thus modifies the Decision of the Arbitrator to award temporary total disability benefits for the period of December 22, 2021 through May 23, 2023 only. Respondent shall be given a credit for all amounts of temporary total disability paid after the MMI date of December 12, 2023.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 28, 2025, is modified as stated herein. In all other respects, the Commission

otherwise affirms and adopts the Decision of the Arbitrator.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits of \$981.06 per week for 73 6/7 weeks, from December 22, 2021 through May 23, 2023, as provided in §8(b) of the Illinois Workers' Compensation Act. Respondent shall be given a credit for any and all temporary total disability benefits paid after the MMI date of December 12, 2023.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent partial disability of \$882.96 per week for 150 weeks, because the injuries sustained caused a 30% loss of the person as a whole, as provided in §8(d)2 of the Illinois Workers' Compensation Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Illinois Workers' Compensation 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.

December 3, 2025

O: 10/8/25

FJS/mek

046

/s/ Frank J. Soto

Frank J. Soto

/s/ Carolyn M. Doherty

Carolyn M. Doherty

/s/ Raychel A. Wesley

Raychel A. Wesley

ILLINOIS WORKERS' COMPENSATION COMMISSION
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Case Number	22WC003098
Case Name	Luke Paladin v. Cook County Sheriff's Department
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Proceeding Type	Request for Hearing
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	23
Decision Issued By	Luana Montoya, Arbitrator

Petitioner Attorney	Al Koritsaris
Respondent Attorney	Katrina Robinson

DATE FILED: 4/28/2025

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



April 28, 2025

/s/ Luana Montoya, Arbitrator
Signature

/s/ Michele Kowalski
Michele Kowalski, Secretary
Illinois Workers' Compensation Commission

INTEREST RATE WEEK OF APRIL 22 2025 4.05%

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**

Luke Paladin

Employee/Petitioner

v.

**Cook County Sheriff's Department,
 (Dep't of Corrections)**

Employer/Respondent

Case # **22** WC **003098**

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 **Luana Montoya**, Arbitrator of the Commission, in the city of **Chicago**, on **January 28, 2025**. 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 **Prospective Medical v. MMI**

FINDINGS

On **December 19, 2021**, 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. *See Decision.*

In the year preceding the injury, Petitioner earned **\$76,523.46** ; the average weekly wage was **\$1,471.60**.

On the date of accident, Petitioner was **41** 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 **\$84,652.25** for TTD, **\$0.00** for TPD, **\$0.00** for maintenance, and **\$0.00** for other benefits, for a total credit of **\$84,652.25**.

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

ORDER***Medical benefits***

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, and as provided in Sections 8(a) and 8.2 of the Act to the following providers: Parkview Orthopedics (\$389.00, itemized in PX3); Oak Brook Surgical Center (\$56,012.00, itemized in PX8); and Oak Brook Anesthesiologists (\$5,250.00, itemized in PX8).

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.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of \$981.06/week for **88 and 1/7** weeks, from December 22, 2021 through May 23, 2023; from December 18, 2023 through December 28, 2023; and from July 21, 2024 through October 16, 2024, as provided in Section 8(b) of the Act.

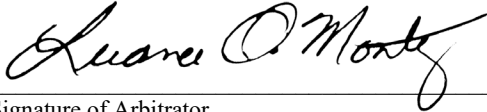
Respondent shall be given a credit of **\$84,652.25** for temporary total disability benefits that have been paid.

Permanent Partial Disability

Respondent shall pay Petitioner permanent partial disability benefits of \$882.96/week for 100 weeks, because the injuries sustained caused the 20% loss of the person as a whole, as provided in Section 8(d)2 of the Act. See Memorandum of Decision of the Arbitrator for Arbitrator's considerations under Section 8.1b(b) 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.

A handwritten signature in cursive script, appearing to read "Luane O'Monty", written in black ink.

Signature of Arbitrator

APRIL 28 2025

Testimony Regarding Medical Treatment and 2023 Return to Work

Petitioner's testimony about the medical treatment he received is consistent with what is reflected in the records summarized separately below. He described the cervical spine treatment including surgery. (Tr. at 36.) The lumbar spine treatment was not approved, therefore he went ahead with work conditioning and returned to work in May 2023 on a trial basis. (Tr. at 39-40.) Petitioner maintained that his low back complaints remained throughout the course of treatment even as the neck improved. (Tr. at 37-39.)

The Section 12 examinations with Dr. Singh, according to Petitioner, were limited in both duration and scope. He testified that they lasted five minutes and that Dr. Singh conducted a minimal or no physical examination. (Tr. at 32, 48.) The second physical examination was limited to Dr. Singh hitting his knees with a reflex instrument. (Tr. at 48, 55.) Dr. Singh reported that Petitioner denied having back pain prior to the accident. When asked if he made that denial, Petitioner stated first, that he did not recall and, in later testimony, that he did not. (Tr. at 58, 63.)

Petitioner was also asked about incidents that occurred after he returned to work for this injury in 2023. First, on June 13, 2023, he fell down a staircase and injured his right knee. (Tr. at 40.) (The subject of a separate workers' compensation application. (Tr. at 52.)) His neck pain at the time was "marginal," but the low back pain continued to be very severe. (Tr. at 31.) On cross examination, he was also asked to confirm whether his knee gave out and he fell onto a workbench at home in September 2023. Petitioner replied that he did not recall, then asked "A workbench? Can you describe what a workbench is?" (Tr. at 53.) He did recall being in a motorcycle accident in September 2023. (Tr. at 53.) That resulted in an impaired gait, injured ribs, and a concussion. (Tr. at 53-54.) He stated that there was no treatment specific to the neck or low back as a result of those accidents. (Tr. at 72.) Petitioner affirmed that he treated for the knee injury, the fall at home, and motorcycle accident through January 2024. (Tr. at 54.)

Petitioner testified that his treater, Dr. Sampat, gave him permanent restrictions of no overtime in December 2023 because, as he worked more, his neck pain got worse. (Tr. at 41-42.) He felt tingling down the left arm again, and his low back pain had not gotten better. (Tr. at 42.)

Testimony Regarding June 2024 Return to Treatment

Petitioner testified about his return to see Dr. Sampat in June 2024. As he worked more, his neck pain worsened, he felt tingling into his left arm again, "the lower back pain always stayed bad. It never got better." (Tr. at 42.) The low back pain and tingling into the foot was getting worse. (Tr. at 42-43.)

According to Petitioner, he took "more time than I can count off using medical time," in the period between when Dr. Sampat released him on December 12, 2023 and when Petitioner saw him again in June. (Tr. at 41-43.) There were days, he stated, in which he "couldn't even get out of bed" or he would wake up and his "feet would be completely numb" or it was hard to turn his head. (Tr. at 43.) Petitioner reported going through the disciplinary process for exceeding his available medical time off. (Tr. at 43-45.)

After Dr. Sampat took Petitioner back off work, he received workers' compensation benefits until after Dr. Singh's September 30, 2024 Section 12 examination. (Tr. at 45-47.) Petitioner went back to work, testifying that he had to, as he had no way to support himself otherwise. (Tr. at 49-50.)

Prior Medical Condition

Petitioner testified that he believed he previously treated for his low back in 2016, due to another injury on the job in which the primary injury was a torn achilles tendon. (Tr. at 23, 41.) He thought that he had physical therapy but did not have injection therapy nor were injections or an EMG for the low back complaints ever recommended. (Tr. at 24, 72.) Those symptoms resolved and he returned to work full duty without restrictions until the current injury. (*Id.* at 24.)

On cross examination, Petitioner expressed that he did not recall whether the lumbar condition was accepted as part of that earlier claim. (Tr. at 60-61.) He acknowledged having a lumbar MRI in December 2017 and continuing to treat in 2018 (with Drs. Karanastasis and Sampat) for the low back and again in April of 2019. (Tr. at 61-62.) He did not recall whether he testified about having low back pain at the July 2022 hearing on the 2016 matter. (Tr. at 63.)

Petitioner also acknowledged treating with a chiropractor for low back symptoms since 2012. (Tr. at 60.)

Testimony Regarding Subsequent Injuries and Current Condition

As far as his current condition, Petitioner testified that he had no improvement in his neck or lower back pain. (Tr. at 50.) He had not reinjured those parts of his body since the December 2021 incident. (*Id.*) When asked how he managed his pain, he replied "a lot of over-the-counter pain meds, Tylenol, Aleve, Advil. There's not much you can do to be honest." (Tr. at 51.)

Summary of Medical Records

Emergency Care (December 19, 2021)

Chicago Fire Department ambulance records indicate that Petitioner was "not sure if he lost consciousness[, he] stated that he had muscular pain in his neck" and a collar was placed as a precaution (PX1 at 13.) At Mount Sinai, Petitioner reported that a detainee put him in a choke hold and they both went to the floor. (PX1 at 2.) He hit his head. (*Id.*) The notes are unclear as to whether he lost consciousness, reading as follows: "remembers umping up sure if he lost consciousness mother officer thought he probably did." [*sic*] (*Id.*) He reported having "some pain in his lower neck." (PX1 at 2) The medical problems listed were abrasion of forehead, blunt head injury, concussion, cervical strain, and left knee strain. (PX 1 at 2-3, 4.) The neck was noted as being tender. (PX2 at 3.) Brain and cervical CT scans revealed no acute findings. (PX at 4, 18-19.) Petitioner was advised to follow up with his primary care provider. (PX 1 at 6.) Records include a page that Petitioner signed, listing forms that he received, one of which was listed as "Return to Work – Tomorrow." (PX1 at 22.) There are no notes about restrictions.

PCP Follow-Up (Dr. Karanastasis – Dec. 2021-Jan. 2022)

Petitioner followed up with his primary care physician, Dr. Karanastasis at Zmedi Helthcare, on December 22, 2021. (PX4 at 12-15.) The records note that he was there for a follow-up from Sinai hospital but there is no narrative addressing the history of injury or complaints. Dr. Karanastasis assessed seven conditions in that encounter, but only mentioned the December 19, 2021 incident

and Mount Sinai stay with respect to one – a concussion. (PX4 at 14.) For that (and the other personal health conditions that he assessed), he recommended that Petitioner be off work from December 19, 2021 until the next appointment in one month. (PX4 at 14.) Among the medical history listed in this visit's record was "MRI TS/LS 12/18; T8 to T9 mild spinal stenosis and L3 to L5 mild CCS and mild NFS." (PX4 at 12.)

When Petitioner returned to Dr. Karanastasis on January 26, 2022, he had complaints of "recurring left arm pain most in forearm" radiating to the wrist, and "recurring upper lower back pain, pain radiates left hip buttock to left leg." (PX4 at 10.) Dr. Karanastasis assessed lumbar and cervical radiculopathy. The notes indicate that since the December 19, 2021 incident, Petitioner had severe "CS and LS pain w/LUE and LLE radiculopathy with pain 8/10." (PX4 at 11.) Dr. Karanastasis also noted that Petitioner had been out of work since December 19, 2021 and should continue to be off work until the next appointment in six weeks. He issued referrals to "spine ortho Dr. Troy" and for lumbar and cervical MRIs. (PX4 at 11.)

MRIs, Physical Therapy, ESIs, Cervical Surgery Recommendation (Feb. 2022-July 2022)

Petitioner had the MRIs on February 4, 2022. (PX2 at 291-294.) The lumbar MRI showed no evidence of acute traumatic injury, did show disc desiccation at L4-5 with preserved disc heights, no facet arthropathy or neuroforaminal or spinal canal stenosis at levels L1-2 through L3-4, and L5-S1. (PX2 at 291-292.) At L4-5 there was a disc bulge with no spinal canal or neuroforaminal stenosis. (PX2 at 291-292.) The cervical MRI showed no evidence of acute traumatic injury, there was cervical degenerative disc disease and joint disease, a disc bulge and mild spinal canal stenosis at C5-6, and neuroforaminal stenosis at both C4-5 (left, mild) and C5-6 (right mild to moderate, left moderate). (PX2 at 293-294.)

Petitioner first saw Dr. Chintan Sampat, at Parkview Orthopaedic, on February 21, 2022. (PX2 at 129.) The chief complaint was left pain radiating into the left arm and low back pain radiating into the left buttock area following a work injury. (PX2 at 129.) He related having been choked with a questionable loss of consciousness and a fuzzy memory regarding the exact events. (PX2 at 129.) He fell to the ground and started having neck pain, upper back pain, low back pain, and some left arm pain including the bicep, dorsal forearm, and ulnar forearm. (*Id.*) Physical examination findings included that Petitioner had neck and low back pain with flexion and extension; a positive Spurling's on the left; and was not tender to palpation over the cervical or lumbar spine. (*Id.* at 130.) Dr. Sampat interpreted the February 4, 2022 MRIs as showing a C5-C6 cervical disc herniation with mild to moderate stenosis and slight disc desiccation and protrusion at L4-5 without areas of critical stenosis. (PX2 at 131.) Citing that Petitioner was asymptomatic before the work injury and symptomatic afterwards, Dr. Sampat wrote that the treatment was related to the work injury. (*Id.*) Finally, Dr. Sampat recommended physical therapy and an off-work status. (*Id.*)

Petitioner had physical therapy in March and April 2022. (*See* PX2 89-128.) He returned to Dr. Sampat on April 12, 2022. Petitioner reported to Dr. Sampat that physical therapy helped his symptoms somewhat but that he was still having quite a bit of symptomatology. (PX2 at 87.) On physical examination, he had mechanical low back pain with flexion and extension, a positive Spurling's on the left and pain radiating down the neck into the left arm. (*Id.* at 87.) Dr. Sampat recommended continued physical therapy and an epidural spine injection (ESI). (*Id.*)

The C6-7 ESI was administered on June 9, 2022. (PX 2 at 367-368.) In a follow-up, Dr. Sampat noted that Petitioner did not have significant improvement from the injection. Also, that Petitioner reported no lasting relief from physical therapy and was therefore considering chiropractic treatment, which Dr. Sampat supported. (PX2 at 85.)

By July 26, 2022, Dr. Sampat recommended C5-6 anterior cervical discectomy and fusion (versus total disc arthroplasty depending on intraoperative findings). (PX2 at 82.) At that point, Petitioner was also having low back pain radiating down the left buttock. (PX2 at 82.) Dr. Sampat reviewed the imaging studies again and stated that they showed a lumbar disc herniation at L4-L5 (which he previously described as a protrusion). (PX2 at 82.) By July 28, 2022, Petitioner had received the L4-5 ESI. (PX2 at 361-362.) To the provider who administered the injection, Petitioner described the pain as sharp, newly onset, constant, worse with standing, and radiating down to the left leg and buttock with intermittent tingling and numbness into the lower leg and extending to the foot. (PX2 at 361.)

Respondent's Section 12 Examination, Dr. Kern Singh (August 8, 2022)

Petitioner had a Section 12 Examination with Dr. Kern Singh at Midwest Orthopedics on August 8, 2022. (RX 8). Dr. Singh authored a chronology of treatment with Drs. Karanastasis and Sampat, and noted that he reviewed physical therapy notes, a job description, an injury report, and the February 4, 2022 MRIs. (PX8 at 1.) According to the report, Petitioner reported "entire spine pain," with neck and midback pain at 8/10 and low back at 9/10. (RX8 at 1.) Petitioner also reportedly denied lower extremity dysesthesias and denied pain prior to the injury date. (*Id.*) The past medical and surgical history that Dr. Singh identified does not include anything related to the spine. (RX8 at 2.) Waddell findings were negative. (RX8 at 3.) A physical examination included neurological, motor strength, and reflex testing. A Spurling's test was negative. (RX8 at 2-3.)

Dr. Singh opined that the February 4, 2022 MRI showed a C5-6 disk protrusion with mild stenosis. (RX8 at 3). The lumbar MRI showed L4-5 central disk protrusion without stenosis and decreased disk signal intensity without height loss. (*Id.*) He concluded that Petitioner sustained a soft tissue strain of the cervicolumbar spine and an aggravation of the C5-6 disk protrusion with stenosis. (RX8 at 3.) He causally related the C5-6 aggravation to the work accident and opined that surgery was appropriate. (RX8 at 3-5.) Regarding the lumbar spine, he diagnosed a strain and L4-5 degenerative disc disease. Dr. Singh noted that the lumbar MRI did not show significant stenosis and that the neurological examination was normal. (RX8 at 3.) Moreover, that Petitioner presented without bilateral lower extremity radiating symptoms. (RX8 at 4.) He therefore concluded that the strain was resolved, no additional treatment was necessary, and that Petitioner was at MMI for the lumbar spine. (RX8 at 5.)

Cervical Surgery and Trial Return to Work (December 2022-May 2023)

Dr. Sampat and Petitioner reviewed Dr. Singh's report on August 16, 2022 and planned for the cervical surgery. (See PX2 at 81.) With respect to the lumbar spine, Petitioner still reported low back, left-sided buttock, and posterior thigh pain with walking and standing. (PX2 at 80.) Dr. Sampat stated that he would "recommend pain management" and "did not see any surgical indications" regarding the lumbar spine at that point. (PX2 at 81.)

It took some time for Petitioner to be cleared for surgery, but he ultimately underwent an anterior cervical discectomy with total disc arthroplasty at C5-6 on December 1, 2022 at Oak Brook Surgical Centre. (PX2 at 297-301.) The postoperative diagnosis was C5-C6 cervical disc herniation, cervical stenosis, and cervical radiculopathy. (PX2 at 297.)

Petitioner began his post-operative physical therapy on January 4, 2023. (See PX2 at 68.) He reported at the initial visit still feeling pins and needles in the fingers and shooting pain in the left hip; moreover, he reported left shoulder blade pain. (PX2 at 69.) Petitioner reported improving left arm radicular symptom complaints (“essentially resolved”) in his January 31, 2023 follow-up with Dr. Sampat, but his lumbar left-sided complaints continued. (PX2 at 39-40.) At that point, the treatment plan was to continue the course of physical therapy and medication. (PX2 at 39.) Dr. Sampat reiterated that he was recommending nonoperative measures for what he identified as the L4-L5 lumbar disc herniation and left-sided lumbar radiculopathy. (PX2 at 39.)

A transition to work hardening occurred over the course of the next two months. (See PX2 at 20.) March 21, 2023 was the last physical therapy session; Petitioner had cancelled 16 sessions and attended 13. (PX2 at 18-19). Work conditioning began on March 29, 2023 at Athletico and continued until May 5, 2023. (PX5 at 90-97; PX5 at 57-61.) Petitioner had cancelled 7 sessions and attended 16. (PX 5 at 59). He had complaints of pain at that point – burning achilles pain, radiating pain in the left upper extremity, and radiating low back pain into the glute – but stated that he was powering through just as he would at work. (PX5 at 60.) The evaluator opined that Petitioner was able to complete all job demands with proper form, that he showed consistent good effort, and recommended he return to work. (PX 5 at 60.) His job level was a medium demand level. (PX5 at 56.) He met goals of being able to lift 50 pounds occasionally floor to waist, 12” to waist, waist to shoulder, as well as 50 pound bilateral carry, and pulling. (PX5 at 60.) His subjective complaints of pain were noted as was the assessment that he did not demonstrate significant mechanical changes with it and was able to complete all job demands, with pain, with proper form. (PX5 at 58.)

Dr. Sampat released Petitioner to a four week trial-return to work on May 9, 2023. (PX2 at 16-17.) On physical examination that day, Petitioner’s cervical spine was unremarkable and range of motion was well maintained. He had 5/5 motor strength and had normal sensation. Cervical x-rays demonstrated a nicely healing fusion with well-positioned hardware; flexion and extension views confirmed good motion at the disc with no issues. Dr. Sampat noted that Petitioner was doing well. He opined that any ongoing neck pain and low back pain were manageable with over-the-counter ibuprofen and Aleve. (The parties stipulated, and Respondent’s records indicate that Petitioner received TTD through May 23, 2023 (AX1 at 2; RX1 at 1), which indicates a May 24, 2023 return to work.) At that visit, Petitioner reported that the tingling in the arms was better and that he had occasional tingling in the hands but that otherwise he was functioning much better. He still reported low back pain with lumbar flexion and extension. (PX2 at 16.) Dr. Sampat opined that Petitioner “will have permanent neck and low back pain, but it appears to be manageable at this point,” and noted that Petitioner was using ibuprofen and Aleve. (PX2 at 16.)

Treatment for Other Injuries; MMI and Full Duty Return to Work (June 2023 – December 2023)

On June 13, 2023, Petitioner returned to see Dr. Sampat and reported that he was tolerating his full duty work well, but that he had fallen the day before and had right-sided knee pain. (PX2 at

14.) Imaging showed “well-positioned surgical hardware and nicely healing total disc arthroplasty.” (PX2 at 14.) He had full cervical spine range of motion. (*Id.*) The lumbar spine was not mentioned. Dr. Sampat opined that Petitioner could work full duty and scheduled a follow-up in September. (*Id.*)

Petitioner’s next visit with Dr. Sampat was not until September but, during this time, physical therapy records (relating to the knee) reflect that he reported additional injuries. Petitioner reported on August 30, 2023 that he fell as he was leaving home over the weekend, landing on his right knee and left side ribs. (PX5 at 29.) On September 8, 2023, he reported that his right knee gave out and he fell into his work bench, bruising his rib and hurting the left knee. (PX5 at 25.) On September 15, 2023, he reported that he had been in a motorcycle accident “last weekend,” that resulted in a concussion and injured ribs. (PX5 at 19.) The last therapy note in the records, from November 1, 2023, indicated that Petitioner was going to return to work “next week.” (PX5 at 2.)

When Petitioner followed up with Dr. Sampat on September 26, 2023, Dr. Sampat noted that although he had cleared Petitioner to return to work, he was still pending clearance by the knee surgeon. (PX2 at 12.). As far as the cervical issue, Petitioner was no longer taking pain medications, and the tingling in the hands and periscapular pain had gotten better. (PX2 at 12.) The physical examination showed him to be neurologically intact with normal sensation from C5-T1 and L2-S1 distributions. (PX2 at 12.). Apart from that finding, there is no note regarding the lumbar spine. Dr. Sampat assessed that Petitioner was doing well regarding the cervical spine. (*Id.*)

Petitioner had two more interactions with Dr. Sampat in December during which he was declared at maximum medical improvement (MMI). In a December 12, 2023 visit, he reported to Dr. Sampat that he used Tylenol and ibuprofen “on and off” for pain. (PX 2 at 10). He reported getting “stiffness in the lower back intermittently,” and that he had a hard time working overtime, “working as best as tolerated.” (PX2 at 10.) According to Dr. Sampat, Petitioner had “tingling in the fingertips intermittently due to the nerve damage from his work injury.” (*Id.*) Cervical spine x-rays showed well-positioned hardware with arthroplasty without complications noted. (*Id.*) At that point, Dr. Sampat placed Petitioner at MMI, with a permanent restriction of working 8 hours per day, 5 days per week and no more than 40 hours per week to avoid further injury to the arthroplasty implant. (PX2 at 10.) In a December 22, 2023 telehealth visit, the hours restriction was removed at Petitioner’s request. (RX2 at 7.) Petitioner reported that he had no new neurological complaints. (*Id.*)

Return to Dr. Sampat, off work, additional treatment recommended (June 2024-September 2024)
 Petitioner returned to Dr. Sampat on June 18, 2024. Petitioner reported that he had missed ten days of work in the preceding three weeks due to neck and low back pain along with tingling and numbness along the buttocks, posterior thighs, forearms, and hands. (PX2 at 4.) The pain, he stated, made it difficult to walk, stand, bend, lift, and twist. (*Id.*) Petitioner reported that he had been working full duty without any new injury. On physical examination, there was neck and low back pain with flexion and extension. A Spurling's test resulted in some neck and periscapular pain. Cervical spine x-rays showed a healed arthroplasty with no hardware loosening, migration, or any other complications; there was a slight ventral osteophyte but no full bridging or fusion.

Dr. Sampat recommended cervical and lumbar MRIs as well as EMGs of the upper and lower extremities.

The EMGs and updated MRI studies were done in June and July 2024. They showed as follows:

- Cervical MRI (PX2 at 277): status post C5-6 fusion, multilevel degenerative changes without significant spinal canal stenosis, and stable mild to moderate neuroforaminal narrowing at C5-C6 and C6-C7.
- Bilateral upper extremity EMG (July 2, 2024) (PX2 at 281-285): read as normal, with no evidence of denervation, cervical radiculopathy, peripheral neuropathy, or entrapment neuropathy.
- Lumbar MRI (July 5, 2024, with comparison to 2/4/2022 MRI) (PX2 at 276): mild diffuse bulge with wide base central disc protrusion at L4-L5, contacting descending L4 nerve roots in the lateral recesses, slightly increased in comparison to previous examination of 2/4/2022. Mild foraminal narrowing at L4-5 (stable).
- Lower extremity EMG (July 12, 2024) (PX2 at 278-280): marked denervation in the left rectus femoris muscle consistent with L3-L4 radiculopathy, but no ongoing denervation in the corresponding lumbar paraspinal muscles. Because of that, the examiner, Dr. Glantz, questioned whether the marked denervation could be related to a pelvic abnormality distal to the nerve roots and suggested correlation with an MRI. He further concluded that all sensory responses were intact and normal, ruling out any sensory distal peripheral neuropathy. He noted that the peroneal motor distal responses were small with prolonged latency on the left, which could indicate distal motor neuropathy.

Following the studies, Petitioner returned to Dr. Sampat on July 19, 2024. (PX2 at 1-3.) Dr. Sampat opined that the lower extremity EMG confirmed lumbar radiculopathy with possible neuropathy and that the lumbar MRI images showed a disc protrusion at L4-L5. He stated that the upper extremity EMG was within normal limits and stated only that he reviewed the cervical MRI. (PX2 at 1.) Petitioner's complaints at that point were of improved symptoms after a C5-C6 anterior cervical discectomy with arthroplasty but with persistent pain, numbness, and tingling. (PX2 at 1.) A physical examination showed "paresthesias in both feet in the left buttock and posterior thigh." (*Id.*) There was "some neck and lower back pain with flexion and extension maneuvers." (*Id.*) Dr. Sampat referred Petitioner for a neurology consultation and to pain management for cervical and lumbar epidural injections. He authorized Petitioner off work indefinitely. Dr. Sampat noted that Petitioner did not have any of these pain symptoms before his injury at work. He "suspect[ed] that the symptoms in the upper extremities are likely coming from the same neurological injury that occurred initially and he still has [the] same symptoms from the L4-L5 disc protrusion." (*Id.*) The need for treatment and time off work, he opined, were due to the work injury.

Respondent's Follow-Up Section 12 Examination, Dr. Kern Singh (September 30, 2024)

Dr. Singh conducted a second Section 12 examination on September 30, 2024. (RX9.) Among the symptoms that Petitioner reported were neck and left arm pain at 7/10; midback pain at 8/10; low back and "right leg" [*sic?*] pain at 10/10; "leg pain is the same as his back pain; and all pain was rated as severe." (PX9 at 2.) Petitioner stated that he took Tylenol and Advil as needed for pain relief.

The 2024 EMGs and MRIs were among the updated records that Dr. Singh reviewed. He described the upper extremity EMG as normal with no evidence of cervical radiculopathy. (RX9 at 3.) The cervical spine showed that it was status post C5-6 total disk replacement without residual stenosis. (RX9 at 3.) He described the lumbar MRI as showing a disc protrusion at L4-5 without significant stenosis. The lower extremity EMG was normal without evidence of lumbar radiculopathy. (*Id.*)

Petitioner had sustained, in Dr. Singh's opinion, soft tissue cervical and lumbar spine strains that had resolved. (RX9 at 3.) He stated, as before, that Petitioner had also aggravated a C5-6 protrusion which led to the disc replacement. Dr. Singh opined that Petitioner's current subjective complaints of pain to the neck, left arm, low back, and right leg were nonanatomic and nonobjectifiable. (RX9 at 3.) Accordingly, he opined that the lumbar spine treatment was excessive and that four weeks of physical therapy three times per week would be appropriate for a soft tissue muscular strain. (PX9 at 4.) Similarly, he stated that the cervical treatment had been excessive, and that appropriate treatment was four weeks of physical therapy, then an FCE, and two to four weeks of work conditioning. (PX9 at 6.) He also opined that Petitioner could return to work full duty without restrictions for both the lumbar and cervical spine conditions and that he was at MMI for both (three weeks after the date of injury for the lumbar and three months after the December 1, 2022 surgery for the cervical spine). (RX9 at 4, 6.) Finally, he also offered an impairment rating of 0% for the cervical and lumbar strains. (RX9 at 5, 7.)

Pre-injury Medical Treatment Records

The record also includes treatment records from September 2016 to August 2020 reflecting back complaints. These followed a September 20, 2016 work injury also sustained after a struggle with a detainee. (*See e.g.* RX5 at 12.) Some of that treatment was with Drs. Karanastasis and Sampat, with whom Petitioner again treated after the injury at issue here.

The records begin with Petitioner presenting to Dr. Karanastasis on September 22, 2016 with complaints of persistent left achilles tendon, left hip, and lower back pain. (RX5 at 1-3.) In a follow-up visit, he reported that the ankle pain began after the September 2016 injury but that "he had low back pain intermittently for a long time before that episode." (RX5 at 4-6.) After that, he started to have left lower extremity radicular distribution pain going into the gluteal area up to the knee and some numbness in the medial part of the left hallux. (RX5 at 4.) Dr. Karanastasis noted low back tenderness with no straight leg test in left or right appreciated. (RX5 at 5.) He suggested an MRI due to the sciatica symptoms, and an EMG for the lower extremities. (RX5 at 5, 6.)

Petitioner continued with low back pain complaints throughout the ensuing three months. An October 2016 note reflected that Petitioner's low back complaints included lower extremity radicular distribution with pain in the left gluteal area and dysesthesia sensation in the left hallux. (RX5 at 9.) During that time, he was undergoing physical therapy for the left ankle. (With indications that the program was modified due to lower back pain. (*See e.g.* PX5 at 19, 20.)) In a November 11, 2016 visit, after stating that his back had gone out, Petitioner expressed to Dr. Karanastasis that he intended to go to a chiropractor while waiting for approval to treat for the low back. (RX5 at 18-19.) Later that month, Dr. Karanastasis noted that the lumbar and thoracic MRIs had not been approved, therefore he would start physical therapy and do an x-ray. (RX5 at 25.) These were denied as well, pending a third party evaluation. (RX5 at 27.)

On January 30, 2017, Petitioner saw Dr. Kathleen Weber of Midwest Orthopaedics at Rush, for a Section 12 examination of the lumbar spine and ankle. (RX5 at 32-33, 35.) At the time, Petitioner described the back pain as across the mid-back as well as some pain to the left buttock which, he said, had resolved over the past couple of weeks; the radiation to the buttock had also resolved. (RX5 at 33.) He also stated that the left toe numbness improved with time. Petitioner also described pins and needles in the hands and feet bilaterally when bending over to brush his teeth. (*Id.*) Petitioner reported going to a chiropractor about once a month for five years for “chronic intermittent lower back pain.” (*Id.*) Findings on physical examination included no tenderness or spasm along the spine and intact sensation throughout the lower extremities except for the distal dorsal aspect of the left great toe. (*Id.*) Dr. Weber went on to diagnose a resolved lumbar strain. She did note that if it was true that Petitioner did not have that numbness before, then there “did appear to be a likely causal relationship.” (*Id.* at 34.) She opined that Petitioner seeing a chiropractor regularly over the past five years as well as the physical therapy note of his back having gone out on him suggested a chronic issue. (*Id.* at 35.)

Throughout 2017, Petitioner’s back complaints varied. For example, Dr. Karanastasis declared the low back pain as resolved in a February 2, 2017 visit (RX5 at 39). Then, Petitioner reported low back pain as 6/10 and “mildly improve[d]” in May. (RX5 at 42.) In August, Dr. Sampat took a history of Petitioner having sustained an injury in September 2016 after which Petitioner had neck and lower back pain, occasional tingling in the hands and feet, and “ample chiropractic treatment which helped a little with his symptoms.” (RX5 at 44.) Prior to the 2016 injury, Petitioner stated, he only had occasional back and neck pain but, since then, it was persistent along with new symptoms that included hand and foot tingling. (*Id.*) In November, after Petitioner noted that his low back radicular symptoms resolved but that he still had pain, Dr. Karanastasis assessed lumbago with sciatica and lumbar arthritis and again recommended a lumbar MRI. (RX5 at 48-49.)

A lumbar and thoracic spine MRI was completed on December 28, 2017. (RX5 at 52.) The MRI findings with respect to the lumbar spine included the following: multilevel degenerative disc disease and degenerative disc height loss with desiccation at L4-L5; an L3-4 mild broad-based disc bulge with ligamentum flavum thickening, facet hypertrophy, mild bilateral neural foraminal narrowing, and mild canal stenosis; and an L4-5 broad-based disc extrusion with annular fissure with ligamentum flavum thickening and facet hypertrophy, mild bilateral neural foraminal narrowing, and mild canal stenosis. (RX5 at 52-53).

On May 15, 2018, Petitioner returned to Dr. Karanastasis, who reviewed the MRI and recommended that Petitioner see a spine surgeon. (RX 5 at 54-56). Dr. Sampat, to whom Petitioner returned on June 26, 2018, reviewed the MRI and noted “mild bulging discs” at L4-5 “but no areas of critical, central, or lateral recess or foraminal stenosis.” (RX5 at 58.) Petitioner still reported “quite a bit” of mid-thoracic back pain and low back pain – with the left foot tingling having gotten better. (*Id.*) Dr. Sampat referred Petitioner for physical therapy (*Id.* at 60). In July, Dr. Karanastasis noted that if there was no improvement he may proceed to an injection (also at that point noting that the pain was mostly at the thoracic spine). (RX5 at 63.)

The next records in evidence are from mid-2019, after Petitioner had ankle surgery. (RX5 at 66-71.) As part of the ankle treatment, Petitioner underwent a functional capacity evaluation (FCE).

(RX5 at 75.) The January 2, 2020 FCE shows that Petitioner was working “primarily a desk job” and that he wanted to return to his full duty job. (RX5 at 74.) He demonstrated the ability to function within the medium physical demand level despite an antalgic gait. (RX5 at 72.) Petitioner did not meet the job demands of frequent standing, frequent walking, occasional agility tasks, occasional running, and job simulations. (RX 5 at 73.) The remainder of the records through 2020 reflect a rheumatologist diagnosing osteoarthritis but otherwise show return visits to Dr. Karanastasis for unrelated medical conditions. (RX5 at 81-89.)

In the July 21, 2022 workers’ compensation hearing on the 2016 matter, Petitioner testified that he had been working full duty from February 17, 2020 until he sustained two additional work accidents, one of which is the December 2021 matter at issue here. (RX6 at 17-18.) At that hearing, he discussed seeing a chiropractor prior to the 2016 accident for what he described as stiffness and mild soreness from being on his feet most of the shift and the weight of his duty belt. (RX6 at 18-20.) After the 2016 accident, he had “extremely sharp pain” in the lower back. (RX6 at 20.) As to what he was feeling at the time of his testimony, Petitioner described: “my thoracic is still that constant pressure where it feels like it radiates hard to take – I feel like when I take deeper breaths, the lower back I still have sharp pains in it.” (RX6 at 23-24.)

II. CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

To obtain compensation under the Act, an employee has the burden of proving, by a preponderance of the evidence, all of the elements of the claim. *O’Dette v. Illinois Industrial Comm’n*, 79 Ill. 2d 249, 253 (1980). Decisions of an Arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). The right to recover cannot rest on speculation or conjecture. *Nunn v. Industrial Comm’n*, 157 Ill. App. 3d 470, 479 (1987). It is the function of the Commission to decide questions of fact and causation, judge the credibility of the witnesses, and to resolve conflicts in the medical evidence and assign weight to witness testimony. *O’Dette*, 79 Ill. 2d. at 253 (internal citations omitted). 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 ILWC 004187 (2010).

In this case, the Arbitrator observed Petitioner during the hearing and finds that, while his testimony in terms of accident and treatment was generally consistent with the evidence presented, there were some inconsistencies and evasiveness that indicate unreliability. For example:

- Petitioner testified that he was “choked unconscious.” Medical records show that he was not sure if he lost consciousness (ER: PX1 at 13; Dr. Sampat: PX2 at 129.)
- Petitioner testified that he presented to the ER with complaints that included his low back and that he was told not to return to work until he saw a primary care physician (Tr. at 20-21.) The records do not corroborate either assertion. (PX1 at 2-3, 4, 12-13, 22.)
- When asked about falling into a workbench at home Petitioner stated that he did not recall and asked what a workbench was. (Tr. at 53.)

- Petitioner testified at one point that he did not deny having prior back problems in the examination with Dr. Singh and, at another, that he did not recall. (Tr. at 58.)

Regarding Issue F, whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds as follows:

The findings of fact and conclusions of law set forth above are adopted and incorporated by reference as though fully set forth herein.

Petitioner testified to a current condition of ill-being involving his neck and lower back. One question is whether the lumbar spine condition was pre-existing. Another, regarding both the cervical and lumbar spine, is whether symptoms that arose several months after he was discharged at maximum medical improvement (MMI) are related to the injury. For the reasons set forth below, Petitioner has shown by a preponderance of the evidence presented, that his condition of ill being regarding the cervical and lumbar spine until the December 12, 2023 MMI discharge is causally related to the December 19, 2021 injury. His condition thereafter is not related to the injury.

Cervical Spine

Petitioner's condition of ill-being with respect to the cervical spine, specifically, the condition for which he underwent the C5-6 anterior cervical discectomy with arthroplasty on December 1, 2022, is causally related to the December 19, 2021 injury. The cervical spine surgery was authorized after Dr. Singh's Section 12 examination concurred that the injury had aggravated Petitioner's C5-6 protrusion with stenosis. There was no evidence of a previous condition regarding the cervical spine. The preponderance of the evidence presented supports that the condition was related to the injury up to the December 12, 2023 finding of maximum medical improvement.

The sharply increased symptoms months later, paired with the lack of objective findings at that time, however, do not support a finding that Petitioner's condition of ill being after that discharge is causally related to the injury.

The documented complaints in the time leading to Petitioner's 2023 return to work show a significant attenuation leading up to the release and ultimate discharge at MMI. At the time that Petitioner was first released to a trial return to work in May 2023, Dr. Sampat noted that Petitioner was doing well and that any ongoing neck and low back pain—which he deemed permanent—was manageable with over-the-counter pain medication. (PX2 at 16.) At the next visit, on June 13, 2023, Petitioner reported that he was tolerating full duty work well (except for knee pain from having fallen the previous day). (PX2 at 14.) In September, Petitioner reported that he was no longer taking pain medications, and that the tingling in his hands as well as periscapular pain had gotten better. (PX2 at 12.) Dr. Sampat noted that Petitioner was “doing well” with respect to the cervical spine. (Id.) Finally, in the December 12, 2023 visit, Petitioner noted that he had “on and off” pain (not specifying which body part), that he was working as tolerated, and Dr. Sampat observed that Petitioner had intermittent fingertip tingling due to nerve damage but that the x-rays showed well-positioned hardware and arthroplasty. (PX2 at 10.) Petitioner reported that he had a hard time working overtime and Dr. Sampat issued restrictions of working no more than 40 hours per week. Petitioner was declared at maximum medical improvement at that time. Days later,

during a telehealth visit, Petitioner reported no new neurological complaints and wanted to have the restrictions removed. Dr. Sampat complied.

When Petitioner returned to Dr. Sampat in June 2024, he reported neck and low back pain as well as tingling and numbness along the buttocks, posterior thighs, forearms, and hands. (PX2 at 4.) The pain, he stated, made it difficult to walk, stand, bend, lift, and twist. To Dr. Singh, Petitioner described the pain as severe and constant, coming on both suddenly and gradually. (RX9 at 2.)

The cervical MRI and upper extremity EMG that followed in July 2024 showed that Petitioner was status post a C5-6 fusion with degenerative changes, with no significant spinal canal stenosis and stable neuroforaminal narrowing. (PX2 at 277.) The EMG was read as normal. (PX2 at 281-285.) Dr. Sampat acknowledged that the EMG was within normal limits and made no comment as to the MRI, except to say that he reviewed it. (PX2 at 1.)

Dr. Sampat does not point to any objective findings to support his conclusion that Petitioner's claimed cervical spine condition in June 2024—and the corresponding recommendation for additional injections and an off-work status—was related to the December 2021 injury. On that point, therefore, his opinion cannot be given greater weight than Dr. Singh's. Dr. Singh observed that the EMG and neurologic examination were normal and the MRI showed no residual stenosis. (RX9 at 3, 6.) Both studies, and Dr. Sampat's assessment of them, coincide with this finding, which makes Dr. Singh's conclusion that Petitioner was at MMI persuasive. No medical record or opinion supports or explains the escalated onset of cervical spine symptoms for which Petitioner sought treatment in June 2024. Therefore, the preponderance of the evidence does not support a finding that the condition continues to be related to the December 2021 injury.

Lumbar Spine

Regarding the lumbar spine, consideration is given to evidence of a pre-existing lumbar condition and injury, to Dr. Singh's opinion that Petitioner sustained a resolved cervicolumbar strain, and to the complaints arising after Dr. Sampat's December 2023 MMI determination. For the reasons set forth below, the Arbitrator finds that, as a result of this injury, Petitioner sustained a lumbar strain for which he reached MMI on December 12, 2023.

To obtain compensation under the Act, a claimant must prove that some act or phase of his employment was a causative factor in his ensuing injuries. A work-related injury need not be the sole or principal causative factor, as long as it was a causative factor in the resulting condition of ill-being. Thus, a claimant may establish a causal connection in such cases if he can show that a work-related injury played a role in aggravating his preexisting condition. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 205 (2003).

The evidence documented a pre-existing lumbar condition. In medical records from 2016 and 2017, Petitioner described long-standing intermittent lumbar pain. (RX5 at 4-6; 33.) In a 2017 evaluation, Petitioner acknowledged seeing a chiropractor once a month for five years for that intermittent pain. (RX5 at 33.) Moreover, in September 2016, Petitioner had a specific work injury in which alleged injuries included the lumbar spine. He came under the care of Drs. Karanastasis and Sampat (as he did after the 2021 injury). During that treatment period, the symptoms that he described included pain radiating into the left buttock, into the knee, and numbness into the foot.

(See e.g., RX5 at 4, 9, 58.) The last records in evidence from that time that specifically mention the low back are from May 2018, when Petitioner reported “quite a bit of low back pain with improvement as far as the left foot tingling.” (RX5 at 58.) At that point, treaters noted that if physical therapy did not help, they would consider injections. (RX5 at 63.) Petitioner’s treatment in 2019 and 2020 centered upon an ankle surgery. (Dr. Karanastasis had identified lumbar arthritis in November 2017 and the 2020 records note that a rheumatologist diagnosed osteoarthritis, though no body part is specified. (RX5 at 48-49, 81-89.)) He returned to work in February 2020. (RX6 at 17-18.)

After this December 19, 2021 injury, Petitioner again experienced an onset of lumbar spine symptoms. Lumbar pain was first described in the records in a January 26, 2022 visit with Dr. Karanastasis. In that visit, Dr. Karanastasis assessed lumbar spine pain at 8/10 with left lower extremity radiculopathy. (PX4 at 11.) The pain was described as radiating “left hip buttock to left leg.” (PX4 at 10.) By July 2022, at the time of the lumbar ESI, Petitioner described pain radiating down the left buttock with intermittent tingling and numbness into the lower leg and extending into the foot. (PX2 at 82, 361.) Petitioner continued to report pain after the ESI. The lumbar complaints continued into 2023 (PX2 at 39-40.) At the conclusion of work hardening in May 2023, Petitioner continued to report radiating low back pain into the glute. (PX5 at 60.) He nonetheless demonstrated an ability to perform all job demands with proper form. (PX5 at 56-60.)

Throughout the rest of 2023, medical visit records reflected improved lumbar symptoms. In the visit releasing him to return to work in May 2023, Petitioner reported low back pain with flexion and extension that Dr. Sampat opined would be permanent but, at that point, manageable. There is no note about the lumbar spine in June 2023 (PX2 at 14) and it is referenced in a September visit only with the mention of “normal sensation from C5-T1 and L2-S1 distributions.” (PX2 at 12.) By December 2023, Petitioner reported getting “stiffness in the lower back intermittently,” (PX2 at 10), which mirrors his pre-injury description. He was taking over the counter medication “on and off” for pain but the notes do not specify whether for the cervical or lumbar spine or both. Dr. Sampat noted that the restriction of no overtime at that point was to avoid injury to the arthroplasty implant (thus referable to the cervical, not lumbar spine). (RX2 at 10.) No new complaints were presented when the work restriction was removed later that month.

Lumbar MRI findings from December 2017 and February 2022 are in the record, however, neither the treaters nor the Section 12 examiner compared the two. Both show findings at L4-L5 (which Dr. Sampat addressed as the source of Petitioner’s lumbar complaints).

Neither the history of Petitioner’s chronic low back condition, the history of complaints following the 2016 injury, or the MRI studies preclude a finding that Petitioner experienced an onset of escalated symptoms referable to the December 19, 2021 injury. After the 2016 work injury, Petitioner experienced complaints like those described after this December 2021 injury and returned to work in February 2020. Low back complaints are not documented again until January 2022, after this injury. The records and chronology therefore support that Petitioner has an underlying lower back condition and that his symptoms have waxed and waned after specific injuries. After the December 19, 2021 injury, his symptoms again worsened until they improved and were stabilized upon his discharge at MMI in December 2023.

Regarding the duration and course of treatment of the lumbar symptoms after this 2021 injury, Dr. Sampat's assessments are more persuasive than Dr. Singh's Section 12 opinion. Dr. Singh's August 2022 assessment that Petitioner had sustained a lumbar strain that was resolved by the time of his examination was based, in part, upon his finding that Petitioner presented without bilateral lower extremity radiating symptoms (and he noted that Petitioner did not report lower extremity dysesthesias). (RX8.) Petitioner, however, did report pain radiating to the left buttock and thigh in visits with Dr. Sampat, including the ones immediately preceding and following the Section 12 examination. Dr. Sampat's notes and assessments regarding Petitioner's symptoms and treatment needs through December 2023 are more reliable because they remained consistent over the course of two years. Given the similarity in findings at L4-L5 in the 2017 and 2022 MRIs, however, Dr. Singh's characterization of the injury resulting from the December 2021 incident as a strain is more persuasive than the bulge/herniation that Dr. Sampat attributed to it.

The next question regarding the lumbar spine arises from Petitioner returning to Dr. Sampat in June 2024 describing difficulty walking, standing, bending, and lifting, and paresthesias in both feet. (PX2 at 4, 1.) For the following reasons, Petitioner did not show by a preponderance of the evidence that his condition at that point was causally related to the December 2021 injury.

- There is a marked difference in the severity of lumbar symptoms from when he was released to return to work in May 2023 and those with which he presented over a year later. These are detailed above but, in sum, Petitioner noted in May 2023 some pain with lumbar flexion and extension that Dr. Sampat opined would be permanent but manageable at that point with Petitioner reporting use of ibuprofen and Aleve. (PX2 at 16.) Petitioner then saw Dr. Sampat on two more occasions, in June and September 2023, with no note made of the lumbar spine. By the December 2023 discharge, Petitioner was reporting intermittent stiffness in the low back. This is the same way in which he described the lumbar condition prior to December 2021 (*see* RX5 at 4-5) and indicates that his lumbar condition had returned to baseline. Moreover, the bilateral paresthesias complaint differed from the earlier left-sided complaints.
- When Dr. Sampat characterized the 2024 symptoms as "the same symptoms from the L4-L5 disc protrusion" from before, he also concluded that Petitioner's symptoms were related to the December 2021 injury because Petitioner did not have any of those symptoms before then. Yet, Dr. Sampat himself treated Petitioner for similar symptoms after the September 2016 work injury, when there was an MRI finding of an L4-L5 disc extrusion (among other findings). Not reconciling those earlier findings makes this an unreliable causation opinion.
- No causation opinion addresses the substantial commonalities and differences among the 2017, 2022, and 2024 lumbar MRIs. Petitioner's lumbar complaints soon after the 2021 injury were found to be related above due to a documented escalated onset soon after the injury. The June 2024 symptoms do not have that circumstantial support. No medical opinion explains whether the MRIs show a stable condition, a progression, or another difference. Moreover, no opinion states which of Petitioner's symptoms relate to which MRI's findings (if any).
- The 2024 EMG introduces a distinct set of findings with no corresponding medical opinion as to how they relate to Petitioner's symptoms. Dr. Sampat notes that the EMG confirms lumbar radiculopathy with possible neuropathy while opining that Petitioner continues with the same symptoms "from the L4-L5 disc protrusion." (PX2 at 1-2.) The EMG, however, discusses L3-L4 radiculopathy (associated with a left rectus femoris muscle denervation which, in turn, the examiner suggested could be related to a pelvic abnormality). (PX2 at 278-280.) This makes Dr. Sampat's assessment unreliable and, as with the lumbar MRIs, leaves no reliable medical

opinion as to which symptoms, if any, correspond to which findings. Dr. Singh's opinion does not assist in this regard either, as he notes that the EMG shows no evidence of radiculopathy at all. (RX9 at 3.)

Other Conditions

Finally, although emergency room records and the first visit with Dr. Karanastasis noted a concussion diagnosis, that was the extent of the discussion of that condition in the records. There is insufficient evidence of a current condition of ill-being referable to that initial diagnosis or any other condition.

Petitioner did not show, by a preponderance of credible evidence, that the June 2024 spine complaints were causally related to the December 2021 injury. As noted above, the records show benign results from the 2024 cervical studies and a lack of explanation about the lumbar studies and the extent to which the renewed complaints were attributable to pre-existing findings or new ones. Petitioner's condition regarding the cervical and lumbar spine is causally related to the December 2021 injury through the December 2023 MMI discharge only.

Regarding Issue J, whether the medical services that were provided to Petitioner were reasonable and necessary and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

The findings of fact and conclusions of law set forth above are adopted and incorporated by reference as though fully set forth herein.

Petitioner's cervical and lumbar condition of ill-being have been found to be causally related to the December 19, 2021 work injury up to the point that Dr. Sampat found him to be at maximum medical improvement on December 12, 2023. The treatment that he recommended during that time is also found to have been reasonable and necessary, as it was supported by Petitioner's ongoing complaints and objective diagnostic examinations – with Dr. Singh concurring up to the point of the cervical surgery. Dr. Singh's assessment that additional cervical treatment and lumbar treatment was not reasonable was based on his opinion that the conditions should be resolved, which, as found above, was not persuasive.

Petitioner submitted copies of medical bills for treatment claimed to have resulted from the December 19, 2021 work accident. The parties agreed that, if awarded, Respondent would be credited for expenses paid and for any payments for which credit may be allowed under Section 8(j) of the Act provided that Petitioner be held harmless for such payments, per the provisions of that Section. (Tr. at 6, 8-9; AX1.) Respondent shall pay any remaining unpaid and awarded medical charges pursuant to the medical fee schedule and Sections 8(a) and 8.2 of the Act (*see also, Perez v. Illinois Workers' Compensation Comm'n*, 2018 IL App (2d) 170086WC, ¶ 17, 96 N.E.3d 524).

The awarded charges as follows:

- Parkview Orthopedics (\$389.00) (for a March 14, 2023 encounter). (PX3 at 4. Visit records at PX2 20-23.) The submitted bill showed \$961.21 in charges owed (PX3 at 19), however,

\$572.21 of those charges are for 2024 encounters that were found to not have been causally related to the injury and those are not awarded.

- The Oak Brook Surgical Center (\$56,012.00). (PX8 at 2.)
- Oak Brook Anesthesiologists (\$5,250.00). (PX8 at 3.)

A statement from ZMedi Healthcare (totaling \$90.64, PX7 at 2) shows balances for the following dates of service: September 13, 2023; September 27, 2023; December 26, 2023; January 4, 2024; November 19, 2024; and December 2, 2024. The ledger reflects payments from Blue Shield PPO and Petitioner. There are no corresponding medical records for those dates of service. Petitioner did not meet his burden of showing that these charges are reasonable, necessary, or causally related to the December 19, 2021 injury. They are not awarded.

Regarding Issue K, Temporary Total Disability benefits in Dispute, the Arbitrator finds as follows:

The findings of fact and conclusions of law set forth above are adopted and incorporated by reference as though fully set forth herein.

Emergency room records indicate that Petitioner was discharged on December 19, 2021 with documentation showing that he could return to work the following day. (PX1 at 22.) Dr. Karanastasis took him off work on December 22, 2021, but made it retroactive to December 19, 2021. (PX5 at 14.) Petitioner did work on December 19, and medical records from that date do not show that he was taken off work, therefore the first supported date of TTD remains December 22, 2021. Petitioner remained off work through May 23, 2023. Thereafter, Petitioner testified to taking some time off between his December 12, 2023 visit with Dr. Sampat and his return visit in June 2024. The records reflect that Petitioner was paid TTD during an agreed period from December 18, 2023 through December 28, 2023. (RX1, AX1 at 2.) Thereafter, Petitioner was paid TTD for an agreed period between July 21, 2024 through October 16, 2024. (RX1, AX1 at 2.) This corresponds to the time between when Dr. Sampat took Petitioner off work in July 2024 and Dr. Singh's September 30, 2024 Section 12 report opining that the condition was not work related.

Based on the above, the Arbitrator finds that Respondent shall pay Petitioner 88 and 1/7 weeks of temporary total disability (TTD) benefits from December 22, 2021 through May 23, 2023; from December 18, 2023 through December 28, 2023; and from July 21, 2024 through October 16, 2024, at a weekly rate of \$981.06. The parties stipulated that Respondent paid TTD benefits in the amount of \$84,652.25 (AX 1) and Respondent shall be given credit for that amount.

Regarding Issue L, the nature and extent of the injury, the Arbitrator finds as follows:

The findings of fact and conclusions of law set forth above are adopted and incorporated by reference as though fully set forth herein.

In determining the level of Permanent Partial Disability, Section 8.1b(b) of the Act directs the Commission to consider: "(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.” 820 ILCS 305/8.1b(b). Further, “[n]o single enumerated factor shall be the sole determinant of disability.” 820 ILCS 305/8.1b(b). The relevance and weight of those factors is explained below.

Regarding subsection (i) of §8.1b(b) (impairment report), the Arbitrator notes that the record contains an assessment by Dr. Singh of overall impairment ratings of 0% for the cervical spine and lumbar spine, with a determination that according to the 6th edition AMA impairment guides Petitioner would be diagnosed with a cervical muscular strain and a lumbar muscular strain. (RX9 at 5-7.) 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. As discussed below, the nature, duration, and course of Petitioner’s treatment supports a permanent partial disability finding greater than what the impairment rating would reflect. The Arbitrator therefore gives *lesser* weight to this factor.

Regarding §8.1b(b)(ii) (occupation), the Arbitrator notes that Petitioner was employed as a correctional officer 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 the potentially physical nature of this position. The Arbitrator therefore gives *greater* weight to this factor.

Regarding §8.1b(b)(iii) (age), the Arbitrator notes that Petitioner was 41 years old at the time of the accident. It can be reasonably expected that Petitioner has a substantial amount of working years ahead of him during which, as a result of this injury, he at a minimum would have to contend with the residual effects of a cervical disc replacement. The Arbitrator gives *greater* weight to this factor.

Regarding §8.1b(b)(iv) (future earnings capacity), the Arbitrator notes that Petitioner returned to his previous employment and there is no evidence that his earnings capacity has been reduced. The Arbitrator gives *no* weight to this factor.

Regarding §8.1b(b)(v) (evidence of disability corroborated by the treating medical records), the Arbitrator notes that Petitioner underwent a total disc arthroplasty at C5-6 with a post-operative diagnosis of a C5-C6 herniation, stenosis, and radiculopathy and a post-surgical course of physical therapy. For the lumbar spine, Petitioner underwent an epidural steroid injection. Upon Petitioner’s pre-MMI release to return to work in May 2023, Dr. Sampat opined that any ongoing neck and lumbar pain would be manageable with over-the-counter medication. At the time, Petitioner was presenting with tingling in the arms and hands and low back pain with lumbar flexion and extension (PX2 at 16.) He reported improvements at a September 2023 consultation at which Dr. Sampat also noted normal sensation along the neck and back. (PX2 at 12). Petitioner then reported “on and off pain” and intermittent low back stiffness when he was declared at MMI in December. (PX2 at 10.) 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 20% disability to the person as a whole, pursuant to Section 8(d)(2) of the Act. Correspondingly, Respondent shall pay Petitioner 100 weeks of permanent partial disability benefits a weekly rate of \$882.96.

Regarding Issue N, whether Respondent is due any credit, the Arbitrator finds as follows:

The parties stipulated that Petitioner has been paid \$84,652.25 in temporary total disability benefits. Respondent is therefore entitled to a credit for TTD benefits in that amount.

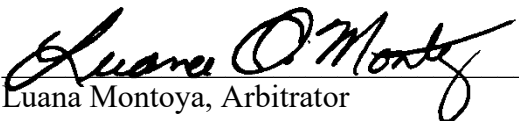
With respect to the awarded bills above, Respondent is entitled to a credit, and Petitioner shall be held harmless for, amounts paid prior to trial, including any amounts paid through a group medical plan for which credit may be allowed under Section 8(j) of the Act.

Regarding Issue O, Prospective Medical Care, the Arbitrator finds as follows:

The findings of fact and conclusions of law set forth above are adopted and incorporated by reference as though fully set forth herein.

As found above, Petitioner reached maximum medical improvement for the injuries sustained on December 19, 2021 and no prospective medical care is awarded.

It is so ordered:


Luana Montoya, Arbitrator

APRIL 28 2025

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	21WC010862
Case Name	Jannet Romero v. AM Staffing Group, Inc.
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	25IWCC0483
Number of Pages of Decision	27
Decision Issued By	Raychel Wesley, Commissioner

Petitioner Attorney	Mark Maritote
Respondent Attorney	Jane Ryan

DATE FILED: 12/3/2025

/s/ Raychel Wesley, Commissioner

Signature

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)
☒ Modify AWW, Temporary Disability, Permanent Disability	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JANNET ROMERO,

Petitioner,

vs.

NO: 21 WC 10862

A.M. STAFFING GROUP 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 Petitioner's average weekly wage, entitlement to temporary disability benefits, and the nature and extent of Petitioner's permanent disability, and being advised of the facts and law, modifies the Decision as set forth below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

CONCLUSIONS OF LAW

I. Average Weekly Wage

The Arbitrator calculated Petitioner's average weekly wage ("AWW") at \$585.00. On Review, Petitioner argues her overtime hours were "regular" and, including those hours at the straight-time rate, her AWW is \$644.74. The Commission observes Petitioner alleged an AWW of \$600.00 on the Request for Hearing form; therefore, her claim for an AWW greater than \$600.00 is barred by *Walker v. Industrial Commission*, 345 Ill. App. 3d 1084, 1088 (4th Dist. 2004). Our review of the record nonetheless reveals Petitioner's AWW at \$585.00 was miscalculated by the Arbitrator.

The evidence reveals Petitioner was employed at Respondent for nine weeks prior to the accident. RX12. Since Petitioner worked for Respondent for less than a year prior to her accident,

the third method under §10 is applicable: “Where the employment prior to the injury extended over a period of less than 52 weeks, the method of dividing the earnings during that period by the number of weeks and parts thereof during which the employee actually earned wages shall be followed.” 820 ILCS 305/10. The Check History Report shows that over the nine weeks of her employment, Petitioner worked 328.03 regular hours; as such, Petitioner’s “number of weeks and parts thereof” is 8.2 ($328.03 / 40 = 8.2$). T. 42. The Check History Report further reflects Petitioner’s regular hourly earnings totaled \$4,920.45. This yields an average weekly wage of \$600.05 ($\$4,920.45 / 8.2 = \$600.05$). However, pursuant to *Walker*, the Commission finds Petitioner’s average weekly wage is capped at \$600.00.

II. Temporary Disability

The Arbitrator concluded Petitioner was not entitled to temporary disability benefits beyond the date Dr. Fernandez “declared [maximum medical improvement] on October 13, 2022.” While the Commission agrees Petitioner failed to prove entitlement to further temporary disability benefits beyond the date she reached MMI, we observe the Decision misidentifies the relevant day. To be clear, Dr. Fernandez’s October 13, 2022 office note reflects Petitioner was to continue aggressive therapy for another month and “will reach MMI at 11/14/2022.” PX2 (Emphasis added). As such, the Commission concludes Petitioner’s entitlement to TTD benefits continued through November 13, 2022. The Commission modifies the Decision to find Petitioner is entitled TTD benefits in the sum of \$400.00 per week for 90 1/7 weeks, representing February 21, 2021 through November 13, 2022.

III. Permanent Disability

The Arbitrator denied Petitioner’s claim for odd-lot permanent total disability and instead determined she sustained 40% loss of use of the right hand. The Commission agrees that Petitioner failed to prove odd-lot status, however we write separately to clarify the relevant legal standard.

The Decision cites to *Economy Packing Co. v. Illinois Workers’ Compensation Commission*, 387 Ill. App. 3d 283 (1st Dist. 2008), for the following propositions: first, there is an affirmative burden on the claimant to submit “detailed supporting job logs in order to support an odd lot finding by a diligent and unsuccessful job search,” and second, when an injured worker is unable to legally work in the United States, “the relevant inquiry in determining one’s employability is whether Petitioner is capable of working in their home country....” The Commission notes neither proposition is accurate. We emphasize *Economy Packing* makes no reference to job search logs; to the contrary, the claimant therein relied solely on expert vocational opinion, and she specifically testified she did not conduct a job search: “According to the claimant, her condition has caused her not to seek employment since the summer of 2003.” *Id.* at 286 (Emphasis added). Moreover, the *Economy Packing* court expressly rejected the proposition that an undocumented claimant should be required to prove “home country” employability and instead concluded the claimant’s burden of proof is unaffected by immigration status:

...we hold that, for an undocumented alien to establish that she is permanently and totally disabled under the “odd-lot” doctrine, she must first prove that she cannot sustain regular employment in a well-known branch of the labor market without regard to her undocumented status. The burden then shifts to the employer to prove that, but for the undocumented alien’s legal inability to obtain employment, suitable

work would be regularly and continuously available. *Economy Packing Co.*, 387 Ill. App. at 295 (Emphasis added).

Having analyzed the competing vocational opinions under this standard, the Commission finds Ms. Bose's opinions are more persuasive than Mr. Pagella's opinions. Of particular note to the Commission is Mr. Pagella's misapprehension of Petitioner's proficiency in English and the artificial limitation he relied upon when assessing her access to the labor market. See *Sunny Hill of Will County v. Illinois Workers' Compensation Commission*, 2014 IL App (3d) 130028WC, ¶ 36 (Expert opinions must be supported by facts and are only as valid as the facts underlying them.)

While the Commission agrees with the Arbitrator's denial of permanent total disability, we view the evidence of her permanent partial disability differently. As detailed below, the Commission finds Petitioner's disability is properly assessed under §8(d)2.

Petitioner's work accident occurred after September 1, 2011; therefore, §8.1b is applicable. Pursuant to §8.1b(b), the Commission is to determine permanent partial disability based upon 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. 820 ILCS 305/8.1b(b).

§8.1b(b)(i) – impairment rating

Neither party submitted an impairment rating. As such, the Commission assigns no weight to this factor and will assess Petitioner's permanent disability based upon the remaining enumerated factors. *Corn Belt Energy Corp. v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC, ¶ 47.

§8.1b(b)(ii) – occupation of the injured employee

Petitioner's pre-accident occupation was warehouse/factory worker. Following her work-related injury, Petitioner was placed under significant permanent restrictions to her right hand, leaving her dominant hand to function as "assist only," and the vocational experts' opinions reflect she is unable to return to her past semi-skilled work. PX10, PX17, RX1. The Commission finds this factor weighs heavily in favor of increased permanent disability.

§8.1b(b)(iii) – age at the time of the injury

Petitioner was 27 years old on the date of her accidental injury. The Commission notes Petitioner is a very young individual and will endure life-altering residual deficits for many years. The Commission finds this factor weighs heavily in favor of increased permanent disability.

§8.1b(b)(iv) – future earning capacity

The record reflects Petitioner's pre-accident hourly rate was \$15.00. RX12. The credible vocational opinions of Ms. Bose indicate Petitioner's current earning capacity is \$16.57 per hour. RX1. The Commission finds this factor weighs in favor of decreased permanent disability.

§8.1b(b)(v) – evidence of disability corroborated by treating medical records

Following Petitioner’s undisputed work accident, she underwent an extensive course of treatment with Dr. John Fernandez, who performed multiple procedures on her right hand:

- March 3, 2021 – right thumb debridement of open fracture, skin, subcutaneous tissue and bone; right thumb soft tissue reconstruction with pedicle flap, first dorsal metacarpal artery island flap; and right forearm full thickness skin graft, 8 square cm;
- November 12, 2021 – right thumb webspace release with four flap Z-plasty, greater than 5 cm; right thumb and hand tenolysis, adductor pollicis and first dorsal interosseous tendons; and right thumb pulp debulking of the skin and subcutaneous tissue; and
- April 8, 2022 – right hand/index finger tenolysis, extensor indicis proprius and extensor digitorum communis to the index finger; right index finger metacarpophalangeal joint dorsal capsulectomy and joint release; and right hand and index finger tenolysis, flexor tendon tenolysis, flexor digitorum profundus and flexor digitorum superficialis tendons. PX2.

On October 13, 2022, Dr. Fernandez imposed “permanent sedentary restriction of less than five pounds with repetition restrictions.” PX2. Petitioner testified she has persistent pain and weakness in her hand; her grip strength is greatly diminished and she has difficulty handling and holding objects with her right hand. T. 59. The Commission finds this factor weighs heavily in favor of increased disability.

Pursuant to §8(d)2, a person as whole award is appropriate when a claimant sustains injuries that “partially incapacitate him[her] from pursuing the duties of his[her] usual and customary line of employment but do not result in an impairment of earning capacity.” 820 ILCS 305/8(d)2. The Commission finds that to be the case herein: Petitioner lost access to her usual and customary employment in the warehouse industry, but there is no resultant impairment of earning capacity. PX17, RX1.

The Commission therefore finds Petitioner suffered a loss of career as a result of her February 20, 2021 work injury. We further find Petitioner sustained a 40% loss of use of the person as a whole, and her permanent partial disability began to accrue as of November 14, 2022, the day she reached maximum medical improvement.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 2, 2025, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of \$400.00 per week for a period of 90 1/7 weeks, representing February 21, 2021 through November 13, 2022, that being the disputed period of temporary total incapacity for work under §8(b) of the Act. Respondent shall have a credit of \$27,446.05 for TTD benefits previously paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of \$360.00 per week for a period of 200 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 40% loss of use of the person as a whole (loss of trade).

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 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 \$75,00.00. 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.

December 3, 2025

RAW/mck

/s/ *Raychel A. Wesley*

O: 10/8/25

/s/ *Carolyn M. Doherty*

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/s/ *Frank J. Soto*

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	21WC010862
Case Name	Jannet Romero v. AM Staffing Group, Inc.
Consolidated Cases	
Proceeding Type	Request for Hearing
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	21
Decision Issued By	Paul Seal, Arbitrator

Petitioner Attorney	Mark Maritote, Mark Maritote
Respondent Attorney	Jane Ryan

DATE FILED: 1/2/2025

*/s/ Paul Seal, Arbitrator*Signature**INTEREST RATE WEEK OF DECEMBER 31 2024 4.14%**

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**

Jannet Romero

Employee/Petitioner

v.

A.M. Staffing Group Inc.

Employer/Respondent

Case # **21** WC **10862**

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 **Paul Seal**, Arbitrator of the Commission, in the city of **Geneva**, on **August 27, 2024 and November 25, 2024**. 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 **Statutory Loss allegation**

FINDINGS

On **2/20/21**, 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 **\$30,420.00**; the average weekly wage was **\$585.00**.

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

Respondent shall be given a credit of **\$27,446.05** for TTD, **\$0** for TPD, **\$0** for maintenance, and **\$2,493.03** for other benefits, for a total credit of **\$29,939.08**.

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

ORDER

PETITIONER IS NOT ENTITLED TO ADDITIONAL TTD OR MAINTENANCE BENEFITS.

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 FACTORY WORKER VIA A STAFFING AGENCY AT THE TIME OF THE ACCIDENT AND THAT SHE IS ABLE TO RETURN TO WORK AS A FACTORY WORKER VIA A STAFFING AGENCY. THE ARBITRATOR THEREFORE GIVES SOME WEIGHT TO THIS FACTOR.

WITH REGARD TO SUBSECTION (III) OF §8.1B(B), THE ARBITRATOR NOTES THAT PETITIONER WAS 27 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 THAT PETITIONER EARNED THE SAME HOURLY RATE IN HER JOBS POST-MMI AS SHE DID AT THE TIME OF THE INJURY. JULIE BOSE ALSO TESTIFIED THAT SHE COULD EARN A MEDIAN WAGE OF \$16.57/HOUR WHEN CONSIDERING THE RESTRICTIONS PER THE FCE AND THE MINIMUM WAGE EQUIVALENT IN HER HOME COUNTRY OF MEXICO. THE ARBITRATOR THEREFORE 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 PETITIONER WAS RELEASED FROM CARE ON OCTOBER 13, 2022 AND HAS SOUGHT NO TREATMENT SINCE THEN. SHE WAS TAKING NO PRESCRIPTION MEDICATIONS. THE ARBITRATOR THEREFORE GIVES SOME 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 40% LOSS OF USE OF A THE RIGHT HAND (82 WEEKS X \$351 = \$28,782.00) LESS THE PPD ADVANCE OF \$2,493.03 FOR A NET AWARD OF \$26,288.77.

PETITIONER IS NOT ENTITLED TO A STATUTORY LOSS.

THE ARBITRATOR DECLINES TO AWARD TO PENALTIES.

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.



JANUARY 2 2025

Signature of Arbitrator

STATEMENT OF FACTS:

Petitioner suffered a work injury on February 20, 2021 when her right thumb was stuck in a machine that printed logos on flags (T1.42-3). She had worked for the Respondent since 2020 (T1.41). She earned \$15 per hour (T1.41). She submitted a false social security card when she applied to work for the Respondent which did not have her signature on it (T1.73-5). She admitted she was not a legal, permanent resident allowed to work in the United States (T1.75). She also submitted a false permanent resident card to the Respondent when applying to work for them (*Id.*).

Petitioner testified she was born in Mexico and had education up to a high school equivalency (T1.31). When in Mexico, she worked as a receptionist at an optical store for 4 years (T1.32). She also worked for a government project to capture computer information (T1.33). She came to the United States in 2015 at which time she had knowledge of the English language (T1.34). She then worked at a cheese factory in packaging (*Id.*). She started earning \$10 per hour but then earned \$14 per hour and was promoted to a supervisor of the department (T1.35). She stated she was promoted due to her ability to translate for her manager (T1.35-6). She then worked at a warehouse in order control earning \$15 per hour (T1.37). She was also a supervisor in that position. (*Id.*).

When Petitioner came to the United States, she knew about 30 percent of the English language (T1.36) and she now knows 70% of the English language due to taking English classes (*Id.* and T1.78). She needed an interpreter at trial as there were “legal terms” she “may not completely understand.” (T1.36-7).

On February 20, 2021, Petitioner presented to the Northwestern Medicine Emergency Department with complaints of a right first finger injury. She was at work where a press came down on her hand and the emergency safety lock did not engage until it was too late. She complained of numbness in her right thumb. The diagnosis was an open fracture. An x-ray showed a compound fracture of the distal phalanx. She was given a splint. A follow up visit was set with Dr. Bendre (Pet.Ex.1).

On February 24, 2021, Petitioner presented to Dr. Fernandez at Midwest Orthopaedics at Rush. Petitioner sustained a right thumb crush injury on a machine at work on February 21, 2021. Petitioner complained of pain and deformity in the right thumb. The diagnosis was postoperative right thumb complex amputation with loss of pulp and exposure of the bone. Petitioner presented for an evaluation of the right-hand x-ray. X-ray revealed no evidence of fracture with the joint but an exposure of the distal phalanx tip bone. Cast dressing was removed and re-applied. She was taken off of work. Dr. Fernandez recommended a radial forearm flap and a first dorsal metacarpal flap (Pet.Ex.2).

On March 3, 2021, Petitioner returned to Dr. Fernandez at Rush Oak Brook Surgery Center. The pre-operative diagnosis was a right thumb crush injury with open fracture distal phalanx with a soft tissue loss, complex. The post-operative diagnosis was the same. The procedure was a right

thumb debridement of open fracture, skin, subcutaneous tissue and bone; right thumb soft tissue reconstruction with pedicle flap, first dorsal metacarpal artery island flap, and right forearm full thickness skin graft, 8 square centimeters (Pet.Ex.2 at 187-9).

On March 9, 2021, Petitioner returned to Dr. Fernandez. Petitioner followed up for an evaluation of her right thumb flap on March 3, 2021. Petitioner presented for a custom orthotic to her right thumb and a home exercise program. Petitioner was fitted with a custom fabricated hand based radial gutter orthosis. asked to follow up in a week to remove the bolster to evaluate the skin graft (Pet.Ex.2).

On March 15, 2021, Petitioner presented for a therapy visit at Athletico Physical Therapy (Pet.Ex.3).

On March 16, 2021, Petitioner returned to Dr. Fernandez. Petitioner presented for a follow up evaluation for her right thumb reconstruction from March 3, 2021. Petitioner had been attending therapy. The diagnosis was post-operative right thumb complex amputation with loss of pulp and exposure of the bone. Petitioner had a cast dressing removal and application. She was assessed with pain in the right thumb. Petitioner restricted from work and was to continue therapy for 6 weeks at a frequency of 2 to 3 times a week (Pet.Ex.2).

On March 18, 19 and 22 of 2021, Petitioner returned for therapy at Athletico Physical Therapy (Pet.Ex.3).

On March 23, 2021, Petitioner returned to Dr. Fernandez for cast dressing removal and application. Petitioner was assessed with pain in the right thumb. Petitioner was restricted from working. Petitioner was asked to continue therapy for 6 weeks at a frequency of 2 to 3 times a week (Pet.Ex.2).

On March 24 and 26 of 2021, Petitioner returned for therapy at Athletico Physical Therapy (Pet.Ex.3).

On March 30, 2021, Petitioner returned to Dr. Fernandez. She presented for post-operative follow up. She rated the pain a 7 out of 10. Petitioner attended therapy 2 to 3 times a week. The diagnosis was postoperative right thumb complex amputation with loss of pulp and exposure of the bone (Pet.Ex.2).

On March 31, and April 1, 2, 5, 7, 9 and 12 of 2021, Petitioner had therapy at Athletico Physical Therapy (Pet.Ex.3).

On April 14, 2021, Petitioner returned to Dr. Fernandez. Petitioner presented for a follow up visit for her right thumb flap from March 3, 2021. Petitioner rated the pain a 7 out of 10. Petitioner attended formal therapy twice a week. The diagnosis was postoperative right thumb complex amputation with loss of pulp and exposure of the bone. Petitioner was asked to continue therapy. Petitioner was restricted to no work (Pet.Ex.2).

On April 15, 16 and May 11 of 2021, Petitioner returned for therapy at Athletico Physical Therapy (Pet.Ex.3).

On May 26, 2021, Petitioner returned to Dr. Fernandez. Petitioner presented for a follow up visit for her right thumb flap from March 3, 2021. Petitioner had significant pain and deformity along her thumb with significant stiffness. She attended therapy and was to continue therapy (Pet.Ex.2).

On June 10, 11, 14, 15, 17, 21, and 22 of 2021, Petitioner had therapy at Athletico Physical Therapy (Pet.Ex.3).

On June 24, 2021, Petitioner returned to Dr. Fernandez. Petitioner presented for an evaluation for her flap she underwent on March 3, 2021. Petitioner was not working at the time of the visit. The assessment made was pain in the right thumb. She was given work restrictions of no work with the right hand and light duty with the left hand. Petitioner had a 10 pound lifting restriction. Petitioner has been in therapy three times a week and continued (Pet.Ex.2).

On June 25 and 29 of 2021, Petitioner returned to Athletico Physical Therapy. On July 1, 2, 6, 8, 9, 13, 14, 15, 19, 22, 26, and 29 of 2021, Petitioner returned for visits at Athletico Physical Therapy. On July 2, 2021, Petitioner returned to Athletico Physical Therapy. On August 3 and 4 of 2021, Petitioner returned to Athletico Physical Therapy (Pet.Ex.3).

On August 5, 2021, Petitioner returned to Dr. Fernandez. Petitioner presented for an evaluation regarding her right thumb first dorsal metacarpal artery flap that she underwent on March 3, 2021. She was “overall doing really well”. Petitioner’s thumb has gotten extremely stiff. Petitioner was interested in the debulking surgery to help with the hand’s functionality. Petitioner was still in therapy. The diagnosis was postoperative right thumb complex amputation with loss of pulp and exposure of the bone. Petitioner would likely need more surgery in the future with tenolysis and debulking surgery with possible webspace opening. Petitioner was going to therapy for the next 4 weeks then re-evaluate at the next visit. Petitioner was limited and restricted from normal work activities with the right hand (Pet.Ex.2).

On August 10, 12, 17, 19, 23, 26, and 31 of 2021, Petitioner returned for therapy at Athletico Physical Therapy (Pet.Ex.3).

On September 2, 2021, Petitioner returned to Dr. Fernandez. Petitioner discussed doing a debulking procedure for the flap as well as a V-plasty for the web space. Petitioner had previous therapy, without much benefit. The diagnosis was postoperative right thumb complex amputation with loss of pulp and exposure of the bone. Dr. Fernandez wanted approval to proceed with surgery to include right thumb debulking at the flap in addition to 4 flap Z-plasty of the webspace regional block anesthetic. Petitioner would need 3 months of recovery to include web spacers. Petitioner may have required index finger tenolysis and/or joint release. Petitioner would engage in therapy following the next surgery. She was restricted from significant work or use of that hand (Pet.Ex.2).

On October 4, 2021, Petitioner presented to Dr. Michael Birman at Hand to Shoulder Associates, S.C. at the request of Respondent. Petitioner presented for independent medical evaluation at Respondent's request. Dr. Birman's diagnosis was a right thumb amputation and right index finger stiffness, with significantly limited active/passive flexion, impacting functional use of the right hand. The diagnosis was causally related to the work injury. Petitioner was limited with the use of the right hand. Petitioner was capable of driving with both hands. Petitioner needed the proposed surgery for debulking. Petitioner's pain complaints were consistent with the objective studies (Pet.Ex.4 at 987-94).

On November 12, 2021, Petitioner returned to Dr. Fernandez at South Suburban Surgical Suites for a right thumb webspace release with four flap x-plasty, greater than 5 cm; right thumb and hand tenolysis, adductor pollicis and first dorsal interosseous tendons; and right thumb pulp debulking of the skin and subcutaneous tissue (Pet.Ex.2 at 183-4).

On November 18, 2021, Petitioner returned to Dr. Fernandez. Petitioner presented for a post-operative follow up for a right thumb debulking and webspace deepening procedure that she underwent on November 12, 2021. Petitioner still had significant pain she rated at a 9 out of 10. She had taken Norco for the pain. The diagnosis was postoperative right thumb complex amputation with loss of pulp and exposure of the bone. Petitioner recommended occupational therapy for fabrication of her splint for protection. Petitioner also restricted from regular work activities (Pet.Ex.2).

On November 18, 2021, Petitioner presented to Dr. Lines at Midwest Orthopedics at Rush. Petitioner presented for an occupational therapy splint on the right thumb. On November 22 and 30 of 2021, Petitioner returned for therapy at Athletico Physical Therapy (Pet.Ex.3).

On December 2, 2021, Petitioner returned to Dr. Fernandez. Petitioner presented for a follow up visit regarding her right thumb debulking and webspace deepening procedure that she underwent on November 12, 2021. Petitioner continued to have pain at an 8/10 and continued with Norco. Petitioner wore a sling and attended therapy twice a week. Petitioner had his sutures removed. The diagnosis was postoperative right thumb complex amputation with loss of pulp and exposure of the bone. Petitioner was restricted from her work activities (Pet.Ex.2).

On December 6, 7, 9, 14, 17, 20, and 23 of 2021, Petitioner had therapy at Athletico Physical Therapy. On January 4, 6, and 11 of 2022, Petitioner returned for therapy visits at Athletico Physical Therapy (Pet.Ex.3).

On January 26, 2022, Petitioner returned to Dr. Fernandez. Petitioner presented regarding her right thumb debulking and webspace deepening that she underwent on November 12, 2021. Petitioner was 10 weeks out from surgery. She continued to have stiffness in the index finger and thumb. The diagnoses were postoperative right thumb complex amputation with loss of pulp and exposure of the bone and right index finger stiffness following the injury. She was to have

continued therapy and future surgery including an index finger tenolysis and joint release. Petitioner restricted to not use of the right hand and to not drive (Pet.Ex.2).

On February 7, 8, 10, 14, 15, 17, 21, 22, 24, and 28 of 2022, Petitioner had therapy at Athletico Physical Therapy. On March 1, 3, 7, 8, 10, 14, 15, 17, and 31 of 2022, Petitioner had therapy at Athletico Physical Therapy. On April 5 and 7 of 2022, Petitioner returned for therapy at Athletico Physical Therapy (Pet.Ex.3).

On April 8, 2022, Petitioner returned to Dr. Fernandez at South Suburban Surgical Suites for a right hand/index finger tenolysis, extensor indicis proprius and extensor digitorum communis to the index finger; right index finger metacarpophalangeal joint dorsal capsulectomy and joint release; and right hand and index finger tenolysis, flexor tendon tenolysis, flexor digitorum profundus and flexor digitorum superficialis tendons (Pet.Ex.2 at 176-8).

On April 12, 2022, Petitioner returned for a therapy visit at Athletico Physical Therapy (Pet.Ex.3).

On April 13, 2022, Petitioner returned to Dr. Fernandez. Petitioner presented for a follow up for right index finger tenolysis from April 18, 2022. She reported pain since the surgery. Petitioner had therapy the day prior and was scheduled for the day after. Petitioner was recommended for therapy 4 times a week. Petitioner planned to follow up the following week for suture removal (Pet.Ex.2).

On April 14, 2022, Petitioner returned for a therapy visit at Athletico Physical Therapy (Pet.Ex.3).

On April 21, 2022, Petitioner returned to Dr. Fernandez. Petitioner presented for an evaluation for the right index finger tenolysis from April 8, 2022. She reported severe pain. Petitioner said therapy was going well. The sutures/staples and right splint were removed. Diagnoses were postoperative right thumb complex amputation with loss of pulp and exposure of the bone and right index finger stiffness following the injury. Petitioner was limited from normal work activities and could not drive (Pet.Ex.2).

On April 25, 2022, Petitioner presented to Dr. Fernandez at Gold Coast Surgery Center. Petitioner presented for a right index finger manipulation, metacarpophalangeal joint, proximal internal phalangeal joint, and distal interphalangeal joint under general nerve block (Pet.Ex.2 at 174-5).

On April 28, 2022, Petitioner returned to Dr. Fernandez. The visit was an evaluation for a right index finger manipulation from April 25, 2022. She had not started therapy yet. Diagnoses were postoperative right thumb complex amputation with loss of pulp and exposure of the bone and right index finger stiffness following the injury. The plan was to start occupational therapy. Petitioner was to remain off work and not drive (Pet.Ex.2)

On May 2, 3, 5, 9, and 10 of 2022, Petitioner returned for therapy at Athletico Physical Therapy (Pet.Ex.3).

On May 12, 2022, Petitioner returned to Dr. Fernandez. This was a follow-up from the right index finger manipulation from April 25, 2022 and a right index finger tenolysis from April 8, 2022. Petitioner underwent occupational therapy 3 times a week. Petitioner finished her steroid pack and continued to take Norco before surgery. The plan was to continue therapy 3 times a week. The Norco prescription was refilled (Pet.Ex.2).

On May 12, 16, 17, 19, 23, 24, and 2022, Petitioner returned for therapy at Athletico Physical Therapy (Pet.Ex.3).

On May 25, 2022, Petitioner returned to Dr. Fernandez. Petitioner complained of stiffness. Petitioner rated her symptoms a 5 out of 10. Petitioner attended therapy on average 3 times a week. She was diagnosed with pain in the right hand. Petitioner was to return to the office in 4 weeks and to continue therapy (Pet.Ex.2).

On May 26 and 31 of 2022, Petitioner returned for therapy at Athletico Physical Therapy. On June 2, 6, 7, 9, 13, 14, 16, and 20 of 2022, Petitioner returned for therapy at Athletico Physical Therapy (Pet.Ex.3).

On June 22, 2022, Petitioner returned to Dr. Fernandez. Petitioner presented in her regards to her right thumb and index finger stiffness. Petitioner has been taking Celebrex and participating in occupational therapy. Petitioner was restricted to sedentary work and no lifting more than 5 pounds. Petitioner was asked to continue therapy (Pet.Ex.2).

On June 23, 27, 28, and 30 of 2022, Petitioner returned for therapy at Athletico Physical Therapy. On July 7, 11, 12, 14, 18, 19, 21, 25, 26, 28 and August 2 of 2022, Petitioner returned for therapy at Athletico Physical Therapy (Pet.Ex.3) .

On August 4, 2022, Petitioner returned to Dr. Fernandez. Petitioner presented for an evaluation for her right thumb and index finger. She underwent a tenolysis and joint release on April 8, 2022 followed by a manipulation on April 25, 2022. Petitioner's pain improved since starting occupational therapy. Petitioner was to remain off work unless she could be accommodated for sedentary work only with no lifting over 5 pounds and minimal use of the right hand (Pet.Ex.2).

On August 4, 8, 11, 16, 18, 30 of 2022, Petitioner had therapy at Athletico Physical Therapy. On September 1, 6, 8, 12, 13 of 2022, Petitioner had therapy at Athletico Physical Therapy (Pet.Ex.3).

On September 15, 2022, Petitioner returned to Dr. Fernandez. Petitioner had been receiving therapy since a manipulation in April. Petitioner was progressing well. Petitioner agreed for a final session of therapy and continuing on the same restrictions. Petitioner was restricted to sedentary work and no lifting more than 5 pounds. Petitioner was asked to follow up in 6 weeks (Pet.Ex.2).

On September 15, 19, 20, 22, 27 and 29 of 2022, Petitioner returned for therapy at Athletico Physical Therapy. On October 4, 2022, Petitioner returned for a therapy visit at Athletico Physical Therapy (Pet.Ex.3).

On October 5, 2022, Petitioner returned to Dr. Birman for an Independent Medical Examination at Respondent's request. Prior to the examination, Petitioner had 3 surgeries and attended therapy 3 times a week at Athletico. The diagnosis included right thumb amputation and right index finger stiffness. The diagnosis was causally related to the injury from February 20, 2021. Petitioner was unable to return to unrestricted full duty. There were no findings for which any additional surgery was expected or recommended. Petitioner was expected to reach MMI once she was done with her therapy prescription. Dr. Birman opined that restrictions were appropriate to guide work for her right hand (Pet.Ex.4 at 971-78).

On October 6, 7, and 11 of 2022, Petitioner returned for therapy at Athletico Physical Therapy (Pet.Ex.3).

On October 13, 2022, Petitioner returned to Dr. Fernandez. Her pain improved and she was to continue occupational therapy for 6 weeks at a frequency of 2 to 3 times a week and physical therapy for 4 weeks at 3 times a week. She had flexion of the index finger to about 70 degrees actively and 80 degrees passively at the DIP joint. She was "doing well" since the manipulation procedure. Petitioner's work restrictions included permanent sedentary restriction less than five pounds with repetition restrictions. Petitioner was expected to reach maximum medical improvement (MMI) on November 14, 2022 (Pet.Ex.2).

Petitioner testified that she had not seen Dr. Fernandez or any doctor since October 13, 2022 (T1.94). As of the August 27, 2024 hearing date, Petitioner testified that her pain level was 4 out of 10 (T1.59). Petitioner testified that from October 22, 2022 to the time of hearing, she was not taking any prescription medications for this injury (T1.94).

On October 14, 18, 21, 25, 26, 28, and 31 of 2022, Petitioner had therapy at Athletico Physical Therapy. On November 2, 7, 9, 11, 14, 16, 21, 28, and 30 of 2022, Petitioner had therapy at Athletico Physical Therapy (Pet.Ex.3).

In June 2023, Petitioner sought and obtained employment at Midway Staffing (Resp.Ex.2). She earned \$15 per hour and worked 40 hours per week (T2.10-1). She was placed at a warehouse making audio visual devices for American Football (T1.52). She was required to examine the material to ensure an order was complete (T1.53).

In January 2024, she sought and obtained employment at Amzugo restaurant as a cashier (T2.12-3, Resp.Ex.13). She testified her job duties included greeting clients, taking their orders via use of an I-pad, collecting payment via credit card, printing tickets and providing client their food orders (*Id.*). She also took phone orders which involved inputting the order via the I-pad, printing a ticket and providing it to the kitchen (T2.13). She earned \$15 per hour in the cashier

position which was the same amount of money she earned at Midway Staffing and for Respondent (*Id.*).

Petitioner testified that after being released by Dr. Fernandez on October 2022, she also worked taking care of a daughter of her friend (T2.18). The child was 3 or 4 years old (T2.19). Petitioner was the only caretaker for the 3 or 4 year old child when she watched her (T2.19-20). Petitioner watched the child for 4 or 5 hours at a time and Petitioner watched her 2 or 3 days per week (T2.20-22). She was paid in food and lodging (T2.20).

Petitioner also worked cleaning homes on one occasion (T2.22). That work was also done in exchange for food (T2.23). She was the only person responsible for cleaning the home (T2.23-4). On re-direct examination, Petitioner also admitted another job she held in between the first hearing of August 2024 and the second hearing of November 2024 which involved helping a friend on maternity leave (T2.26). She was also paid in food (*Id.*).

Petitioner testified that she did not recall whether she filed a tax return in 2022 or 2023 (T2.24-5).

Respondent's vocational counselor, Julie Bose, of MedVoc Rehabilitation, Ltd., authored a report dated March 26, 2024 (Resp.Ex.1, Ex.2). Ms. Bose opined that Petitioner was a candidate for positions of lobby attendant, light office cleaner, mail clerk/sorter, greeter, and office helper. She noted the restrictions imposed by Dr. Fernandez of limited lifting up to 5 pounds with the right hand and avoiding highly repetitive work with the right hand. She noted there was no restriction to the left hand or any limitations to standing, sitting or walking. A labor market survey was conducted, and 31 employers were contacted. Seventeen prospective employers rescinded and of those 17, 15 employers were able to accommodate Petitioner's restrictions. The median wage of these employers was \$16.50 hour which would increase with promotion and advancement opportunities.

On April 23, 2024, Petitioner returned to Athletico Physical Therapy for a job specific functional capacity evaluation (Pet.Ex.5). It was unclear who referred Petitioner for the FCE. She "did not remember" if her attorney referred her for it (T2.15). There was no evidence that Dr. Fernandez ever reviewed this FCE or changed the restrictions he imposed in October 2022 (Pet.Ex.2). Petitioner demonstrated capabilities and functional tolerances to function within the sedentary physical demand level with the heaviest weight able to lift within the demand level is 5 pounds.

Petitioner sought a vocational report from Mr. Edward Pagella of Health Connection of Illinois, P.C. on May 2, 2024 (Pet.Ex.10). He authored a report dated May 8, 2024. He met with Petitioner via Zoom. He noted she had no children which was inaccurate based on Petitioner's testimony that she had a child in June 2023 (T1.57). He also stated she was born in Mexico and came to the United States in 2018 (Pet.Ex.10 at 2). She testified she came to the United States in 2015 (T1.34,76). Petitioner is not a citizen of the United States.

She reported a past vocational history as a receptionist in Mexico making an unknown wage, a warehouse worker earning \$15 per hour and her position with A.M. Staffing earning \$15 per hour. He noted that as a warehouse worker, she was also a supervisor and was “bilingual”. She was able to speak and understand some English and would translate for her supervisor to her coworkers. In May 2024, she worked as a cashier at Amuvgo Restaurant (*sic*) earning \$15 per hour.

Mr. Pagella opined that Petitioner “lacks any transferable skills.” He opined there was “no suitable or viable occupation for her” when utilizing the United States Department of Labor classifications within the “Chicago Metropolitan Labor Market”. He stated that even if she was provided vocational services there was “no guarantee that an employer will hire an individual who cannot speak, read or each in the English Language and has permanent restrictions with an inability to repetitively utilizes their right upper extremities (*sic*) to perform work related tasks.” Mr. Pagella noted she would have an “exceedingly tough time” finding an employer who would be willing to accommodate her (Pet.Ex.10).

Nowhere in his report did Mr. Pagella note that Petitioner had been hired in June 2023 by Midway Staffing. Nowhere in his report did he note that she had worked as a babysitter, house cleaner and personal assistant. Nowhere in his report did he address whether Petitioner was employable in her home country of Mexico (Pet.Ex.10).

Ms. Bose, Respondent’s vocational counselor, authored a second vocational report dated June 14, 2024 (Resp.Ex.1, Ex.3). She reviewed the April 2024 Functional Capacity Examination, Edward Pagella’s vocational report, and paystubs from Midway Staffing (*Id.*). It was noted that the FCE placed Petitioner at a 2.5-pound lifting restriction as opposed to 5 pounds imposed by Dr. Fernandez. She noted that since being released at MMI, Pettioner held jobs with both Midway Staffing and as a cashier at a restaurant. Based on this updated information, Ms. Bose updated the labor market survey targeting positions as a lobby attendant, light office cleaner, mail clerk, and greeter in a Hispanic neighborhood. The new median hourly wage for these positions was \$16.57 per hour.

Ms. Bose also noted that per Mr. Pagella’s vocational report, Petitioner was not able to legally work in the United States. She reiterated that per the CRC code of ethics, job placement could not be offered. Seventeen employers responded and 15 could accommodate the 2.5 pound restriction from the FCE. Ms. Bose also noted that in Mexico, Petitioner could work as a general worker, cashier, and assistant secretary. Petitioner’s pre and post injury work history included factory work and receptionist work and that she would earn the same wage of minimum wage in Mexico (Resp.Ex.1, Ex.3).

Finally, Ms. Bose noted that Mr. Pagella’s report stated that Petitioner was an odd lot total permanent – despite the fact that she held at least 2 jobs post-MMI (Resp.Ex.1,Ex. 3). She noted that the sedentary work restriction was only stated due to the lifting restriction and not due to any

limitation with respect to the lower extremities or any inability to walk or stand. Also, Ms. Bose noted that Mr. Pagella did not perform a labor market survey.

Mr. Pagella's deposition occurred on June 18, 2024 (Pet.Ex.17). He stated that he met with Petitioner on one occasion (*Id.* at 25). That meeting occurred by Zoom (*Id.*) He stated that Petitioner "understood and spoke minimal English (*Id.* at 8, 25-6). On cross examination, he stated that in her prior position with SureStaff, she worked as a translator and supervisor "because she understood Spanish and could speak some English." (*Id.* at 37-8).

He testified that Petitioner was totally and permanently disabled. When asked what restrictions he was basing his opinion on, he stated it was based on her ability to work at a sedentary level of physical tolerance (*Id.* at 27). He testified that he only used the conclusions of the FCE and Dr. Birman's 2021 report to formulate his opinion (*Id.* at 29-30). He was not provided the restrictions from Dr. Fernandez until presented with them on re-direct examination (*Id.* at 54-5). Petitioner's counsel precluded Mr. Pagella from answering Respondent's counsel's question as to whether his opinions were based on Dr. Fernandez's permanent restrictions. Eventually, he testified he "did not have that document" when making his conclusions, in reference to Dr. Fernandez's restrictions (*Id.* at 59-60).

Mr. Pagella testified that he "did not see any job logs." (*Id.* at 31-2).

He noted that Petitioner worked in the restaurant position from February 2024 through the date of his Zoom meeting of May 2024 (*Id.* at 41). He noted she earned \$15 per hour in that position – the same amount she made at SureStaff and the same amount she earned for Respondent (*Id.* at 42-3).

When asked whether he had any knowledge of the current job market in Mexico, he stated – "I'm familiar but would be unable to testify to it because I'm the one to familiarize myself even further before I will give any opinions." (Pet.Ex.17 at 53).

There is nothing in Mr. Pagella's deposition testimony that he was aware Petitioner had been employed at Midway Staffing, as the sole caretaker of a child, as a home cleaner, or as a personal assistant (Pet.Ex.17).

Ms. Bose's deposition occurred on June 19, 2024 (Resp.Ex.1). She testified that she is a certified vocational counselor by the Commission of Rehabilitation Counselors (*Id.* at 4-5). She reiterated the opinions contained in her reports of March 26, 2024 and June 14, 2024. Based on the restrictions imposed by Dr. Fernandez, she opined that Petitioner was capable of working as a lobby attendant, light office cleaner, greeter, mail sorter, and office working in a Hispanic neighborhood earning, on average, \$16.50 per hour (*Id.* at 8, 14). This hourly rate was slightly higher than what Petitioner was earning while she was working for Respondent (*Id.* at 15). Fifteen of 17 employers said they could accommodate the 5-pound lifting restriction.

Based on the restrictions imposed per the FCE, Petitioner was also capable of being employed. She was capable of earning, on average, \$16.57 per hour (*Id.* at 21-2). Ms. Bose noted that Petitioner had been employed by Midwest Staffing, working 40 hours per week earning \$15 per hour (*Id.* at 22-3). She also testified it was “quite significant” that Petitioner was not capable of legally working in the United States as (1) employers will not hire an individual who cannot legally work and (2) the vocational code of ethics does not allow vocational counselors to provide job placement services to someone who is not able to legally work as that is “promoting illegal behavior.” (*Id.* at 23). She explained that her company submitted a case analysis the committee and inquired at to whether a vocational counselor could provide vocational services to someone not legally able to work in the United States and they opined that it would be unethical to do so (Resp.Ex.1 at 70-1). She explained – “Well, when you are providing job placement services, you are acting as an advocate to the person you are working with. If you know they can’t do something legally and you’re helping them do that, they felt that that would be an ethical violation” (*Id.* at 71). She offered to provide a copy of the Board’s response, if subpoenaed (*Id.* at 71-2).

In addition, Ms. Bose testified that Petitioner’s immigration status “decreases employment opportunities.” (*Id.* at 24). Ms. Bose opined that Petitioner was employable in her home country of Mexico as a cashier, general worker or assistant secretary (*Id.* at 26).

Ms. Bose disagreed with Mr. Pagella’s conclusion that Petitioner was non-employable. She disagreed due to the fact that Petitioner worked post-injury at Midway Staffing and was employed as a cashier at a restaurant on the date of his report in May 2024. She also stated that his opinions were in accurate as he was improperly considering her to only be capable of sedentary work when in fact that categorization of sedentary was only due to her lifting ability and not due to any limitations with the lower extremities. She noted that there was nothing in the FCE that showed any limitation to the lower extremities (*Id.* at 72, 74, 78).

In summary, Ms. Bose concluded that Petitioner was employable with the 2.5-pound lifting restriction in positions such as office cleaner, lobby attendance, mail clerk, and greeter in a Spanish neighborhood and that these positions would earn on average \$16.57 per hour (*Id.* at 32). Ms. Bose also testified that Petitioner is also employable in her home country of Mexico (*Id.*).

CONCLUSIONS OF LAW:

Average Weekly Wage

Petitioner claims an average weekly wage of \$600.00. Respondent claims an average weekly wage of \$585.00. Respondent offered a wage statement as Respondent’s Exhibit 12 showing that Petitioner earned \$4,920.45 in 9 weeks. In 2 of the 9 weeks, she worked less than 40 hours per week (23.95 and 24.08 in weeks 2 and 3 of employment). There was no testimony regarding whether overtime was mandatory. Therefore, the Arbitrator finds an average weekly wage of \$585.00.

Temporary Total Disability

Respondent paid TTD from February 22, 2021 through October 13, 2022 at a rate of \$391.95/week (AWW \$585) for a total of \$27,446.05 (Resp.Ex.10). Respondent offered a TTD payment ledger as Respondent's Exhibit 10 proving these payments as well as a permanency advance of \$2,493.03 (Arb.Ex.1, T1.6, Resp.Ex.10) which was made on September 23, 2021.

Petitioner alleged TTD was owed through the date of hearing yet provided no evidence why TTD would be owed beyond the date Dr. Fernandez declared MMI on October 13, 2022. Subsequent to reaching MMI, Petitioner could be conflating TTD with a claim for maintenance. However, besides properly notating that on the stipulation sheet, that argument fails for lack of proof. As the Appellate Court recently reaffirmed in the case of *Currey v. IWCC*, the entitlement to maintenance benefits is conditional upon participation in either formal or self-directed vocational rehabilitation. 2022 ILApp (1st) 210829WC-U (2022). "If the claimant is not engaged in some type of physical rehabilitation program, formal job training, or a self-directed job search, the employer is not obligated to provide maintenance." (*Id.* at 23 quoting *Roper Contracting*).

In the instant matter, no job logs were provided on which to predicate an award of maintenance. Mr. Pagella testified that he reviewed no job logs (Pet.Ex.17 at 31-2). Petitioner testified that she looked for employment but outside of the jobs that she was able to obtain, Petitioner did not provide any details regarding her job search such as the name of the potential employers contacted, the positions involved, when she did so. Absent such supporting information, no award of maintenance can be made. Therefore, the Arbitrator finds no further benefits are owed.

Nature and Extent

Petitioner is claiming to be permanently and totally disabled. Under the Act, there are 3 methods to be found permanently and totally disabled: medically, statutorily, or as an "odd lot". No medical provider has found Petitioner to be permanently and totally disabled so Petitioner does not meet the requirements to be medically permanently and totally disabled. Nor did she sustain the types of injuries which would meet the requirements to be found statutorily permanently and totally disabled. The only possible remaining theory under which Petitioner could be found permanently and totally disabled is under an odd lot theory.

"There are two ways an employee can ordinarily satisfy her burden of proving that she fits into the "odd-lot" category: (1) by showing a diligent but unsuccessful job search, or (2) by demonstrating that because of her age, training, education, experience, and condition, she is unable to engage in stable and continuous employment." *Economy Packing Co. v. Illinois Workers' Compensation Commission*, 387 Ill. App. 3d 283, 293 (Ill. App. Ct. 2008). The Appellate Court went further to say that an unspecific and undocumented job search is not sufficient. There need to be detailed supporting job logs in order to support an odd lot finding by a diligent and unsuccessful job search.

Relative to the availability of a stable and continuous job market, it is now undisputed that Petitioner is not legally able to work in the United States. This was previously not clear as she presented a false social security number and permanent legal resident card to Respondent when she applied to work for them (Resp.Ex.9, T1.75). Given those circumstances, the Appellate Court held in *Economy Packing* that when determining permanent and total disability in a scenario where the Petitioner is not legally able to work in the United States, the relevant question is whether there is a stable job market in the country the Petitioner is legally capable of working in.

To support their contention that there is no stable and continuous job market available for Petitioner, they provided only the testimony of Mr. Edward Pagella. Mr. Pagella is a vocational counselor in the United States who issued a report indicating that given Petitioner's lack of English, her restrictions, and her experience, she is an odd lot total permanent based on his knowledge of the job market and vocational rehabilitation in the United States. The Arbitrator finds that that opinion is flawed in several ways. First, it was determined that Petitioner is not able to legally work in the United States. This was previously not clear as she presented a false social security number and permanent legal resident card to Respondent when she applied to work for them (Respondent's Exhibit 9, T1.75). Per *Economy Packing*, when an injured worker is not able to legal work in the United States, the relevant inquiry in determining one's employability is whether Petitioner is capable of working in their home country, here, in Mexico. Mr. Pagella's report and deposition testimony are silent on whether Petitioner is employable in her home country of Mexico. He did not testify that he had any knowledge regarding the job market in Mexico such that he was capable of opining on her vocational abilities in her home country. In fact, he testified that he was "unable to testify" as to the current job market in Mexico (Pet.Ex.17 at 53).

In contrast, Respondent engaged certified rehabilitation counselor, Julie Bose, of MedVoc Rehabilitation, Ltd., She opined that Petitioner was employable in both the United States and her home country of Mexico. She further opined that Petitioner could earn the minimum wage equivalent in Mexico. This is the only evidence in the record as to whether Petitioner is capable of working in Mexico.

Furthermore, the basis for Mr. Pagella's opinions was that she could not read or write English. Petitioner testified that she would understand and write 70% of the English language. When applying to work for the Respondent, she stated she was bilingual (T1.78-9). She testified that she needed a translator at trial for understanding of "legal terms". Her vocational history included supervisory positions which included translation skills (T.80-1). In addition, there was no indication that Mr. Pagella was aware that she also held positions at Midway Staffing doing warehouse work, as a babysitter, house cleaner and personal assistant. He also ignored a multitude of transferable skills. When applying for work with the Respondent, Petitioner reported that her skills included team lead, line lead and supervisor (T.85-6). She also stated that she had administrative skills and 10 years of experience with Word and Excel (T.86). She also

reported 5 years of office work skills including fax, filing, copier, and scanner (T.86). Therefore, it is clear that she holds skills beyond those of manual labor.

Even without the significant impediment of her immigration status, the evidence proves that Petitioner is still employable in the United States. Not only is that shown through Ms. Bose's reports and deposition testimony, but more significantly, Petitioner has admittedly held at least five jobs since being released by Dr. Fernandez.

First, she found work through Midwest Staffing in June 2023 earning \$15 per hour. The Arbitrator notes that this is in the same industry – factory work via a staffing agency – that she did before the accident, and when the accident happened (A.M. Staffing). Petitioner testified that Midway Staffing placed her at a warehouse making audio visual devices for American Football and that she worked 40 hours per week (T1.52). She was required to examine the material to ensure an order was complete (T1.53). At the second hearing of November 25, 2024, Petitioner claimed she was “let go” from that position (T2.11) yet at the August 2024 hearing, she stated she was contracted for 3 weeks (T1.52). Petitioner's testimony was inconsistent. Rather, it is consistent with staffing agency work that a placement is for a set period of time and not a permanent placement.

Next, she also worked as a cashier at Amuzgo restaurant. Petitioner also testified that she worked as a cashier for Amuzgo approximately 25 hours per week (T.55). She testified that she was able to use an I-pad, which would require use of both hands, as well as communicate/interact with customers, take in person and online order, check out customers.

The Arbitrator notes that proof of these jobs and wages was put into evidence by Respondent – not Petitioner. Petitioner's counsel had the Amuzgo paystubs in evidence and then withdrew it at the second trial (T2.34-5, 39-40, 62-3). It is suspicious to the Arbitrator why Petitioner's counsel would object to said information coming into evidence or offer it themselves.

Her third job was working as a babysitter which included being the sole caretaker to a 3 or 4 year old child for 2 to 3 days per work, 4 to 5 hours at a time. She also testified that she worked as a house cleaner and as a personal assistant in exchange for food and housing. Respondent counsel explicitly asked Petitioner on cross examination what jobs she had held since being released in October 2022. She admitted to holding 4 jobs but on re-direct, she admitted to holding a fifth job, only when questioned by her attorney. It is unclear to the Arbitrator why she admitted to this position on re-direct but not on cross examination and it again calls Petitioner's credibility into question.

In addition, the fact that Petitioner did not “recall” whether she filed tax returns, also is concerning at that would be the best evidence to prove where, when, for whom, and what she was paid for positions held after MMI was reached.

In conclusion, the Arbitrator finds that Petitioner is not an odd lot total permanent. Per *Economy Packaging*, one must prove they are not employable in their home country if they cannot legally work in the United States. Petitioner has not proven that as Mr. Pagella did not testify to her ability work in Mexico. The inquiry stops there. Only Respondent's vocational expert, Julie Bose, offered testimony that Petitioner is employable in Mexico. Mr. Pagella also did not have Dr. Fernandez's restrictions or MMI finding. He also did not consider her 70% mastery of the English language, transferrable skills, itemized in the employment application, nor was he aware she had secured jobs via Midway Staffing, as a babysitter, house cleaner and personal assistant post-MMI. As such, Mr. Pagella's opinions are not credible.

Next, Petitioner testified that she has worked 5 jobs that we know of since MMI – (1) Midway Staffing, (2) Amuzgo Restaurant, (3) babysitter, (4) house cleaner and (5) personal assistant. Finally, Petitioner presented no evidence of a diligent job search. Not a single job log was entered into evidence, nor did Petitioner's vocational expert review any job logs. Therefore, the Arbitrator concludes that Petitioner is not an odd lot total permanent.

As Petitioner is clearly not an odd lot permanent total, the Arbitrator must consider other forms of permanency. Next, the Arbitrator finds that Petitioner is not a wage differential. Prior to February 2021, Petitioner earned \$15 per hour as a supervisor in warehouse jobs. In her position with Respondent, she earned \$15 per hour. In the jobs she worked after being placed at maximum medical improvement by Dr. Fernandez, she earned \$15 per hour (T.52). Those positions included work for Midway Staffing (T1.52, T2.10, Resp.Ex.2) and Amuzgo Restaurant (T.54, Resp.Ex.13). Again, these exhibits were put into evidence by Respondent – not Petitioner.

She is also not a loss of trade. First, staffing agency work is not a skilled trade or profession. Petitioner's position was with Respondent was factory work as assigned via a staffing agency. Many of her prior positions were also with staffing agencies. The nature of staffing agencies is project-based work and not permanent positions that could be considered a trade or a profession. Petitioner worked for Respondent for 9 weeks and for Midway Staffing for 3 weeks. After being released at MMI within her permanent restrictions, through another staffing agency, she was placed at a warehouse and worked 40 hours per week. This is a very similar situation to her position with Respondent who placed her at a flag factory 40 hours per week. This is reflected in the employment paperwork contained in the A.M. Staffing application (Resp.Ex.9). It states: "A.M. Staffing offers their employees ongoing work assignments of various durations ranging from one week to one year."

The petitioner failed to prove by a preponderance of the evidence of record that could not find employment. In fact she testified on both direct and cross examination that she found several jobs post injury, suffering no earnings diminution. The record is devoid of any evidence proving her incapable of continuing to work.

Therefore, this is a specific loss case. When applying the five factors imposed by Section 8.1B(b), the Arbitrator states as follows:

- I. PPI rating: no party put a PPI rating into evidence. No weight was given to this factor.
- II. Occupation: as noted above, staffing agency work does not qualify as an occupation, profession or trade. Even if it was considered an occupation, Petitioner was placed at factory/warehouse positions both before during and after the accident. Some weight was given to this factor
- III. Age: Petitioner was 27 years old at the time of the injury. Some weight was given to that factor.
- IV. Future Earnings Capacity: Two of the positions Petitioner obtained after being declared at MMI were for the same rate of pay as her earnings at the time of the injury - \$15/hour. Julie Bose also testified she could earn a mediation wage of \$16.57/hour when considering the restrictions per the FCE and the minimum wage equivalent in her home country of Mexico. Greater weight was given to this factor.
- V. Evidence of Disability in the Medical Records: Petitioner testified that she has seen no doctor for her thumb injury since being released by Dr. Fernandez in October 2022. She was taking no prescription medications. Some weight is given to this factor.

Respondent does not refute that Petitioner has permanent restrictions as a result of the thumb injury and involvement of the index finger. Dr. Birman, Respondent's IME agreed that an FCE was needed to assess permanent restrictions (Pet.Ex.4 at 971). Said FCE was not performed until nearly 2 years after Petitioner was found to be a MMI but was relatively consistent with the 5-pound restrictions and limited repetitive use restriction imposed by Dr. Fernandez. The Arbitrator notes that Petitioner has sought no treatment since October, was not taking any prescription medications, and rated her pain as a 4 out of 10. The Arbitrator therefore awards 40% loss use of the hand (82 weeks x \$351 = \$28,782.00). The Arbitrator also awards Respondent a credit for the PPD advance paid of \$2,493.03. Therefore, the total permanency award is \$26,288.97.

Statutory Loss

Petitioner is claiming to be entitled to statutory loss based upon a statutory amputation. To qualify as a statutory amputation, bone loss of at least 1/8 of an inch must occur. In the instant matter, the operative report of March 3, 2021 does not show any bone was lost. The medical records consistently refer to it as an amputation of "pulp." No medical opinion was submitted into evidence that there was any bone loss to constitute or support an entitlement to statutory amputation. It states – tissue loss and bone exposure – not bone loss. The February 24, 2021 initial record from Dr. Fernandez notes: "There is significant loss of the pulp involving the thumb with exposed bone at the tip with the wound extending all the way to the IPJ proximally" (Pet.Ex.2 at 171). Under appearance he further notes: "Inspection revealed, loss of the thumb pulp with exposure of the tip of the bone." The bone is specifically mentioned as being exposed but no bone loss is confirmed at any point. Therefore, the Arbitrator declines to award the statutory loss.

Penalties

Penalties and fees are denied.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	23WC002610
Case Name	Charles Branch v. Marten Transport
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	25IWCC0484
Number of Pages of Decision	18
Decision Issued By	Amylee Simonovich, Commissioner

Petitioner Attorney	Michael Rom
Respondent Attorney	Rich Lenkov

DATE FILED: 12/3/2025

/s/Amylee Simonovich, Commissioner

Signature

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)
☐ Modify	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHARLES BRANCH,
 Petitioner,

vs.

NO: 23 WC 002610

MARTEN TRANSPORT,
 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, temporary total disability, and 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 24, 2025 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.

December 3, 2025

O: 11/25/25

AHS/ma

051

/s/ Amylee H. Simonovich
 Amylee H. Simonovich

/s/ Stephen J. Mathis
 Stephen J. Mathis

/s/ Kathryn A. Doerries
 Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	23WC002610
Case Name	Charles Branch v. Marten Transport
Consolidated Cases	
Proceeding Type	Request for Hearing
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	16
Decision Issued By	Paul Cellini, Arbitrator

Petitioner Attorney	Michael Rom
Respondent Attorney	Rich Lenkov, Daniel Flores

DATE FILED: 4/24/2025

/s/ Paul Cellini, Arbitrator

Signature

INTEREST RATE WEEK OF APRIL 22 2025 4.05%

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**

CHARLES BRANCH

Employee/Petitioner

v.

MARTEN TRANSPORT

Employer/Respondent

Case # **23** WC **02610**

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 **Paul Cellini**, Arbitrator of the Commission, in the city of **Joliet**, on **February 19, 2025**. 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 **December 14, 2022**, 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 **\$124,800.00**; the average weekly wage was **\$2,400.00**.

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

Respondent shall be given a credit of **\$N/A** for TTD, **\$N/A** for TPD, **\$N/A** for maintenance, and **\$N/A** for other benefits.

Respondent is entitled to a credit of **\$N/A** under Section 8(j) of the Act.

ORDER

The Petitioner has shown by the preponderance of the evidence that he sustained accidental injury arising out of and in the course of his employment on December 14, 2022

The Petitioner's right ankle/Achilles condition of ill-being is causally related to the December 14, 2022 accident.

Respondent shall pay Petitioner temporary total disability benefits of \$1,600.00 per week for 55-5/7 weeks, commencing December 15, 2022 through January 8, 2024, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to Sections 8(a) and 8.2 (Medical Fee Schedule) of the Act, as indicated in the "Conclusions of Law" below.

Respondent is entitled to credit towards any awarded medical expenses that were paid by Respondent prior to the hearing date, 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 \$998.02 per week, the maximum allowable statutory rate, for 33.4 weeks, because the injuries sustained caused the loss of use of 20% of the right foot, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **December 14, 2022** through **February 19, 2025**, 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.



Signature of Arbitrator

APRIL 24 2025

STATEMENT OF FACTS

Petitioner is a 15 year CDL truck driver with Respondent. Respondent dispatches him to pick up or deliver trailer containers in/out of a rail yard or to/from customer facilities. He testified he worked 68 to 70 hours per week over six days. The step up/down from the cab was about 15" from the ground and he estimated he would enter and exit the truck about 10-12 times per day, including to perform truck inspections. He is 5'8" and about 300 pounds, with fluctuating weight over the last few years.

On 12/14/22, Petitioner testified he was picking up an empty trailer. It was raining and dark when he was getting down out of his truck in a sloped customer lot. As he got down from the cab he felt a pull in the back of his right Achilles. He didn't think much of it at the time and continued to connect the trailer. As he was going up a ramp to the trailer, he felt an odd tingling but hoped it would pass. When he was finishing his shift around 10 p.m., Petitioner testified he had "ridiculous" pain in the back of his right ankle. After dropping the trailer at the rail yard, he told the dispatcher he couldn't do anything else due to his ankle pain. He could not recall the name of the dispatcher and isn't aware of an accident report being prepared, but testified he is supposed to report a work injury to his dispatcher.

Petitioner had previously fractured his right foot playing football at age 16, approximately 1979. It was casted, he rehabbed, and he went back to football. He testified x-rays indicated no fractures, including in films obtained shortly before the 12/14/22 accident, but did not undergo any treatment at that time and was continuing to work his full regular duties. He has had periodic problems with his foot since the football injury. He testified the front portion of his foot would swell up to where he couldn't wear a shoe and that he has sought treatment for the foot, though it hadn't gone beyond a steroid injection. He also acknowledged back issues over the years, though this was not described in any detail. Any ongoing foot problems were intermittent, including in the days prior to the alleged accident, but he testified that he never previously had any symptoms felt similar to what he was feeling in his Achilles after 12/14/23.

Petitioner testified he went to urgent care the next day, 12/15/22, reporting he felt a pull getting down from his truck. He was given crutches because he couldn't walk and was referred to the emergency room. No records from this urgent care visit are in evidence.

The triage ER report from MacNeal Hospital on 12/15/22 indicates Petitioner reported several days of right foot swelling and that urgent care advised he might have gout but was referred to the ER for hypoxia. Another ER note reports: “Patient states he has been having ankle pain chronically for most of his life with worsening recently and inability to walk today”, and “He states his ankle is more swollen and tender than normal and he is unable to put weight on it.” Diffuse swelling was noted on exam and pain with passive dorsiflexion but not with plantarflexion. X-ray was limited by patient positioning, but no fracture or dislocation was noted. There was mild diffuse soft tissue swelling. Diagnoses were right ankle/foot joint pain, and most likely right Achilles tendonitis versus gouty arthritis versus ankle fracture, with the latter being less likely due to lack of “trauma.” An ortho shoe was applied and Petitioner was to be non-weightbearing for a week. He was to return to work on 12/21/22 and to follow up with podiatry. (Px1).

A separate note from the MacNeal ER references complaints of right ankle pain and swelling: “States he has a history of chronic ankle pain/swelling that recurs from time to time. Attributes it to an old football injury. Has been seen in the ER here previously for same. Patient reports that generally a course of prednisone helps to alleviate the symptoms. He went to urgent care today because his pain had increased causing him difficulty working (works as a truck driver).” A note of Dr. Insua states: “... (Petitioner) presents for evaluation of nontraumatic swelling and pain to the right ankle. History of same in the past, recurrent multiple times. Differential includes possible Achilles tendinitis as patient has definitive tenderness to the Achilles and evidence of calcification on the x-ray. Alternative diagnoses include possible osteoarthritis or gout. . . Seems very reasonable to try a course of prednisone as this has worked for him in the past.” The doctor advised him to follow up with podiatry “as he has never done so for his chronic and recurrent ankle issues.” (Px1).

Petitioner testified that while he did report intermittent chronic right ankle pain, he also mentioned he was getting in and out of his truck at work, whether the reports state this or not. The ER recommended he see a specialist, Dr. Anderson, as they did not have an MRI machine. Petitioner saw Dr. Anderson (Orthopedic Associates of Riverside) on 12/22/22, advising he was still unable to put weight on his right foot due to the heel and Achilles – “He denies any specific trauma or injury he drives a truck for work and thinks he aggravated it while working.” Noting the shoe, medication, and non-weightbearing hadn’t resolved the pain, an x-ray was obtained showing calcification of the Achilles at the posterior heel. Diagnoses were Achilles tendinitis and possible calcaneus stress injury. A CAM boot and MRI were prescribed along with pain medication, and Petitioner was to have minimal right weightbearing. (Px2).

The 1/5/23 right foot/ankle MRI showed: 1) moderate distal Achilles tendinopathy without discrete tear and mild associated retrocalcaneal bursitis and Achilles paratenitis with marrow edema within the posterior calcaneus likely representing a stress reaction, 2) chronic anterior talofibular ligament sprain, 3) moderate flexor hallucis tendon tenosynovitis, 4) mild right ankle joint effusion, and 5) multilobulated ganglion cyst abutting the interosseous syndesmosis ligament. On 1/10/23, Petitioner had remained off work with some improvement. Noting the MRI results and that Petitioner was still significantly swollen and tender to touch, Dr. Anderson continued the CAM boot and ordered physical therapy. He was restricted to seated work with no driving. He was 280 pounds and was also referred to his primary provider for weight management. (Px2).

Dr. Anderson issued a causation letter on 1/23/23. He noted Petitioner reported on 12/22/22 that he had been at the ER “as he was not able to put any weight on his foot following what he described as an aggravating injury while working.” He also reported no previous pain or problems with his right foot during that time. Dr. Anderson opined that the right foot condition was causally related to the reported work injury. He had no previous injury to his Achilles tendon and started having pain after the incident he described, and Dr. Anderson indicated the reported injury and symptoms were consistent with what he described. (Px2).

After starting therapy, Petitioner reported some increased pain and Dr. Anderson prescribed a Medrol dosepak and reinstituted the CAM boot. On 2/21/23, Petitioner was improved without the boot, so therapy was continued along with work restrictions. On 3/9/23 Petitioner was not using the boot or a brace but indicated he wasn't comfortable returning to work unless he wasn't restricted. On 3/23/23, restrictions were continued, and the doctor felt that surgery could be indicated, though he believed the pathology indicated on MRI "should respond to conservative care." Petitioner reported minimal improvement and significant pain on 4/20/23, noting he "was forced to run across the street the other day which aggravated his pain even more." Petitioner wanted to discuss surgery, and Dr. Anderson planned to seek surgical authorization while continuing therapy. It was noted on 5/11/23 that surgery had been denied by the workers' compensation carrier. On 6/8/23, Petitioner indicated he planned to get authorization through his wife's group health carrier and again reported he was not comfortable working at that time. (Px2).

Petitioner attended Premier Physical Therapy from 2/3/23 through 7/19/23. The records noted on 1/24/23 that Petitioner's doctor put therapy on hold for two weeks. The initial exam after that was on 2/3/23, and the therapist recorded a history of Petitioner climbing down from his truck and feeling a pull and pain upon reaching the ground. After attempting to walk it off, he continued to work and finish his shift in pain with swelling, and he eventually saw a doctor who referred him for therapy. The last note indicates he was discharged per doctor's orders. (Px3). Petitioner testified the therapy didn't help and he continued to have significant difficulty walking due to Achilles pain. He was not having any frontal foot problems at that point and that the treatment was related to the Achilles. The doctor recommended he try to walk in March and April, but when he did, he had swelling and increased pain. He acknowledged he didn't try to return to work at a temporary job Respondent offered making candles but didn't take it because it included packaging and standing, given he was unable to walk. He testified that Dr. Anderson never released him to perform this candle job. He was using a scooter he purchased around his house and still had an air cast boot.

On 7/20/23, Dr. Anderson's office documented a call from Petitioner saying that their report indicating he'd had a prior right ankle surgery was incorrect. He was advised this information had been provided by him in his intake form, and Petitioner said he'd had a fracture while playing football at age 16 and was casted for three weeks before being released to all activities. (Px2).

On 7/31/23, Petitioner underwent surgery with Dr. Anderson, described as right Achilles tendon debridement, excision right Haglund, and retrocalcaneal bursectomy. Pre- and post-operative diagnoses were 1) right Achilles tendonitis, 2) bursitis, and 3) juvenile osteochondrosis of right tarsus. The report notes the Achilles tendon was hypertrophic and thickened at the calcaneal insertion. After reflecting it off the posterior calcaneus, a very large retrocalcaneal bursa and a Haglund's deformity were revealed, both of which were removed. Three anchors were used to re-attach the Achilles to the calcaneus. (Px1).

Petitioner remained non-weightbearing on 8/8/23 and was weaning from Norco. On 9/5/23, Petitioner was to transition to full weightbearing in the CAM boot. On 9/19/23, Petitioner reported swelling and pain and was referred for venous doppler testing to rule out deep vein thrombosis. This testing was negative, and Petitioner was advised to begin physical therapy. (Px1).

On 10/30/23, Petitioner was examined by orthopedic surgeon Dr. Lee at Respondent's request (Section 12). He advised that on 12/15/22 [sic] "he was simply climbing out of the cab of his work truck and descended on his right ankle. He felt a sudden pain in the right posterior aspect of his ankle and heel. He did not specifically slip or fall out of the truck. This is normal activity that he performs several times a day getting in and out of the truck. Since that time, he has had 'pain, pain, pain'. He initially reported this injury and presented to the emergency department." Petitioner reported improvement with surgery but remained very symptomatic with tenderness and swelling. He hadn't returned to work since the injury, noting he didn't feel he could return to his

regular job, but he was walking 15 to 20 minutes several times a day to increase his tolerance. Dr. Lee referenced 6/7/21 and 12/22/21 right ankle x-ray reports, and the noted clinical histories were of swelling and pain, without indication of the specific location. Petitioner advised this was from ER visits for dorsal foot pain and swelling and he didn't recall any follow up visits. Exam reflected some reduction of plantarflexion, some loss of strength on the right versus the left, and sensitivity over the right posterior distal Achilles and heel to palpation. There was no instability, and the Achilles was intact. Dr. Lee noted postsurgical changes to the posterior calcaneus at the insertion on current x-ray, while the 2021 x-rays reflected mild insertional Achilles tendinopathy with mild insertional edema within the calcaneus. Dr. Lee diagnosed right insertional Achilles tendonitis, status post-surgery, noting there was no specific trauma or injury, just a normal daily activity of stepping down out of his truck. He noted the 2021 x-rays showed evidence of preexisting distal Achilles calcifications and tendinitis/tendinopathy, confirmed by the 1/5/23 MRI. Based on Petitioner's initial 12/14/23 presentation, Dr. Lee indicated he appeared to have an acute-on-chronic condition. Subjective complaints were corroborated by the objective testing but there appeared to be a level of symptom magnification. Dr. Lee opined that there appeared to be a causal relationship between his current diagnosis and the reported initiation of symptoms on 12/14/22, but noting the prior x-rays, he believed it would be helpful to see what the related ER reports indicated as to the preexisting symptoms that led to the x-rays being obtained. The causal relationship of any additional treatment, such as further therapy or work conditioning, was difficult to determine given the preexisting issues. Dr. Lee opined that Petitioner should be currently restricted to seated/sedentary work only, but that it was unclear if this would be causally related to work or not. Petitioner would not reach maximum medical improvement MMI for an additional 6 to 9 months given the July surgery. (Rx2).

On 10/10/23, Petitioner reported improved pain and swelling and was advised by Dr. Anderson to discontinue his ankle brace. On 10/31/23, Petitioner was much improved with just occasional minor incisional pain. On 11/21/23, Petitioner advised that he was ready to return to work in a couple weeks if possible, and on 12/5/23, Dr. Anderson released him to return to work with a 10 pound lifting restriction. The note indicates Petitioner was comfortable and "has a range of motion not to drive." (Px2). It is unclear if this was a typo or not, so it is unclear if he was released to drive or not. (Px2).

Petitioner attended post-operative therapy at Premier from 9/27/23 to 12/29/23 (18 visits). He complained of pain and stiffness with prolonged sitting. He generally showed consistent improvement prior to returning to work. On 12/7/23, it was noted Petitioner's doctor was sending him back to work by the following Monday. The 12/17/23 report notes he attempted to return to work and the doctor indicated he should complete the prescribed therapy. On 12/29/23, it was noted Petitioner was stretching at home to offset stiffness from sitting most days. He was better with light walking. He had reached 65% to 75% of the indicated short and long term goals. At his initial visit his pain complaints ranged from 5/10 to 7/10, while at discharge the range was 3/10 to 5/10. A 1/26/24 note states that Petitioner "self-discharged." (Px3).

On 12/28/23, Petitioner continued to deny heel pain but reported occasional leg numbness and pain radiating from the posterior thigh to the lateral leg and foot. He felt ready to return to unrestricted work, and Dr. Anderson felt he would be able to physically perform his job. On 1/18/24, Petitioner continued to report posterior leg pain, but returned to work and felt comfortable with only occasional heel pain. He still was unable to do a single heel raise. He had not been regularly attending therapy due to returning to work but was advised to continue as he was able. On 4/4/24, Petitioner continued to do well with only occasional pain. He was to continue home exercise. On 5/2/24, Petitioner reported the shooting pain from the right posterior thigh to heel, and Dr. Anderson ordered an EMG, noting it seemed to be coming from the low back and he wanted to rule out radiculopathy. Dr. Anderson noted on 6/13/24 that Petitioner was unable to get the EMG due to swelling, and it does not appear this testing was ever completed. (Px2). An 8/13/24 left ankle x-ray reflected extensive soft tissue swelling an edema and chronic changes, including chronic dystrophic calcification at the Achilles insertion, with small effusion (Px2), and at the last visit with Dr. Anderson on 8/15/24, Petitioner reported pain

in the left Achilles that was similar to what he had on the right and that it felt like the Achilles would give out/tear. An MRI was ordered to rule out tendinosis/partial disruption of the Achilles. (Px2).

Petitioner was reexamined by Dr. Lee on 6/20/24. He noted Petitioner had been released to and returned to unrestricted work as of January 2024. While significantly improved after surgery, Petitioner reported ongoing right lower extremity symptoms with “good and bad days”, and pain and swelling in the morning or after prolonged sitting. Petitioner also reported pain radiating from the right buttocks to the posterior thigh and calf and into the medial foot, and that he’d had this since the original injury. He used ice and over-the-counter anti-inflammatories as needed. Exam indicated that strength and range of motion were symmetric bilaterally, but there was mild atrophy of the right calf. X-rays showed post-surgical changes but no other bony abnormalities. Dr. Lee again agreed the injury was causally related to the reported work accident, that Petitioner had reached MMI and needed no further treatment, and that he was capable of unrestricted work duties. He provided an AMA rating of 2% of the right lower extremity. (Px3).

Dr. Lee testified via deposition on 11/26/24. He testified consistent with his 10/30/23 and 6/20/24 reports. Asked about his causation opinion, Dr. Lee believed Petitioner had a preexisting chronic right Achilles insertional condition that was otherwise aggravated or accelerated by the work incident. Prior to the second exam on 6/21/24, Dr. Lee reviewed the updated records of Dr. Anderson and physical therapy, none of which changed his opinions. The doctor also reiterated his findings and opinions from the 6/21/24 report. The AMA rating he provided was based on the diagnosis of an Achilles rupture. (Rx4).

On cross-examination, Dr. Lee indicated his assumption was Petitioner drove a semi-truck at work and his understanding was “it’s his kind of repeated climbing in and out of the cab to get in and out of the truck. So, at some point while stepping – stepping out of the cab to get down onto the ground he felt that pain.” He also believed it wasn’t like getting in and out of a normal vehicle. He could not say if Petitioner drove the truck daily or how many times he would get in and out of the truck daily. Dr. Lee agreed that Petitioner never alleged this was something that happened over time, he alleged a specific incident, and he believed that the mechanism of injury was a competent cause of the injury. His true diagnosis was Achilles tendinitis/tendinopathy. Again, noting he reviewed the pre-accident right ankle x-ray reports but not any related progress notes, Dr. Lee testified – “when I specifically discussed this with him, he indicated that he did not recall any of these visits to the ER...”, other than that he went due to swelling and pain and didn’t recall any follow up visits. Petitioner’s treatment since 12/14/22 was reasonable and standard for his condition, though his time off work was atypical – most people wouldn’t be out of work for two years with his condition. It appeared that was the time it took for him to feel he could go back to work. Petitioner was working at the time of Dr. Lee’s second exam and there was no indication of exaggeration or symptom magnification. There was nothing unusual about his ongoing complaints, including from the buttocks to foot. He described in detail how he came to his AMA rating, including that one of the classes included Achilles strain, tendinitis, and rupture. Dr. Lee testified that calf atrophy is common with Petitioner’s type of surgery – “...they’ll typically never get the same calf circumference as the opposite side or preinjury.” Functionally, this would exhibit as weakness. Though any weakness probably wouldn’t be noticeable with everyday activities, weakness or fatigue could be seen if you specifically isolated each limb and tested it. (Rx2).

Orthopedic surgeon Dr. Higgs was retained by Respondent in May 2023 to provide a utilization review opinion regarding the Petitioner’s need for surgery. The report is contained as an exhibit in his 6/22/23 evidence deposition. The report indicates, and the doctor essentially testified, that he agreed that the surgery prescribed by Dr. Anderson was reasonable per the ODG guidelines, but that he couldn’t certify it based on the Respondent claims adjuster’s denial of the claim. His opinion was significantly based on the Petitioner’s imaging and the fact that he hadn’t improved after about 5 months of conservative treatment, noting the guidelines

recommended only 3 months of such treatment before surgery would be reasonable. On cross-exam he indicated that the reason for the denial of the claim was not provided to him. (Px8).

Petitioner returned to his full work duties when he was released in January 2024 and has continued to work regular duty since. He's had no treatment for the unrelated right foot problem since the alleged accident date. He testified his right Achilles overall feels good now, with occasional fatigue, nothing like before surgery, which was definitely successful. His left leg is much stronger than the right, which he can tell when pushing off with his feet, which he tries to avoid doing to avoid any re-injury. It still doesn't feel normal, like its fatigued or cramping. He currently runs three to four loads and estimates he's in and out of his truck 20 to 30 times per day. He testified he can get a funny feeling in the Achilles when it is damp or cold.

Petitioner reiterated on cross exam that he advised MacNeal's ER he had right Achilles pain which happened at work. He testified he told Dr. Insua that he had right Achilles pain and his whole ankle was swollen. He did indicate he had problems with his foot in the past and had recurrent ankle pain, on the front, and reported his old football injury. He nevertheless had increased pain and pain that he'd never had before. He had no idea why the doctor did not specify a work injury, or why the report notes non-traumatic swelling/pain. He was advised at MacNeal to see a specialist, and Dr. Anderson was recommended. Petitioner testified he told Dr. Anderson on 12/22/22 about his prior injury and about his Achilles tendon. He agreed he advised he did not suffer a specific trauma. He did not attend the originally scheduled Section 12 exam with Dr. Lee on 8/21/23 because he'd had surgery shortly before but did attend the rescheduled 10/20/23 exam. He continues to work for Respondent in his regular job, generally the same hours as before, but alleged that when he returned to work his normal \$30.50 per hour rate was reduced to \$30.00 per hour. Respondent indicated his regular wage before he went off work was \$30.00 per hour. He was not currently taking any medication for his Achilles, and performs calf raises at home. On redirect, as to the initial report of Dr. Anderson indicating he denied a specific trauma, Petitioner testified he indicated he drove a truck for work and believed he aggravated it while working.

Respondent witness Cassandra (Cassie) Severson testified she has worked for Respondent for 10 years, a claims representative for the last three years. She will work up a workers compensation claim as best she can, as they are self-insured, until litigation when others become involved. She completes the initial accident reports. Ms. Severson testified she initially became aware of Petitioner's claim when he called it in about 9 days after the alleged accident date. After talking to Petitioner, she immediately prepared an initial report (Rx1), which included all the details. She identified Rx1 as a true and accurate copy of a document she completed in the ordinary course of business on 12/23/22. She is not aware of Respondent receiving any notice of injury prior to this, though all she could say for sure is that she was initially told about this on 12/23/22. Rx1 was based on talking to Petitioner – he alleged that on 12/14/22 he was at Bolingbrook Cold storage, and when he stepped out of the truck down onto his left foot initially, then his right foot, and felt pain in the right foot and ankle. He finished his workday and when he went home his wife had to help him into the house due to the pain. He said the next morning he had pain and went to the ER, negative x-rays, they took him off work until the 21st, he went to an ortho, and sometime after that he called in. (See Rx1).

Ms. Severson continued to handle Petitioner's claim as it went on. At some point he was released to light duty. She testified that Reemployability is a company used to find light duty in a claimant's area. They have employees all over the place and locate non-profits that will work with the restrictions in the geographical area. She worked with Reemployability in Petitioner's case, and Rx7 is a packet with information about a light duty offer. This was created by Reemployability, signed off on by Severson, and then sent to Petitioner on Respondent's behalf. To her knowledge, she believed a call was made to the facility, but she didn't recall the specifics, but somehow or another there was something that didn't add up right and the nonprofit didn't want to follow through with placement.

Ms. Severson agreed that the notification (Rx1) to her doesn't indicate anything about any investigation of what may have occurred in the 9 days prior. There was no investigation to her knowledge, and she didn't contact dispatch or anyone else to see if Petitioner had made a prior report of an injury. Severson agreed it is possible someone else took a report of injury from Petitioner. If a worker doesn't show up for a week without notification, she doesn't know exactly how that applies to a truck driver. At Respondent, HR would likely be in charge of this or someone else. She would not be involved, however, with off work time of a driver. She was the initial claims handler in this case until it became litigated. Her understanding is they get as much medical as they can, and in this case it was sent to a company to review the records. She can't say if she had all of Petitioner's records, but she did supply them to for the utilization review and to examiner Dr. Lee. She had no reason to believe she didn't have all the records. Ms. Severson did not recall why Reemployability didn't want to accommodate Petitioner's light duty, and she had no evidence of an email chain indicating why Petitioner didn't take the transitional job that had been offered to him.

Ashley Reibling, a resolution specialist for Reemployability, testified that her job generally involves pulling documents. She was familiar with Petitioner's case and identified Rx8 as her referral email, which is created in ordinary course of business. Once the case was referred to her, her responsibility was pulling the necessary documents from Petitioner's file and then assigning the case out to a client service coordinator and placement specialist. They then try to secure a position within the claimant's restrictions with one of their non-profit partners. In this case, an offer package was created for Petitioner for a light duty job (Rx7) with HHP Lift in Chicago. Petitioner was to assist with making candles and soaps and wrapping small items. The restrictions she noted were no driving, and that he could stand and walk for 15 minutes per hour. An offer is sent and faxed to the claimant's attorney, a start date is secured, and then there is follow up with the nonprofit to see if the claimant reported to work. In this case, Petitioner's start was scheduled for 4/20/23 at 9:30 a.m., and he did not show up.

On cross-exam, Ms. Reibling testified she sent the information on behalf of Respondent. She was not aware of where the physical restrictions were obtained, as they would have been provided by Respondent. She has no knowledge of an individual outside of what is provided by Respondent. To her recall, the job was about 7.5 miles from Petitioner's home. She agreed one of his restrictions involved no driving. She doesn't ask a doctor to approve the temporary job. HHP Lift's Alejandra indicated the Petitioner didn't show up. She doesn't have a copy of the email with her indicating this, but she has seen the documentation, and it should be part of the records. She had an independent recollection of the email she sent to Ms. Severson, in which they reported that Petitioner called the day prior and indicated he would not be reporting, that he had a doctor's appointment, and that he would have had to take a bus to get to the job. Again, as to any driving restriction Petitioner had, she didn't secure this replacement job, so doesn't know if he was expected to take a bus. Again, any restrictions are based on what is received from Respondent. She could not comment as to Severson's statement that she wasn't aware of such email, other than that the email was sent to Severson.

On rebuttal, Petitioner agreed he was offered the temporary job, but when it was presented to him, he indicated he was still in a boot and could barely walk. He testified he advised this to someone from Respondent, the name of whom he couldn't recall, and was advised they would look for something else. He advised he didn't know how this would work since he couldn't walk more than 15 minutes, could only do seated work, and couldn't drive. He testified he could have done the candle work if he could have performed the job from home. The bus stop was 2 blocks away from his home. Petitioner also submitted evidence of a 4/18/23 email from Respondent referencing a light duty job offer and requesting Petitioner's compliance. Petitioner's counsel responded that Petitioner needed to clear the job with his doctor, and noting his understanding that Petitioner was not supposed to drive and asking if transportation would be provided. (Px9).

CONCLUSIONS OF LAW

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:

The Illinois Workers' Compensation Act (the "Act") provides: "To obtain compensation under this Act, an employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment." 820 ILCS 305/1. A petitioner must establish both the "arising out of" and the "in the course of" elements were present to prove a compensable injury. *Univ. of Ill. v. Indus. Comm'n*, 365 Ill. App. 3d 906, 910 (2006).

If the Petitioner's injury occurred as described, he was well within the course of his employment on 12/24/22. Getting in and out of his truck while in the process of his work duties would clearly support that the Petitioner's injury occurred in the course of his employment with Respondent by the preponderance of the evidence. The key disputed accident issue in this case is the "arising out of" element and whether an accident occurred on 12/14/22 as testified to by Petitioner.

Petitioner testified that he would get in and out of his truck approximately 10 to 12 times per shift. He testified that on the alleged accident date he was stepping down out of the truck cab, which involved an approximate 15" step down from the last step, onto an uneven ground level. The Arbitrator would note that the step down distance of 15" appears to be greater than that to which the general public would typically be exposed. Petitioner testified that he reported his injury to dispatch at the time he had the pain increase stepping out of his truck. He did not recall the name of the dispatcher at the time. The Respondent provided no rebuttal to the Petitioner's testimony regarding these facts. While Ms. Severson testified that she had no notice of Petitioner's alleged accident until 9 days later, she acknowledged she did no investigation of the claim and could not say if any other Respondent representative, including dispatch, had received notice of Petitioner's injury.

The Petitioner denied any prior problems with his posterior foot/ankle or his Achilles tendon, testifying his preexisting condition impacted the front or anterior right foot. This is questionable given the initial medical records referencing Petitioner stating that his current problem was similar in nature to his prior problems and specifically referencing the right ankle as opposed to the right foot. The initial urgent care records for some reason are not part of the evidentiary record, as neither party submitted them. Petitioner testified that he told the MacNeal Hospital ER staff that he had injured his foot while stepping out of a truck. The recorded history in the records is of ankle pain and swelling with a history of chronic ankle pain and occasional recurrent swelling that he attributed to an old football injury. It was also documented that he had been seen there previously for the condition and had recovered successfully with prednisone.

Both treating surgeon Dr. Anderson and Section 12 examiner Dr. Lee have opined, after reviewing the initial history contained in MacNeal Hospital records, to a causal connection between the Petitioner's current condition and need for surgery and the work accident of 12/14/22. Dr. Anderson indicates in his 1/23/23 report that, based on his 12/22/22 note, Petitioner had been previously evaluated in the ER and was not able to put weight on his foot, calling the injury aggravated by working. In reviewing Petitioner's records, Dr. Lee was aware that Petitioner had a preexisting condition and opined that the preexisting Achilles/right ankle condition was aggravated or accelerated by the work injury.

In the Arbitrator's view, it is understandable that the Petitioner may not have initially considered stepping down from his truck cab as a "specific injury." Petitioner's acknowledgement that he told Dr. Anderson he didn't sustain a specific trauma would be consistent with this. He noted on 12/15/22 to MacNeal that he had more swelling and tenderness than normal and couldn't put weight on the right leg. Additionally, while the records

note that he had recurrent pain, Petitioner testified that the pain was different than what he felt previously. No prior records were included in the evidentiary record to support a different conclusion of where the Petitioner's symptoms had been prior to the accident date and what his diagnosis or diagnoses may have been. While Dr. Lee noted he reviewed x-ray reports from 2021, and wanted to review the associated records, it is unclear why the associated records were not obtained or submitted into evidence. The act of stepping down from his truck can while working for Respondent 10 to 12 times per shift from a height of 15" off the ground, in the Arbitrator's view establishes that the Petitioner sustained injury during an employment risk which increased the risk of injury to the right lower extremity.

Based on the totality of the noted facts, the Arbitrator finds that the Petitioner has established by a preponderance of the evidence that he sustained an accidental injury to the right Achilles which arose out of and in the course of his employment with Respondent on 12/14/22.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

An employee's injury is not compensable solely because symptoms arose while the employee was at work, nor is it sufficient that the injury occurred at work, it must be proven that the injury was the result of an accident that was incidental to the employment. *Quarant v. Indus. Comm'n*, 38 Ill.2d 490, 492, 231 N.E.2d 397, 399 (1967); see also *Caterpillar*, 129 Ill.2d at 64, 541 N.E.2d at 670 ("[T]his court is not prepared to adopt the position that whenever an injury is suffered on work premises during work hours it is compensable, regardless of whether the conditions or nature of the employment increased or contributed to the risk which led to the injury.") (citing *Rodriguez v. Indus. Comm'n*, 95 Ill.2d 166, 447 N.E.2d 186 (1983)).

As noted above, the Petitioner did have a preexisting condition involving the right foot, but the evidence supports that this condition changed after the 12/14/22 accident, both in location and in quality. Dr. Anderson believed Petitioner's injury was related to the work accident as Petitioner reported it, and because Petitioner had no previous injury to his Achilles tendon. Petitioner only started having pain in this area after the incident he described above. The reports of 12/22/22 and 1/22/23 both indicate that Petitioner denied any specific trauma or injury but that he drives a truck for work and thinks he hurt his right foot while working, which is consistent with stepping out of the truck, a regular part of his workday. As the Arbitrator notes above, it is understandable that an employee might not consider stepping out of his truck to be a "specific accident." The key is whether this constituted an accident under the Act, and the Arbitrator has determined that it did.

Respondent's Section 12 examiner Dr. Lee testified that he believed there was a causal relationship between Petitioner's diagnosed right ankle condition and the reported 12/14/22 accident. He testified that Petitioner "had a preexisting condition that was otherwise aggravated or accelerated by the incident." Dr. Lee was aware of prior films that had been taken of Petitioner's foot and ankle, but again no records were provided to him or entered into evidence of medical treatment which predated 12/14/22.

Based on the preponderance of the evidence, including the opinions of Dr. Anderson and Dr. Lee, the Arbitrator finds that the Petitioner has established that his right ankle and Achilles condition of ill being is causally related to the 12/14/22 work accident. More specifically, Petitioner suffered an injury to his Achilles tendon necessitating a right Achilles tendon debridement with Haglund's deformity resection with retrocalcaneal exostectomy and debridement. His current condition remains related to the injury of 12/14/22.

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:

It appears to the Arbitrator that all three physicians in this case, Drs. Anderson, Lee, and Higgs, agree that Petitioner's treatment was reasonable and necessary, including the right ankle/Achilles surgery performed by Dr. Anderson. While Dr. Higgs' UR report did not certify the procedure, he testified this was only because the employer indicated the claim had been denied, and that otherwise the surgery satisfied the DOT guidelines.

Petitioner testified that some of his bills were paid by his wife's group health carrier, BC/BS, but he could not say which bills were paid, or whether any of his causally related medical bills had been paid by any other carrier.

The following medical bills were submitted into evidence:

1. MacNeal Hospital: The billing in this exhibit indicates that the 7/31/23 charges are unclear. While the bill indicates a total of \$63,093.36, adding the total of the individual entries indicates billing of \$50,595.61. Of the \$63,093.36, it indicates under PAYMENTS a total of \$404.43 from "ACCOUNT/PATIENT", and under ADJUSTMENTS a total of \$4,191.38 from ACCOUNT/PATIENT. Blue Cross is listed as the payor of \$58,497.55. As such, it is unclear if the additional amounts indicated as "paid" are actual payments by Petitioner or if they are write off/adjustments. Billing under 12/15/22 is indicated to total \$8,306.48; however, again, adding the individual entries totals only \$7,248.48. No payments towards this bill are reflected other than a \$3.34 adjustment regarding United Healthcare. Billing from 9/20/23 was \$1,368.00, which was paid in full by BC/BS. Yet another billing statement in this exhibit reflects charges from 12/15/22, 7/26/23, 7/31/23, and 9/20/23. Some of the bills were paid by United Healthcare, others by BC/BS, and there appears to be a balance of \$1,834.00 for anesthesia. The bills "paid" may not actually be paid – the total paid or adjusted is indicated as \$589.00, and of this \$252.55 was actual contractual adjustment, \$210.00 "Denial Adjustment – Medical Necessity", \$35.53 in insurance payments, and prepayment of \$60.92. The Arbitrator notes that Petitioner's proposed decision alleges billing due of \$8,303.14. (Px4).
2. Orthopedic Associates of Riverside: Again, the billing is unclear. Petitioner claims the amount of \$2,066.18 in the proposed decision and in the Amount Due section of the bill, which also reflects payments of \$709.04. The Arbitrator's calculation of the individual entries totals \$11,784.00. A deeper dive into the bill shows several entries of bad debt write offs and specific payments by Petitioner totaling \$407.50. There are multiple entries indicated as "Transfer from Insurance", and other entries reflecting payments by BC/BS. The last page of the bill indicates a balance of \$1577.14, of which there is an insurance balance of \$220.00 and a patient balance of \$1,357.14. (Px5).
3. Premier Physical Therapy in the amount of \$22,895.00 for treatment between 2/3/23 and 7/19/23 (\$12,010.00), and between 9/27/23 and 12/29/23 (\$10,885.00). (Px6).
4. Blue Cross Blue Shield of Illinois subrogation claim of \$27,745.55, which was wat BC/BS paid for billing totaling \$75,737.37 from multiple providers. (Px7).

The Arbitrator did not find evidence of a specific \$5,000 deductible for surgery via the BC/BS coverage, as testified to by Petitioner.

The Arbitrator has reviewed the evidence and finds that the noted medical bills incurred were reasonable and necessary based on the applicable medical records in order to alleviate the Petitioner's condition of ill being, specifically the injury to his right Achilles tendon caused by the work accident.

Unfortunately, the billing itself that was submitted is very difficult to discern in terms of what has been paid by BC/BS, how United Healthcare may be involved in this case, and whether the payments made by BC/BS constituted full payment of the bills submitted to them. Whatever amount the applicable providers accepted from BC/BS as full payment of the billing submitted constitutes the reasonable charges for the medical services. The Medical Fee Schedule would only apply if the Fee Schedule calculation were less than the amount paid by BC/BS. The maximum the Respondent would otherwise be liable for is the Fee Schedule amounts. If the provider or providers accepted less than the Fee Schedule from BC/BS in full payment of each applicable medical charge, Respondent is only liable for reimbursement to BC/BS.

The Respondent is liable and shall pay the Petitioner the expenses contained in Px4, Px5, and Px6 as indicated above pursuant to Sections 8(a) and 8.2 of the Act, and is entitled to credit for any of the awarded bills which were paid by Respondent prior to the hearing date. Respondent also is responsible for the repayment of the causally related medical expenses paid by BC/BS contained within the \$27,745.55 that is being claimed. Respondent shall hold Petitioner harmless with regard to any such credited medical expenses.

Pursuant to Illinois law, the medical payments would be payable to the Petitioner, not the providers. The Respondent shall also repay the Petitioner any out of pocket expenses which are reflected in the documented medical evidentiary record.

For the bills paid by BC/BS, the Respondent is not liable for any additional amounts on any bills where the provider accepted the BC/BS payments as full payment of the bill(s). Any bills which remain unpaid, and are not improper balance billing, are Respondent's responsibility pursuant to Sections 8(a) and 8.2 of the Act. It is up to the parties to resolve what is paid or unpaid, by which insurer, and what is actually owed by Respondent. It appears to the Arbitrator that this will require updated billing from each provider and more detailed information from BC/BS as to which bills were paid by them and whether any balance remained which would be Petitioner's responsibility.

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:

Petitioner alleges that he is entitled to TTD from 12/15/22 through 1/8/24.

The medical records from Dr. Anderson indicate that Petitioner had never been released to full duty work during this period. He was released and did return to full duty work after 1/8/24. Respondent presented the testimony of Ashley Reibling of Reemployability, who indicated that Petitioner had been offered a job making candles, soap and wrapping small items for a company called HHP Lift (see Rx7). It appears this was sent to Petitioner's counsel via the 4/14/23 letter. Px9 is a 4/18/23 email from Respondent's counsel to Petitioner's counsel attaching the noted job offer and asking Petitioner to comply. Petitioner's counsel responded later that day that Petitioner had a medical appointment and thus couldn't attend the Thursday initial meeting, and advised he would discuss the job with his doctor at that time, noting counsels' understanding that Petitioner was restricted from driving and asking if transportation to the job was being provided. (Px9).

The Arbitrator notes that the testimony of Ms. Severson and Ms. Reibling does not make clear what the outcome of this job offer was. There is no evidence of whether the transportation issue was ever discussed. To

their recall, Petitioner was a no show to the job. The email from Petitioner's counsel to Respondent's counsel indicates the reason Petitioner was initially a no show, and no other evidence was presented of how this may have been followed up on. Ms. Reibling's understanding was that Petitioner did not take the light duty job because he could not walk and was in a boot. Petitioner testified that at the time of the job offer he was not able to walk and was restricted from driving. There is simply too much uncertainty as to this job offer and why there was no follow up after Petitioner's counsel's 4/18/23 email to consider it as a basis to discontinue TTD.

The Arbitrator finds that the preponderance of the evidence supports the Petitioner on this issue. Accordingly, the Petitioner is awarded TTD benefits from 12/15/22 through 1/8/24.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Pursuant to §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 (AMA) "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.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of 2% of the right lower extremity as determined by Dr. Lee pursuant to the most current edition of the American Medical Association's (AMA) Guides to the Evaluation of Permanent Impairment. 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. In the present case, Dr. Lee indicates that Petitioner's diagnosis is attributed to the Achilles tendon rupture, and he does not indicate how the other two diagnoses addressed in Dr. Anderson's surgery may impact this rating. The Arbitrator gives this factor some weight.

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 truck driver at the time of the accident and that he has returned to his regular duty position. This factor carries some weight in the permanency determination.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 59 years old at the time of the accident. Neither party has submitted medical evidence which would tend to show how the Petitioner's age

impacts his permanent disability resulting from the work accident. This factor carries no real weight in the permanency determination.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the Petitioner indicated that he earned \$.50 less per hour than he had been earning prior to the accident, but this is disputed by the Respondent. Given the dispute and the minimal difference, the Arbitrator finds that this factor carries minimal weight in the permanency determination.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the preponderance of the evidence supports that the Petitioner had a preexisting right Achilles tendon insertion condition. He aggravated that condition on the accident date, and eventually underwent surgery. Following the surgery, the Petitioner had a generally good result and was able to return to his regular work duties. He testified to ongoing symptoms, including soreness, pain and weakness in the right foot/ankle, and medical records document atrophy, which Dr. Lee indicated is common to see after the surgery Petitioner underwent and which indicates a level of weakness, though the weakness may not be obvious without isolating the body part.

Based on the above factors, the record taken as a whole and a review of prior Commission awards with similar injuries and similar outcomes, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of the loss of use of 20% of the right foot pursuant to §8(e) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	22WC009413
Case Name	Daniel Ramirez v. Mighty Movers, Inc. & National Van Lines, Inc.
Consolidated Cases	
Proceeding Type	Remand
Decision Type	Commission Decision
Commission Decision Number	25IWCC0485
Number of Pages of Decision	6
Decision Issued By	Carolyn Doherty, Commissioner

Petitioner Attorney	Randall Manoyan
Respondent Attorney	Peter Havighorst

DATE FILED: 12/3/2025

/s/Carolyn Doherty, Commissioner

Signature

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)
☐ Modify	☐ PTD/Fatal denied.
☒ ON REMAND FROM APPELLATE COURT	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DANIEL RAMIREZ,

Petitioner,

vs.

NO: 22 WC 9413
2024 L 50134

MIGHTY MOVERS, INC. and
NATIONAL VAN LINES, INC.,

Respondents.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Illinois Appellate Court. In accordance with the opinion of the Appellate Court filed on October 3, 2025, the Commission on remand considers the issues of (1) average weekly wage (hereinafter "AWW") and temporary total disability (hereinafter "TTD") benefits and (2) penalties and fees pursuant to Sections 16, 19(l) and 19(k) of the Illinois Workers' Compensation Act. 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).

I. PROCEDURAL BACKGROUND

Petitioner's claim was the subject of arbitration hearings held on February 3, 2023 and April 3, 2023. In a decision filed on July 12, 2023, the arbitrator found Petitioner had met his burden of proving he suffered an accident on March 24, 2022 that arose out of and in the course and scope of his employment and that the right ankle fracture was causally related to that work accident. The Arbitrator determined that Petitioner's AWW was \$412.50 and calculated the TTD rate to be \$275.00. As such, the Petitioner was awarded TTD benefits, unpaid medical bills, prospective medical treatment, and penalties and fees pursuant to Sections 19(k), 19(l) and 16. The Arbitrator's award of TTD and penalties was calculated

using the AWW of \$412.50 and the TTD rate of \$275.00.

Both Petitioner and Respondent sought a review by the Commission, which issued a Decision and Opinion on Review on February 5, 2024, wherein the Commission modified the Arbitrator's award. The Commission concluded the proper AWW was \$341.92, which resulted in a statutory minimum TTD rate of \$320.00. Accordingly, the Commission modified the TTD award based on the statutory minimum rate. The Commission also vacated the award of penalties and fees pursuant to Sections 19(k), 19(1) and 16.

Petitioner then sought judicial review of the Commission's decision before the Circuit Court of Cook County. The circuit court confirmed the Commission's decision. Petitioner then appealed.

On October 3, 2025, the Illinois Appellate Court filed an opinion reversing the judgment of the circuit court, setting aside the Commission's decision, and remanding this matter to the Commission with directions that the Commission (1) "reevaluate" AWW and TTD benefits without consideration of the payroll records contained in RX 2 and (2) "reinstate" the arbitrator's award of penalties and fees under Sections 16, 19(k) and 19(l). Ramirez v. Illinois Workers' Compensation Comm'n, 2025 IL App (1st) 242467WC.

II. FINDINGS OF FACT

The Commission hereby incorporates by reference the "Findings of Facts" and findings included in the "Conclusions of Law" contained in the Arbitrator's Decisions filed on July 12, 2023, attached hereto and made a part hereof, to the extent they do not conflict with the Illinois Appellate Court opinion filed on August 11, 2023. The Commission also incorporates by reference the August 11, 2023 Illinois Appellate Court opinion, which delineates the relevant facts of the case and the court's analysis of the issues of the AWW and TTD and penalties and fees, attached hereto and made a part hereof. Any additional findings of fact in this Decision and Order on Remand will be specifically identified in the discussion below.

III. CONCLUSIONS OF LAW

In an effort to comply with the opinion of the Appellate Court on remand, the Commission is charged with following the court's order. See Noonan v. Illinois Workers' Compensation Comm'n, 2016 IL App (1st) 152300WC, ¶ 11. The Commission initially observes that a reviewing court's mandate vests a lower court with jurisdiction only to take action that complies with the reviewing court's mandate. See Fleming v. Moswin, 2012 IL App (1st) 103475-B, ¶ 28. On remand, the Commission lacks the authority to exceed the scope of the mandate and must follow the court's precise and unambiguous directions. *Id.* If the direction is to proceed in conformity with the opinion, then, of course, the content of the opinion is significant. *Id.*

Accordingly, the Commission will now (1) "reevaluate" AWW and TTD benefits and (2) "reinstate" penalties and fees pursuant to Sections 16, 19(1) and 19(k) of the Illinois Workers' Compensation Act, as ordered by the Appellate Court in its opinion filed on October 3, 2025.

A. Average Weekly Wage and TTD Benefits

1. Average Weekly Wage

The Commission acknowledges the Appellate Court's order to "reevaluate AWW and TTD benefits without consideration of the payroll records contained in RX 2." Accordingly, the Commission turns to other wage evidence properly admitted into the trial records, specifically Petitioner's testimony and Petitioner's Exhibit 14 (hereinafter "PX 14"), in order to comply with the Appellate Court's mandate.

Petitioner testified that he started working with Mighty Movers at the beginning of March of 2022, noting he had worked a few "unofficial days" at the end of February. Petitioner stated from the beginning of March until the date of the accident on March 24, 2022, he worked more than 40 hours per week, but none of it was ever recorded. He did not "clock-in," but rather it was an informal process of texting scheduled hours. Petitioner testified that he worked anywhere from 8 to 12 hours per day, noting "that's just how moves work." He testified that he was paid \$21.00 per hour and was paid via direct deposit. He explained that Mighty Movers' bank, Wells Fargo would deposit the money directly into his account. Petitioner testified that prior to the work accident on March 24, 2022, Petitioner received three direct deposits from Mighty Movers. Petitioner explained he "wasn't paid for his hours completely," but he was still in the field working and happy to be working at that time. Petitioner testified he was underpaid, working a 70-hour work week and not even receiving half of what he worked for. However, Petitioner admitted that he did not reach out to his supervisor for an explanation for the underpayment because he was too busy working. (T. 29-36).

Pursuant to the instructions of the Appellate Court, the Commission cannot consider the payroll records in RX 2. However, regarding PX 14, the Commission notes it was offered into evidence by Petitioner and admitted into evidence by the Arbitrator without objection from Respondent. The Commission observes that PX 14 consists of two screenshots showing a direct deposit from Mighty Movers on March 17, 2022 in the amount of \$650.03 and March 31, 2022 in the amount of \$323.24. PX 14 also contains a banking statement for the period of April 1, 2022 through April 30, 2022 showing a direct deposit on April 1, 2022 in the amount of \$323.24 and a banking statement for the period of March 1, 2022 through March 31, 2022 showing a direct deposit on March 18, 2022 in the amount of \$650.03. (PX 14/T. 532-540).

In reevaluating AWW, the Commission notes Petitioner's testimony that he was paid \$21.00 per hour while working more than 40 hours per week is contradicted by the evidence contained in PX 14. Likewise, the AWW of \$840.00 claimed by Petitioner on AX 1, the Request for Hearing Form is also contradicted by the evidence contained in PX 14. His claim that he received three direct deposits before the work accident is also contradicted by PX 14. Given the contradictions, the Commission gives more weight to PX 14, as the best evidence of Petitioner's earnings while working for Respondent. PX 14 shows two direct deposits from Respondent to Petitioner. The first deposit on March 17, 2022 (screenshot) or March 18, 2022 (bank statement) was in the amount of \$650.03 and the second deposit on March 31, 2022 (screenshot) or April 1, 2022 (bank statement) was in the amount of \$323.24. The direct deposits for the period of March 1, 2022 through April 1, 2022 total \$973.27. Further, the Commission notes Petitioner's testimony that he started working with Mighty Movers at the beginning of March is un rebutted. Accordingly, the Commission finds that Petitioner's period of employment from March 1, 2022 through the date of the accident on March 24, 2022 to be 24 days or 3-3/7ths weeks. Petitioner's total earnings of

\$973.27 divided by 3-3/7ths weeks results in an average weekly wage of \$283.75.

Nevertheless, the Commission remains unable to utilize the reevaluated Commission calculated average weekly wage of \$283.75 because the Commission is bound by the *Walker* case. *See Walker v. Industrial Comm'n*, 345 Ill.App.3d 1084 at 1088 (4th Dist. 2004) (holding it has been held that the language of section 7030.40, now 9030.40, provides that the request for hearing is binding on the parties as to the claims made therein). Therefore, the Commission again finds that the AWW is \$412.50 pursuant *Walker* as to the stipulated AWW on the request for hearing form. *See* AX 1.

2. TTD Rate and Award

After reevaluating and concluding the AWW is \$412.50, the Commission now reevaluates the TTD rate and TTD award. The Commission notes that TTD benefits are owed from March 25, 2022 through April 3, 2023, representing 53-4/7 or 53.571 weeks. The Commission observes Petitioner is single, with no dependents. The Commission also observes that the statute provides that the applicable minimum TTD rate for a March 24, 2022 date of accident is \$320.00. The Commission finds that 2/3 of \$412.50 is \$275.00, which is less than the applicable statutory minimum TTD rate of \$320.00. Therefore, the proper TTD rate is the statutory minimum of \$320.00, as was ordered in the Commission's Decision dated February 5, 2024.

Here, TTD benefits were owed from March 25, 2022 through April 3, 2023, representing 53 4/7 or 53.571 weeks. However, the Commission notes that the Arbitrator used the TTD rate of \$275.00, which is below the minimum rate, to calculate the TTD award. Pursuant to the Appellate Court order, the Commission reevaluates the TTD benefits as follows: the minimum TTD rate of \$320.00 x 53.571 weeks, results in a total of \$17,142.72 TTD benefits. The Commission further notes that the Request for Hearing form, AX 1 indicates the parties stipulated that Respondent is entitled to a TTD credit of \$12,646.07 for benefits paid. Therefore, after application of the stipulated TTD credit, the Commission awards \$4,496.65 in TTD benefits. The Commission observes this reevaluation of AWW and TTD issues results in rates consistent with our prior Decision.

B. Penalties and Fees

The Commission observes on remand, that after reevaluating the AWW and TTD issues pursuant to the Appellate Court's instructions, the Arbitrator's award of penalties and fees is inaccurate because the Arbitrator used a TTD rate of \$275.00 when calculating Section 16 fees and Section 19(k) penalties. On remand, the Commission acknowledges that Section 16 and Section 19(k) penalties should be reevaluated using the minimum TTD rate of \$320.00, as discussed above, which would result in penalty amounts different from those awarded by the Arbitrator.

Nevertheless, the Commission was instructed to reinstate rather than reevaluate the Arbitrator's award of penalties and fees on remand. Therefore, the Commission reinstates the Arbitrator's award of Section 16 fees in the amount of \$3,975.60, the award of Section 19(l) penalties in the amount of \$10,000, and the award of Section 19(k) penalties in the amount of \$1,043.03.

In all other respects, the Commission affirms and adopts the Appellate Court Order on Remand.

IT IS THEREFORE FOUND BY THE COMMISSION that the Petitioner's average weekly wage is \$412.50.

IT IS THEREFORE ORDERED BY THE COMMISSION Petitioner's TTD rate is the statutory minimum rate of \$320.00.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of \$320.00 per week for the period of March 25, 2022 through April 3, 2023, a period of 53-4/7ths weeks, for temporary total disability benefits under Section 8(b) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent, shall pay Section 16 fees in the amount of \$3,975.60, Section 19(l) penalties in the amount of \$10,000, and Section 19(k) penalties in the amount of \$1,043.03.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, including but not limited to \$12,646.07 for TTD benefits paid, to or on behalf of the Petitioner on account of said accidental injury.

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 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.

Bond for the removal of this cause to the Circuit Court is hereby fixed at the sum of \$52,800.00 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.

December 3, 2025

d: 12/03/25
CMD/jjm
045

/s/ Carolyn M. Doherty
Carolyn M. Doherty

/s/ Raychel A. Wesley
Raychel A. Wesley

/s/ Frank J. Soto
Frank J. Soto

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	22WC032749
Case Name	Cami Joplin v. Soderstrom
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	25IWCC0486
Number of Pages of Decision	6
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Kevin Elder
Respondent Attorney	Joseph Blewitt

DATE FILED: 12/4/2025

/s/Marc Parker, Commissioner
Signature

22 WC 32749

Page 1

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)
☐ Modify	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CAMI JOPLIN,

Petitioner,

vs.

NO: 22 WC 32749

SODERSTROM DERMATOLOGY,

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 causation and prospective medical treatment, and being advised of the facts and law, reverses the Decision of the Arbitrator, and finds Petitioner's current condition is causally related to the work accident, and awards prospective medical. 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).

I. FINDINGS OF FACT

Petitioner, a 37-year-old registered nurse, suffered an undisputed fall at work on January 22, 2020. Petitioner testified she was walking on the sidewalk to her car after leaving work when she slipped on ice and landed on her back. After falling, Petitioner called her husband and drove to Urgent Care, where she was diagnosed with a head injury/cervical strain and instructed to follow-up with her primary care provider. Petitioner's primary care provider diagnosed her with cervical strain and whiplash and referred her to Dr. Mulconrey.

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Petitioner presented to Dr. Mulconrey on March 7, 2020 with moderate to severe headaches and significant neck pain after a fall at work. Petitioner reported a previous history of axial neck pain and headaches, which worsened after the fall. Dr. Mulconrey ordered cervical x-rays and diagnosed Petitioner with cervical disc disease at C5/6. Physical therapy was prescribed.

Petitioner sporadically attended physical therapy for several months, but there were delays due to Covid.

Petitioner continued to treat with Dr. Mulconrey. By March 1, 2021, Petitioner continued to report pain in the lower cervical spine radiating to the right shoulder and periscapular area. Cervical MRI showed mild degeneration and foraminal narrowing at C5/6. Petitioner underwent epidural injections at C5/6 on November 17, 2021, and December 17, 2021, which provided 50% pain relief. Petitioner continued to report mid back pain, intermittent upper extremity symptoms, and axial neck pain. A cervical MRI on June 22, 2022, showed multilevel foraminal narrowing at C4/5 and C5/6. Dr. Mulconrey recommended a possible ACDF at C5/6.

Petitioner presented to Dr. Van Fleet for a Section 12 exam on November 15, 2022. Dr. Van Fleet reviewed medical records and digital images from x-rays and MRIs, which showed degenerative disc disease at C5/6. On exam, Petitioner reported pain at the base of her skull and above her bra line. Dr. Van Fleet diagnosed Petitioner with pre-existing degeneration temporarily exacerbated by the work accident resulting in cervical strain and whiplash. He felt Petitioner was at MMI and did not require additional treatment. He opined Petitioner's reported pain did not correlate with her MRI findings.

At trial, Petitioner introduced the medical opinion of Dr. Mulconrey into evidence. Dr. Mulconrey treated Petitioner over the course of three years. Dr. Mulconrey testified Petitioner's objective and subjective complaints worsened over that period, including worsening degeneration at C5/6, and continued axial neck and thoracic pain into the periscapular region. Dr. Mulconrey acknowledged Petitioner had a history of treatment for axial neck pain and headaches but did not know specifics of her treatment. Dr. Mulconrey agreed Petitioner had pre-existing degeneration at C5/6 level but opined Petitioner's hard fall on her back caused an aggravation of her condition. Since Petitioner failed conservative treatment, Dr. Mulconrey recommended an ACDF fusion at C5/6 to treat, at least in part, Petitioner's worsening neck pain since the work accident. Dr. Mulconrey testified he recommended the fusion regardless of causation.

Respondent introduced the medical opinion of Dr. Van Fleet into evidence. Dr. Van Fleet opined Petitioner had pre-existing degeneration at C5/6 level evidenced by her treatment history of axial neck pain and headaches. According to Dr. Van Fleet, Petitioner had chronic degeneration well visualized on her MRI, which would continue to deteriorate over time. He felt Petitioner's work accident caused a temporary aggravation of her underlying degenerative condition, or more specifically, a cervical strain/whiplash which would have resolved by the end of 2020. He did not feel her symptoms or treatment, including steroid injections, into 2021 and beyond were reasonable and necessary. He did not believe additional medical treatment, including surgery, was necessary.

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According to Dr. Van Fleet, Petitioner's symptoms of mid thoracic pain did not correlate with her objective MRI findings at C5/6. Van Fleet testified he would not operate on Petitioner regardless of causation because there was a disconnect between her subjective pain and objective findings.

The Arbitrator found Petitioner's current cervical condition was not related to the work accident based on Petitioner's pre-existing symptoms and the opinions of Dr. Van Fleet. Prospective medical treatment was denied.

II. CONCLUSIONS OF LAW

1. Causation

A claimant in a workers' compensation action has the burden of proving, by a preponderance of the evidence, some causal relationship between her employment and her injury. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 63, 541 N.E.2d 665, 133 Ill. Dec. 454 (1989). Whether a causal relationship exists between a claimant's employment and her injury is a question of fact to be resolved by the Commission. *Certi-Serve, Inc. v. Industrial Comm'n*, 101 Ill. 2d 236, 244, 461 N.E.2d 954, 78 Ill. Dec. 120 (1984). "Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was a causative factor in the resulting condition of ill-being." (Emphasis in original.) *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003). Even if the employee had a preexisting condition which made her more vulnerable to injury, recovery for an accidental injury will not be denied if she can show that the employment was also a causative factor. *Id.* at 205. An employee may establish a causal connection in such cases if she can show that a work-related injury played a role in aggravating or accelerating a preexisting condition. *Id.* at 204-05.

The Commission views the evidence differently than the Arbitrator and finds Petitioner's current condition was causally related to the work accident based on her immediate pain/symptoms following the work accident, her increase in symptoms as recorded in her medical records, and the persuasive opinions of Dr. Mulconrey.

It was undisputed Petitioner had pre-existing cervical disc degeneration at C5/6 with a history of treatment for axial neck pain and headaches. It was further undisputed Petitioner sustained cervical injuries from a fall at work requiring treatment for almost a year and had objective worsening of her C5/6 pathology on MRI.

Dr. Mulconrey treated Petitioner over the course of three years. Despite conservative treatment, Petitioner continued to have progressive symptoms and worsening arthritis at C5/6. Dr. Mulconrey testified Petitioner's C5/6 pathology was, at least in part, a source of her ongoing neck pain and need for treatment. He further opined Petitioner's mechanism of injury permanently aggravated her underlying condition at C5/6. We agree. Petitioner's medical records clearly document her worsening symptoms following the work accident, and although she did report temporary improvements in pain, she had obvious deterioration of her C5/6 pathology on MRI and

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her symptoms never resolved. Since previous medical records regarding treatment for axial neck pain and headaches were not introduced into evidence, the Commission relies on Petitioner's un rebutted testimony that her symptoms worsened after the fall and finds her pre-existed condition was aggravated.

Conversely, we are not persuaded by Dr. Van Fleet's opinions. Specifically, we find his opinion Petitioner's work accident caused cervical injuries requiring treatment for nearly a year incongruous with his opinion those injuries arbitrability resolved at the end of 2020. The medical records show Petitioner continued to exhibit significant cervical based pain, axial neck pain, and limitations with daily living skills from early 2021 through the date of trial. Additionally, we are not persuaded by Van Fleet's opinion the etiology of Petitioner's symptoms was unclear. Although Van Fleet opined the location of Petitioner's reported pain did not likely correlate with C5/6 pathology, he acknowledged "there was no way to know this for certain." As an aside, we find Petitioner's improved symptoms following her epidural injections supports C5/6 as a source of Petitioner's pain.

Accordingly, we agree with Dr. Mulconrey and find Petitioner's cervical condition related to the work accident.

2. Prospective Medical

Based on the above findings, we award prospective medical treatment of ACDF at C5/6 as recommended by Dr. Mulconrey, and all reasonable and necessary attendant care. Despite temporary improvements in pain following conservative treatment, Petitioner's symptoms never fully resolved. Dr. Mulconrey testified Petitioner's neck symptoms and need for surgery were related, at least in part, to her pathology at C5/6. Therefore, we award the prospective surgery.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed May 25, 2024, is hereby reversed for the reasons stated above.

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 Respondent shall authorize and pay for the ACDF at C5/6 recommended by Dr. Mulconrey, and all reasonable and necessary attendant care, as provided in Section 8(a) of the Act.

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

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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.

December 4, 2025

o: 11/6/25

MP/ns

068

/s/ Marc Parker

Marc Parker

/s/ Maria E. Portela

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	22WC031454
Case Name	Kevin Boksa v. UPS
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	25IWCC0487
Number of Pages of Decision	25
Decision Issued By	Raychel Wesley, Commissioner

Petitioner Attorney	Christopher Freeman
Respondent Attorney	Kristen Wasieleski

DATE FILED: 12/4/2025

/s/ Raychel Wesley, Commissioner

Signature

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)
☒ Modify Causal connection, medical expenses, TTD	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KEVIN BOKSA,

Petitioner,

vs.

NO: 22 WC 31454

UPS,

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 whether Petitioner's current condition of ill-being is causally related to the November 29, 2022 accidental injury, entitlement to medical expenses, as well as prospective medical care, and entitlement to temporary disability benefits, and being advised of the facts and law, modifies the Decision of the Arbitrator as set forth below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission remands this case to the Arbitrator for further proceedings for a determination of additional temporary total compensation or compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327 (1980).

FINDINGS OF FACT

The Commission adopts the Findings of Fact as set forth in the Decision of the Arbitrator and incorporates such facts herein.

CONCLUSIONS OF LAW

I. Causal Connection

It is well established that an accident need not be the sole or primary cause—as long as employment is a cause—of a claimant’s condition. *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 205 (2003). Furthermore, an employer takes its employees as it finds them (*St. Elizabeth’s Hospital v. Illinois Workers’ Compensation Commission*, 371 Ill. App. 3d 882, 888 (5th Dist. 2007)), and a claimant with a pre-existing condition may recover where employment aggravates or accelerates that condition. *Caterpillar Tractor Co. v. Industrial Commission*, 92 Ill. 2d 30, 36 (1982). As the Appellate Court held in *Schroeder v. Illinois Workers’ Compensation Commission*, 2017 IL App (4th) 160192WC, the inquiry focuses on whether there has been a deterioration in the claimant’s condition:

That is, if a claimant is in a certain condition, an accident occurs, and following the accident, the claimant’s condition has deteriorated, it is plainly inferable that the intervening accident caused the deterioration. The salient factor is not the precise previous condition; it is the resulting deterioration from whatever the previous condition had been. *Schroeder*, at P26.

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 Commission*, 93 Ill. 2d 59, 63 (1982).

Herein, the Arbitrator found causation, but only through June 14, 2023—the date of Dr. Stanford Tack’s §12 examination. The Arbitrator opined there were material contradictions between Petitioner’s testimony and the evidence in the record, which led to her deeming Petitioner an unreliable witness. The Arbitrator initially questioned Petitioner’s credibility, wondering why Petitioner returned to work the day after the accident and attempted to begin his shift, rather than immediately speaking to a supervisor when he arrived at work. Petitioner slept with a heating pad the night of the accident, and awoke the next day with a stiff back before returning to work. Thus, the Arbitrator surmised Petitioner’s injury must not have been as bad as he claimed, based on Petitioner’s decision to attempt to work the day after the accident. The Arbitrator also noted Petitioner’s hesitancy in answering certain questions, as well as his unexplained confusion during his testimony.

Additionally, the Arbitrator noted that after being prescribed medication and undergoing two therapy sessions at Concentra in December 2022, four sessions at Loyola in January and February of 2023, and 11 sessions at ATI in March and April of 2023. Petitioner underwent the §12 examination at Respondent’s request with Dr. Tack on June 14, 2023. After this examination, Dr. Tack opined Petitioner suffered a lumbar strain as a result of the accident, but there was no objective evidence that he would benefit from further treatment. Dr. Tack also opined Petitioner had reached maximum medical improvement (“MMI”), and he could return to full duty work.

Subsequently, on September 10, 2024, Respondent’s Dr. Matthew Coleman also performed a §12 examination. He noted symptom magnification in the form of “cogwheeling” and give way weakness with leg strength testing. He also opined that the injury Petitioner suffered at Costco in October 2023—which led to an emergency room visit at Gottlieb Hospital—was further evidence

of symptom magnification. Dr. Coleman opined that Petitioner's act that day of reaching over a shelf could not aggravate a lumbar disc herniation.

The Commission does not find that any of the above indicates a material contradiction between the testimony and evidence. In so finding, the Commission notes that the Arbitrator's description of Petitioner's demeanor during testimony is purely subjective, as is Dr. Coleman's opinion of symptom magnification. Further, Dr. Coleman's opinion on symptom magnification directly contradicts the opinion of Dr. Tack, who found no symptom magnification. Lastly, regarding Petitioner's "failure" to report the injury the next day, prior to beginning his workday, we reach a different conclusion than does the Arbitrator. An employee who continues to work on a regular basis despite his own progressive ill-being should not be punished merely for trying to perform his duties without complaint. *Durand v. Industrial Commission*, 224 Ill. 2d 53, 70 (2006) (quoting *Three "D" Discount Store v. Industrial Commission*, 198 Ill. App. 3d 43, 49 (1989)). Therefore, we decline to penalize Petitioner for his attempt at working through his injury. In sum, the Commission finds that the totality of evidence overrides any perceived credibility issues with Petitioner.

Turning to strictly substantive issues, both treating physician Dr. Bartosz Wojewnik and Respondent's Dr. Tack agreed that Petitioner aggravated a preexisting degenerative lumbar condition as a result of his work injury. However, there is no evidence in the record that Petitioner exhibited any symptoms related to this preexisting condition prior to the November 29, 2022 date of accident. In addition, Petitioner provided un rebutted testimony denying any prior lumbar pain as well. Petitioner was a seasonal employee for Respondent, and he had been working full duty delivering packages for five days leading up to the instant accident.

However, after the accident, Petitioner felt two pops and his back tightened up. That night he slept with a heating pad. The following morning, he woke up stiff, but still attempted to work. While loading his car with packages, he determined that his symptoms were too much for him to work through, and asked his supervisor if he could go home. Two days later, he presented at the Gottlieb Hospital emergency room complaining of low back pain. He indicated he had been taking Naproxen, which provided some relief. After lumbar x-rays he was prescribed medication and diagnosed with acute right-sided low back pain with right sided sciatica.

On December 5, 2022, Petitioner presented at Concentra with low back pain radiating down his right leg. He also complained of incontinence and testicular pain (He had just urinated himself prior to this visit). Petitioner rated his pain as 8 out of 10. He was diagnosed with a lumbar strain and lumbar radiculopathy, and was referred for physical therapy. *PX 3, p.177-181*. He returned on December 7, 2022 and was released to modified duty of lifting/pushing/pulling up to 10 pounds occasionally, trunk rotation occasionally, and no bending. *PX 3, p.192*. Petitioner underwent two sessions of physical therapy, which did not help. He testified that during one session he again suffered urinary incontinence.

Shortly thereafter, a lumbar MRI was performed and revealed an L4-5 disc bulge causing slight mass effect on the left subarticular zone with bilateral neural foraminal narrowing. *PX 5, p.303*. Petitioner was then referred for physical therapy. In the interim, Petitioner's complaints continued, and he expressed difficulty getting into his car and bending to tie his shoes.

By March 17, 2023, Petitioner's leg pain had resolved. Dr. Wojewnik reviewed the December 2022 lumbar MRI and found no reason for urinary incontinence, which Petitioner

indicated had also resolved. Dr. Wojewnik opined that the MRI revealed an L4-5 disc protrusion with mild to moderate lateral recess stenosis bilaterally. Petitioner was released to light duty with 10-pound lifting/pushing/pulling restrictions. *PX 5, p.351-352*. Respondent was unable to accommodate these restrictions, and Petitioner was referred to additional physical therapy.

On May 2, 2023, Petitioner's symptoms persisted, and Dr. Wojewnik recommended an L4-5 epidural injection on the right. He also referred Petitioner for pain management and maintained his light duty restrictions. *PX 5, p.359*. On August 30, 2023, Petitioner presented to Dr. Troy Buck for pain management. At that time Petitioner's right leg radicular pain had returned, his pain was worse with chores and errands, and he was also worsening overall. An examination revealed a positive Faber's test. Dr. Buck agreed with Dr. Wojewnik that an L4-5 transforaminal epidural steroid injection should be administered. *PX 5, p.421-429*.

On September 19, 2023, Dr. Wojewnik drafted a narrative report. Therein, he opined that Petitioner suffered a work-related lumbar strain with radiculopathy and back pain. He opined it was an aggravation of a pre-existing lumbar condition that was asymptomatic before the accident and became symptomatic afterwards. Dr. Wojewnik reiterated his light duty restrictions and his recommendation for an L4-5 epidural injection and work conditioning. He opined that Petitioner's condition of ill-being and correlating treatment were causally related to the accident, and that the mechanism of injury was consistent with causing a lumbar strain and aggravating a preexisting condition. *PX 12, p.721-723*.

On October 25, 2023, Petitioner was shopping at Costco when he reached to grab something off a shelf. He felt a shooting pain on the right side of his back. He was taken via ambulance to the Gottlieb Hospital emergency room, where he was diagnosed with an L4-5 disc bulge causing slight mass effect on the left subarticular zone, as well as mild bilateral neural foraminal narrowing. Thereafter, Petitioner's pain improved with medication and Lidoderm patches, and he was discharged to return to work on October 27th.

On November 13, 2023, Petitioner underwent his first epidural steroid injection. *PX 5, p.438-447*. Petitioner reported 70% pain relief for two weeks and improvement in function following the injection. From February 6, 2024 through February 26, 2024, Petitioner underwent another round of physical therapy. His pain complaints continued. During a therapy session on February 26, 2024, Petitioner suffered urinary incontinence again while doing a weightless squat. On February 19, 2024, Petitioner underwent a second epidural injection. *PX 5, p.501-503*. He testified it did not help his pain.

On March 1, 2024, Petitioner followed up with Dr. Wojewnik with complaints of lumbar pain and intermittent pain down his right leg down to the knee. He indicated the first injection helped for two weeks, and the second injection was still helping some. It was noted that Petitioner underwent an MRI after his most recent incontinence episode, but the MRI did not show any central compression consistent with urinary issues. The compression that *was* found also did not explain his right leg issues. An examination revealed groin pain with right hip range of motion ("ROM"), which could be hip-related. Petitioner was recommended to follow up with Neurology for his urinary and leg issues. Dr. Wojewnik opined Petitioner had reached MMI for his work-related injury, recommended a functional capacity evaluation ("FCE"), and opined that any restrictions would be permanent at this point. *PX 5, p.532-535*.

On March 18, 2024, Petitioner attempted the FCE, but was unable to complete it due to instability and difficulty bending, lifting, twisting, and reaching. It was noted that Petitioner gave maximum effort, and that he was only capable of sedentary duty.

On March 29, 2024, Dr. Wojewnik reviewed the valid FCE results and reiterated his opinion that Petitioner had reached MMI with respect to his work injury, and he placed Petitioner on permanent sedentary duty.

The overarching issue in this case is the causal connection for Petitioner's continued complaints of pain. According to Respondent's Dr. Tack, Petitioner suffered a lumbar strain which aggravated his preexisting condition, but he reached MMI as of June 14, 2023, and his condition had resolved enough for him to return to full duty work. However, according to treating physician Dr. Wojewnik, Petitioner suffered an aggravation of a previously asymptomatic lumbar condition which continued to require treatment beyond June 14, 2023. Dr. Wojewnik essentially found that Petitioner's condition failed to return to baseline after the accident, and eventually required permanent restrictions. Based on the totality of evidence, the Commission finds the opinions of Dr. Wojewnik more persuasive, and modifies the Arbitrator's decision accordingly.

Dr. Wojewnik was aware of Petitioner's previously asymptomatic condition, and opined that the mechanism of injury was consistent with causing a lumbar strain and aggravating his preexisting condition. Dr. Wojewnik also opined that Petitioner's condition and treatment were causally related to the accident. Subsequent to June 14, 2023, Dr. Wojewnik recommended additional treatment in the form of an epidural injection. This recommendation was echoed by pain management physician Dr. Buck, who recommended the same in August of 2023. Petitioner reported 70% pain relief for two weeks after the injection, prompting a second injection. However, after the second one, it became clear to Dr. Wojewnik that progress had stalled. At that point, he also found Petitioner to be at MMI with permanent restrictions—but not until March 29, 2024—after an FCE was attempted.

In addition to Dr. Buck's agreeing that additional treatment was necessary, the 'chain of events' analysis also supports Petitioner's claim. A previously asymptomatic Petitioner suffered an accident followed by disabling effects, and has since failed to reach a full resolution of his symptoms. Petitioner testified that his complaints remain ongoing, and his testimony is buttressed by the medical records.

Although the ultimate conclusion from Respondent's Dr. Tack (and by extension Dr. Coleman) differs from Dr. Wojewnik, there are aspects of Dr. Tack's opinion which support Petitioner's claim. Dr. Tack admitted that Petitioner suffered an aggravation of a preexisting condition, and also that Petitioner exhibited no signs of symptom magnification. Additionally, the Commission notes that Dr. Tack's MMI designation was provided after only medication and physical therapy had been attempted. In the instant matter, we find it premature to proclaim Petitioner reached MMI prior to exhausting all reasonable recommended conservative measures.

Next, we turn our attention to the May 16, 2023 utilization review, which non-certified the epidural injection, for the reason that Petitioner's symptoms did not meet the criteria, which included radiculopathy and symptoms being unresponsive to conservative treatment. §8.7 of the Act provides, in pertinent part: "When an employer denies payment of or refuses to authorize payment of...medical...services under §8(a) of this Act, if that denial or refusal to authorize complies with a utilization review program...then there shall be a rebuttable presumption that the

employer shall not be responsible for payment of additional compensation...” 820 ILCS 305/8.7(j). When payment for medical services has been denied pursuant to utilization review, “the employee has the burden of proof to show by a preponderance of the evidence that a variance from the standards of care used by the person or entity performing the utilization review...is reasonably required to cure or relieve the effects of his or her injury. 820 ILCS 305/8.7(i)(4).

The record reflects that the bills for the non-certified injections were in fact paid prior to hearing. See *PX 6, p.603*. Accordingly, the Commission finds the injections to be reasonable and necessary. See *Paul Harris v. City of East St. Louis*, 2008 Ill. Work Comp. LEXIS 627 (May 30, 2008); and *Patricia Babb v. Victoria’s Secret*, 2010 Ill. Work Comp. LEXIS 51 (January 15, 2010) (it is a long held principle of the Commission that a paid bill is presumed to be reasonable even when the treatment has been scrutinized by utilization review). Had these injections been deemed unreasonable, there would be no basis for Petitioner to request a modification of the MMI date, as the injections were the only additional medical recommendations made by treating physician Dr. Wojewnik—and Dr. Wojewnik opined Petitioner would reach MMI after said injections. Thus, since the injections are reasonable and necessary, they provide a further basis for the Commission to modify and extend the MMI date from June 14, 2023 to March 29, 2024.

Regarding the October 2023 Costco injury, the Commission does not find the incident to be an intervening accident which breaks the causation chain. Petitioner’s testimony along with medical evidence reflect that this was no more than a temporary exacerbation that improved with medication and Lidoderm patches shortly after Petitioner arrived at the Gottlieb emergency room. This is corroborated by the fact that Petitioner was discharged to return to work just two days after this injury.

Lastly, regarding the surveillance reports submitted into evidence, we do not find them to be inconsistent with Petitioner’s stated physical limitations. Petitioner testified to virtually everything he was observed doing while under surveillance. The reports did not indicate he consistently performed any activities which would give any implication that he could perform anything above sedentary duty.

The Commission finds that the record in total supports a finding that Petitioner’s lumbar condition deteriorated after the instant accident, and he had not reached MMI until exhausting all recommended reasonable conservative care and until Dr. Wojewnik had the opportunity to review the FCE results to find that Petitioner reached MMI on March 29, 2024. The permanent restrictions issued by Dr. Wojewnik are consistent with Petitioner being unable to complete an FCE and his continued complaints of low back symptoms with difficulty sitting for long periods. Based on the totality of the credible evidence in the record, the Commission modifies the Arbitrator’s decision and finds that Petitioner’s condition of ill-being was casually related to the accident of November 29, 2022 through the date Petitioner reached MMI on March 29, 2024.

II. Medical Expenses

Petitioner underwent the treatments recommended to him by treating physicians, to varying degrees of success. §8 of the Act states a Respondent is responsible “...for all the necessary first aid, medical and surgical services, and all necessary medical, surgical, and hospital services thereafter incurred, limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury...” 820 ILCS 305/8(a). Consistent with the above causation

analysis, the Commission finds Respondent liable for all reasonable and necessary medical expenses related to the treatment of Petitioner's lumbar spine through Dr. Wojewnik's MMI date of March 29, 2024, pursuant to §8 and §8.2 of the Act. Respondent shall receive credit for all amounts paid.

III. Prospective Medical Care

Upon establishing causal connection and the reasonableness and necessity of recommended medical treatment, employers are responsible for necessary prospective medical care required by their employees. *Plantation Mfg. Co. v. Industrial Commission*, 294 Ill. App. 3d 705, 711-12 (2d Dist. 1997). Petitioner has undergone conservative lumbar treatment, including medication, injections, and physical therapy. However, he continues to have pain complaints. Nevertheless, upon finding Petitioner had reached MMI for his causally related lumbar condition, treating physician Dr. Wojewnik recommended Petitioner follow up with Dr. Buck (pain management) and Neurology to look into his incontinence and right hip issues, which he found to be unrelated to the instant accident. To that end, Dr. Buck later recommended an EMG. However, as these recommendations pertain to Petitioner's unrelated condition and not to the lumbar condition, the Commission finds Petitioner is not entitled to prospective medical care and no prospective medical care is awarded.

IV. Temporary Total Disability

A claimant is temporarily totally disabled from the time an injury incapacitates him from work until such time as he is as far recovered or restored as the permanent character of his injury will permit. *Westin Hotel v. Industrial Commission*, 372 Ill App. 3d 527, 542 (1st Dist. 2007). In determining whether a claimant remains entitled to receiving TTD benefits, the primary consideration is whether the claimant's condition has stabilized, *i.e.*, whether the claimant has reached maximum medical improvement, and whether she is capable of a return to the workforce. *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission*, 236 Ill. 2d 132, 142, 148 (2010). Once an injured employee's physical condition stabilizes, she is no longer eligible for TTD benefits. *Archer Daniels Midland Co. v. Industrial Commission*, 138 Ill. 2d 107, 118 (1990).

Per the *Request for Hearing* form, Petitioner alleges that TTD benefits should be awarded from December 5, 2022 through the trial date of November 18, 2024. The record reflects Petitioner was taken off work on December 5, 2022, but was returned to modified duty two days later. For the remainder of his treatment, Petitioner was either off work completely or restricted to modified/light duty. There is no evidence that Respondent ever accommodated these restrictions. Accordingly, the Commission finds that Petitioner was temporarily and totally disabled commencing December 5, 2022 through March 29, 2024, the date of MMI.

V. Maintenance

Effectuated by Dr. Wojewnik's finding that Petitioner required permanent sedentary duty, Petitioner was unable to continue as a delivery driver for Respondent. There was no evidence that Respondent was willing and/or able to accommodate Petitioner's permanent sedentary restrictions.

At trial, Petitioner testified that he had been conducting his own job search via Indeed. Based on this history, maintenance is addressed below.

Employers may be liable for maintenance costs while the employee is in a prescribed vocational rehabilitation program. *Connell v. Industrial Commission*, 170 Ill. App. 3d 49, 53 (1st Dist. 1988); *Hunter Corp. v. Industrial Commission*, 86 Ill. 2d 489, 496 (1981). The term “vocational rehabilitation” includes not only a formal program of retraining or education, but an injured worker’s search for a new job. An employee’s inability to find work without further education or assistance is one of the factors to be considered in determining whether the employee is entitled to vocational rehabilitation under *National Tea v. Industrial Commission*, 97 Ill. 2d 424, 432 (1983). If an employee proves entitlement to vocational rehabilitation, it is, in part, because the employee has failed to find a job on his or her own. Such an employee would be entitled to maintenance.

A more recent case is also instructive. Although it is a Rule 23 Order, it was issued after January 1, 2021, therefore it may be cited for persuasive purposes. In *Asplundh Brush Control v. IWCC*, 2022 IL App (1st) 211522WC-U, the court found: “If the claimant is not engaged in some type of physical rehabilitation program, formal job training, or a self-directed job search, there is no obligation to provide maintenance. *Greaney v. Industrial Commission*, 358 Ill. App. 3d 1002, 1019 (1st Dist. 2005). An employee’s self-initiated and self-directed job search or vocational training may constitute a “vocational-rehabilitative program” under §8(a). *Roper Contracting v. Industrial Commission*, 349 Ill. App. 3d 500, 506 (5th Dist. 2004).

Here, there is no evidence in the record that Petitioner was engaged in a physical rehabilitation program, nor any formal job training with respect to his lumbar condition. Conversely, Petitioner did submit job logs from a self-directed job search from March 25, 2024 through November 7, 2024. However, a review of the logs reveals that they are handwritten, largely illegible, and provided little detail other than “applied online” or “took test.” There is no evidence of any follow ups performed or how Petitioner was qualified for these jobs. The search appears to be rather concocted, and not in good faith. In essence, Petitioner’s job search appears to be a sham, and does not satisfy the activity necessary to trigger any obligation of maintenance. Accordingly, the Commission finds that Petitioner has not met the criteria for entitlement to maintenance benefits after the MMI date.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 29, 2025, as modified above, is hereby affirmed and adopted.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner’s lumbar condition of ill-being was causally related to the work accident, but only through the MMI date of March 29, 2024.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of \$475.98 per week for a period of 68 & 5/7ths weeks, representing December 5, 2022 through March 29, 2024, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b), 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. Respondent shall have a credit of \$19,426.77 for benefits already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that no award for maintenance benefits shall be granted to Petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the medical expenses incurred from the date of accident through March 29, 2024, as provided in §8(a), subject to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that no award for prospective medical care shall be granted, as there are no prospective medical treatment recommendations which are germane to Petitioner's lumbar spine.

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.

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 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 \$17,700.00. 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.

December 4, 2025

RAW/wde

/s/ *Raychel A. Wesley*

D: 10/8/25

/s/ *Frank J. Soto*

43

/s/ *Carolyn M. Doherty*

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	22WC031454
Case Name	Kevin Boksa v. UPS
Consolidated Cases	
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	15
Decision Issued By	Jennifer Bae, Arbitrator

Petitioner Attorney	Christopher Freeman
Respondent Attorney	Kristen Wasieleski

DATE FILED: 1/29/2025

/s/ Jennifer Bae, Arbitrator

Signature

INTEREST RATE WEEK OF JANUARY 28 2025 4.14%

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)

KEVIN BOKSA,
 Employee/Petitioner

Case # **22** WC **031454**

v.

UPS
 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 **Jennifer Bae**, Arbitrator of the Commission, in the city of **Chicago**, on **November 18, 2024**. 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 **Prospective Medical**

FINDINGS

On **11/29/2022**, 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 **\$5,963.78**; the average weekly wage was **\$713.97**

On the date of accident, Petitioner was **54** years of age, *single* with **1** 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 **\$19,426.77** for TTD, \$ **0** for TPD, \$ **0** for maintenance, and \$**0** for other benefits, for a total credit of **\$19,426.77**.

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

ORDERMedical Bills:

Respondent shall pay for any treatment that Petitioner received up to June 14, 2023, pursuant to the medical fee schedule and Section 8(a) and 8.2 of the Act.

Prospective Medical:

Petitioner is not entitled to any prospective medical care as provided in Section 8(a) and 8.2 of the Act because he reached MMI on June 14, 2023.

Temporary Total Disability:

Respondent shall pay Petitioner temporary total disability benefits of **\$475.98/week** for **27 3/7** weeks, commencing **December 5, 2022**, through **June 14 2023**, as provided in Section 8(b) of the Act. Respondent shall be given credit of \$19,426.77 for temporary total disability benefit already paid.

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.

Jennifer Bae

Signature of Arbitrator

JANUARY 29 2025

STATE OF ILLINOIS)
) SS
 COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

KEVIN BOKSA,	)	
	)	
Petitioner,	)	
	)	
v.	)	
	)	Case No. 22WC031454
UPS,	)	
	)	
	)	
Respondent.	)	

MEMORANDUM OF DECISION OF ARBITRATOR

I. PROCEDURAL HISTROY

Mr. Kevin Boksa (“Petitioner”), by and through his attorney, filed an Application of Adjustment of Claim for benefits under the Workers’ Compensation Act (“Act”). *820 ILCS 305/1 et seq. (West 2014)* Petitioner alleged that he sustained an accidental injury on November 29, 2022 while employed by UPS (“Respondent”). A hearing was held on November 18, 2024 on the following issues: causation, medical treatment, prospective medical, and temporary total disability.

Petitioner testified in support of his claim. Mr. Hernan Sanchez and Mr. Day Dairy testified on behalf of Respondent. Respondent introduced Section 12 IME report and an addendum from Dr. Stanford Tack and Section 12 IME report from Dr. Matthew Coleman. (RX 5; RX 15; RX 16) The parties requested a written decision, including findings of fact and conclusions of law pursuant to the Act. (AX 1)

II. FINDINGS OF FACT

Petitioner is a 54-year-old delivery driver for Respondent, who testified that he was hired on a temporary basis for the Christmas season in December of 2019. (T. 16-17) Petitioner testified that he worked as a Christmas seasonal delivery driver for Respondent in 2020 and 2021. (T. 17) Petitioner again returned to Respondent as a seasonal delivery driver in November of 2022. (T. 17)

Petitioner testified that he used his personal vehicle (a pick-up truck) to deliver packages for Respondent. Most of the packages were delivered to personal residences and the size and nature of the packages varied. (T. 19-21) Petitioner testified that his shift generally began at 10 am at which time he would report to Respondent’s facility in Franklin Park. (T. 21) First, he would sort his assigned packages and load them on to his truck in numerical order based on Respondent’s

system. (T. 21-22) Petitioner testified that he made deliveries by leaving the package at the residence and marked “delivered” on a phone provided by Respondent. (T. 23) His shift generally lasted about 8 hours with approximately 180 packages delivered. (T. 21-22)

Accident

Petitioner testified that on November 29, 2022, he was delivering his last package of the day at approximately 6:00 pm when he lifted a box from his truck, all the weight shifted to one side and as he tried to catch the box, he felt a jerk to his back. (T. 23-24) Petitioner testified that he was unsure of the weight but thought it weighed approximately 20 pounds. (T. 24) He believed that the item in the box had not been packed correctly. (T. 24)

Petitioner testified that he felt “two pops” when he jerked his back and that “everything tightened up.” (T. 26) He knew there was something wrong. (T. 26) After the accident, Petitioner returned to Respondent’s Franklin Park facility and looked for someone to whom he could report the accident. (R. 26) Petitioner stated that nobody was around. (T. 26) Petitioner testified that he left and at home, he slept with a heating pad and woke up with a stiff back the next morning. (T. 27)

The following morning, Petitioner returned to the Franklin Park facility and attempted to begin his shift as usual. (T. 27) Petitioner testified that he had loaded some packages on his truck and felt pain in his low back, at which point he reported to his supervisor, Hernan, that he had injured his back the night before and could not continue to work due to pain. (T. 27)

Petitioner’s Testimony Regarding Medical Treatment and Summary of Medical Record:

Petitioner initially presented for treatment at the Gottlieb Hospital ER on December 1, 2022, at which time he complained of right-sided low back pain radiating down his right leg since lifting a box at work on November 29, 2022. Diagnosis was acute right-sided low back pain with sciatica. (PX 1 pp.13,16)

Respondent subsequently sent Petitioner to Concentra on December 5, 2022. (PX 3) Petitioner gave a history of accident and subsequent right-side low back pain radiating down the right leg. (PX 3 p. 9) Petitioner specifically rated his pain as 8/10 and stated that he had just recently had an episode of urinary incontinence in which he soiled himself. (PX 3 p.10) The diagnosis was lumbar radiculopathy and Petitioner was prescribed restrictions as follows: lifting, pushing, and pulling 10 pounds occasionally, no bending and occasional trunk rotation. (PX 3 p. 13) Petitioner returned to Concentra and his diagnosis remained the same on December 7, 2022. He underwent low back focused physical therapy through December 9, 2022. (PX 3 pp. 14-50)

Petitioner then presented to Dr. Bartosz Wojewnik, orthopedic spine surgeon at Loyola University Medical Center on December 13, 2022. (PX 5) Petitioner gave a history of lifting a large package containing auto parts on November 29, 2022 and immediately developing pain across his low back, lower right extremity to the back of his leg and foot, and into the right testicle. (PX 5 p. 49) Petitioner further stated that he had experienced urinary incontinence 5 times since the accident, and complained of numbness and tingling, especially in the bottom of his foot. (PX 5 p. 49) On exam, Dr. Wojewnik noted a diminished sensation over the plantar surface of the right foot, and a

positive straight leg raise on the right. (PX 5 p. 50) He ordered an MRI and removed Petitioner from all work. (PX 5 p. 50)

Petitioner then underwent an MRI of the lumbar spine on December 14, 2022. The MRI revealed disc bulge at L4-5 causing a slight mass effect on the left subarticular zone, with bilateral neural, foraminal narrowing at that level. (PX 5 pp. 104-105)

From January 27 to February 24, 2023, Petitioner underwent a course of physical therapy at Loyola and returned to Dr. Wojewnik on March 17, 2023. (PX 5 pp. 75-113) On March 17, 2023, Petitioner reported having one physical therapy session after which time he was forced to go to the ER at Gottlieb Hospital for pain in his low back. (PX 1 pp. 32-39) Petitioner reported that his low back pain had improved and that his leg pain had resolved. Dr. Wojewnik noted a disc protrusion at L4-5 with mild to moderate lateral recess stenosis bilaterally. He recommended Petitioner to continue with physical therapy and released him to work with restrictions - no pushing, pulling, or lifting more than 10 pounds. (PX 5 pp. 15-18)

Petitioner then underwent another course of physical therapy at ATI from March 23, 2023 to April 27, 2023, returning to Dr. Wojewnik on May 2, 2023. (PX 8) Petitioner continued to have low back pain, rated 2/10 for pain, and wanted to try an injection. Dr. Wojewnik recommended transforaminal lumbar epidural steroid injection at L4-5 on the right and referred Petitioner to pain management. Dr. Wojewnik kept Petitioner's light duty restrictions of no pushing, pulling, or lifting more than 10 pounds. (PX 5 p. 125)

Petitioner returned to Dr. Wojewnik on June 20, 2023, with continued complaints of low back pain ranging from 2/10 to 6/10 depending on the day. Dr. Wojewnik reiterated his recommendation for a lumbar epidural steroid injection at L4-5 followed by a course of work conditioning. Dr. Wojewnik noted that if an injection was not performed, he would consider Petitioner at maximum medical improvement. (PX 5 p. 134)

On June 14, 2023, Petitioner met with Dr. Stanford Tack, Respondent's Section 12 IME. (RX 1)

Petitioner presented to Dr. Troy Buck at the Loyola Pain Center on August 30, 2023, at which time gave a history of accident and symptoms. At this visit, he described the pain as located in the low back, radiating into the right lower extremity, specifically to the plantar aspect of the right foot. He described the pain as intermittently shocking, gnawing, and constant in character. The pain was rated 6/10 usually but 3/10 currently. Petitioner reported the pain was worse with activity and better with nothing specific and had been steadily increasing leading up to the visit. Petitioner suffers from leukemia and is limited in terms of the medications he can take. (PX 5 p. 194)

On October 25, 2023, Petitioner was shopping at Costco when he went to reach for an item on a shelf and felt excruciating pain in his low back. He was taken by an ambulance to Gottlieb Hospital. (PX 10)

On October 29, 2023, Dr. Wojewnik created a narrative report in response to Dr. Tack's IME report. (PX 12) Dr. Wojewnik stated that he reviewed Petitioner's Concentra records, the UPS tracking form regarding the package Petitioner was delivering when the accident occurred, various

utilization review reports, and the initial IME report from Respondent. Dr. Wojewnik summarized his findings and previous treatment for Petitioner and acknowledged the opinion of Respondent's IME. Dr. Wojewnik stated to a reasonable degree of medical certainty that Petitioner had a work-related injury--specifically a lumbar strain along with radiculopathy and back pain, both secondary to that same strain. He diagnosed an aggravation of preexisting degenerative lumbar changes and stenosis that was asymptomatic before the injury and became symptomatic after the injury. Dr. Wojewnik reiterated his treatment recommendations, which consisted of transforaminal epidural steroid injections at L4 -5 and work conditioning three times per week for four weeks. It was Dr. Wojewnik's opinion that Petitioner's conditioning treatment were causally related to the work accident. Dr. Wojewnik reiterated that the mechanism of injury was consistent with Petitioner's diagnosis and continuing symptoms. Dr. Wojewnik concluded that Petitioner would be at maximum medical improvement ("MMI") after the injections and that if the symptoms persisted, an FCE will be needed to assess permanent restrictions. (PX 12)

Petitioner underwent lumbar epidural steroid injections with Dr. Buck at Loyola on November 13, 2023 and February 19, 2024. Petitioner testified that the first injection provided pain relief for roughly a week and gradually returned to his post-accident baseline. (PX 5; T. 38-39) Petitioner testified that the second lumbar ESI provided temporary relief like the first, and that by the time he returned to Dr. Wojewnik on March 1, 2024, his condition was largely unchanged and that his right leg "felt weaker." (T. 41) Petitioner reported having continue low back and intermittent radiating pain to the back of the right leg mostly down to the knee. He reported that the first ESI helped him for about two weeks, and that the second injection was still helping some. He reported restarting physical therapy but again suffered urinary incontinence during a session and was again sent to the ER for an evaluation where another MRI was done on December 14, 2023. (PX 5 pp. 355-360) A consulting neurologist recommended outpatient follow-up. Dr. Wojewnik's exam demonstrated right-sided groin pain with random motion in the right head . Dr. Wojewnik reiterated that Petitioner was likely not a surgical candidate and that he is at MMI for the work injury and recommended an FCE. (PX 5 p.301)

Petitioner returned to Loyola for an FCE on March 18, 2024. (PX 5 pp.309-330) He was unable to complete the FCE and reported difficulty with bending, lifting, twisting, and reaching. It was noted that he was unable to tolerate sustained positioning either standing or sitting and that his pain was rated between 5-9/10 in general and 8/10 following the aborted FCE. Petitioner testified that the administering therapist first had him perform various routines, and when he had to start lifting, his right leg kept giving out. (T. 40-42) Petitioner stated that the therapist told him that if he can't lift safely, he cannot complete the exam. (T. 42)

Petitioner testified that the occasional falls that he experienced since the accident did not change the nature of his ongoing symptoms in any way. (T. 47) He testified that prior to this accident, the last time he received any treatment for his back was roughly 20 years ago after a car accident that involved his mid-back and not his low back. (T. 48)

Petitioner returned to Dr. Wojewnik on March 29, 2024 where Dr. Wojewnik documented the continuation of the previously reported symptoms. Dr. Wojewnik reiterated that Petitioner was at MMI and that the FCE placed him at the sedentary level of work. The restrictions were permanent and he referred Petitioner back to Dr. Buck for further pain management. (PX 5 pp. 338-339)

Petitioner last saw Dr. Buck on September 6, 2024 where he reported pain in the low back radiating into the right leg, specifically to the plantar aspect of the right foot. The pain was described as shocking and constant in character rated 6/10 in general. Dr. Buck reiterated a diagnosis of lumbar spondylosis, prescribed Robaxin and suggested the possibility of pursuing a spinal cord stimulator. Petitioner was prescribed an EMG, which he has yet to undergo. (PX 5 pp. 355-360)

Petitioner testified that he was advised to be as active as possible and that in a typical day he tries to go to the Harlem and Irving indoor mall to walk, where he can stop and rest if necessary. Petitioner stated that he typically goes to a mall to walk three times per week in addition to walking his dog in the neighborhood roughly once a day. (T. 50) Petitioner also attempted to continue the home exercise program given by his physical therapists. The home exercise consists of leg raises, back raises, and “core stuff.” (T. 50-51)

Petitioner testified that he had never suffered from urinary incontinence before this accident. (T. 52-53) He also testified that he had been prescribed lidocaine pain patches and was wearing one during the hearing. (T. 58)

Employment History/Job Search

Petitioner testified that since being released to sedentary duty, he has been looking for work within his restrictions, with no luck. (T. 51; PX 13) On cross-examination, Petitioner testified that his job search consists largely of going on indeed.com and looking for jobs within his restrictions. (T. 53)

In terms of his job history, Petitioner testified that he graduated from Gordon Tech High School in 1987. Upon graduation from high school, he started a sign company and worked as a glass vendor for four years. After that he took a job as a courier delivering packages for five additional years. At that point he worked in his father's hot dog/beef stand for three years. He then obtained certificates to perform low voltage electrical work specifically on fiber optics and networking. He worked for AT&T until 2017. In 2017, Petitioner was diagnosed with leukemia and was unable to work. He then reentered the job force in 2018 delivering food for Panera Bread. After Panera Bread, he worked for a company called Heath, surveying and identifying gas leaks for the gas company, which was a warm-weather seasonal job, and then would deliver packages and/or construction materials as an independent contractor or for Respondent. (T. 12-17)

Respondent's Witnesses Testimony:

Hernan Sanchez

Hernan Sanchez, a business manager for Respondent, testified that a seasonal worker is a person that helps for short periods of time, usually in November and December in a temporary position. (T. 60-61) The seasonal worker makes deliveries with their personal vehicle, when there are too many packages during Christmas time (November 15th through January 15th). (T. 61-62) Petitioner was hired on October 26, 2022, and worked six-to-seven-hour per day and longer depending on the number of packages to be delivered on a particular day. (T. 62 – 63) From October 26, 2022,

through November 29, 2022, Petitioner earned \$2,297.29 while working as a seasonal worker for Respondent. (T. 63)

Day Dairy

Day Dairy (“Dairy”) testified that he is an investigator for Digistream and that he was contracted to conduct surveillance of Petitioner. Dairy viewed Petitioner go to McDonald’s and walk in the mall several times. Specifically, he testified that he viewed Petitioner fall on June 6, 2023. (T. 68-72)

Respondent’s Section 12 Examiner – Dr. Stanford Tack

Dr. Tack met with Petitioner on June 14, 2023 for Section 12 examination. Dr. Tack’s IME report dated June 23, 2023 was admitted into evidence. Dr. Tack diagnosed Petitioner with a lumbar sprain/strain superimposed upon pre-existing disc degeneration at L4-5 and L5-S1. He believed that there is no objective evidence to support alternative diagnoses. He further opined that there is no objective evidence of ongoing conditions that will benefit from further treatment. Dr. Tack opined Petitioner could return to unrestricted occupational activities. Petitioner had reached maximum medical improvement from the accident on November 29, 2022. (RX 5)

Dr. Tack’s addendum IME report dated January 31, 2024 was admitted into evidence. Dr. Tack reviewed additional medical records that included the treatments with Dr. Buck through November 13, 2023, and the Gottlieb Emergency Room visit on October 25, 2023. The additional medical records did not alter Dr. Tack’s opinions rendered in his June 23, 2023 report. He opined that the appropriate diagnosis remains a lumbar sprain/strain superimposed upon pre-existing degenerative change at L4-5 and L5-S1. He further opined that there is no evidence to support continued objective evidence of conditions which would preclude unrestricted return to occupational activity. (RX 15)

Respondent’s Section 12 Examiner – Dr. Matthew Coleman

Dr. Coleman’s IME report, dated September 10, 2024, was admitted into evidence. In this report, Dr. Coleman reviewed Dr. Tack’s prior IME reports, along with the records from Dr. Wojewnik, Dr. Buck, Gottlieb Hospital, and diagnostic images/reports. Dr. Coleman detected signs of symptom magnification, “clearly exhibiting cogwheeling and giving way weakness when tested for motor strength in the lower extremities.” Further, the radiographs were within the normal limits and an MRI report indicated mild-to-minimal disc bulging without significant spinal stenosis. The neurological exam is essentially normal aside from Petitioner’s cogwheeling and effort-based weakness on the right lower extremity. Although Petitioner claimed that he felt a pop in his back with delayed onset of significant right lower extremity radiating pain, Dr. Coleman was “unable to determine if Petitioner had any traumatic injury on November 29, 2022” because “the x-rays did not demonstrate any evidence of an acute traumatic condition.” (RX 16) At most, Dr. Coleman believed that Petitioner “sustained a minor lumbar sprain or strain as a result of the incident on November 29, 2022[,] which is long since resolved.” (RX. 16) He concluded that Petitioner was able to return to work without restrictions.

Dr. Coleman went on to opine that the current condition has no relation to the date of incident. Lumbar strain/sprain injuries are expected to resolve within six to twelve weeks when there are no complicating factors such as Petitioner. Dr. Coleman found that there were no organic explanations for Petitioners ongoing complaints.

As to the October 25, 2023, Gottlieb Emergency Room visit, Dr. Coleman stated that “reaching over a shelf at Costco” does not have a sufficient mechanism to aggravate or cause a new lumbar disc herniation and may be further evidence of symptom magnification. (RX 16)

As to the FCE dated March 18, 2024, which placed Petitioner at sedentary work with no lifting more than 10 pounds, Dr. Coleman found this to be significant because he would disagree with obtaining an FCE to begin with. Dr. Coleman goes on to explain that Petitioner did not have a significant lumbar injury, and all objective findings reveal a lumbar sprain/strain at most, “without significant acute herniated disc, fracture, dislocation, or any other acute traumatic condition.” (RX 16) Therefore, Dr. Coleman concluded that Petitioner has no objective reason to have any work restriction, and he believed that the examiner of the FCE was swayed by Petitioner’s subjective pain complaints. (RX 16)

III. CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). 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 demeanor of the witness and any external inconsistencies with his/her testimony. Where a claimant’s testimony is inconsistent with his/her 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).

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 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). 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 ILWC 004187 (2010).

In the case at hand, the Arbitrator observed Petitioner during the hearing and finds him to be a witness that exaggerated or embellished his past and/or current conditions. Petitioner was hesitant to answer certain questions and was easily confused for no apparent reason. The Arbitrator compared Petitioner’s testimony with the totality of the evidence submitted and did find material contradictions that would deem the witness unreliable.

Issue F, whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds as follows:

To obtain compensation under the Act, a claimant must prove that some act or phase of his employment was a causative factor in his ensuing injuries. A work-related injury need not be the sole or principal causative factor, as long as it was *a* causative factor in the resulting condition of ill-being. Even if the claimant had a preexisting degenerative condition which made him more vulnerable to injury, recovery for an accidental injury will not be denied as long as he can show that his employment was also a causative factor. Thus, a claimant may establish a causal connection in such cases if he can show that a work-related injury played a role in aggravating his preexisting condition. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003). "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 Com.*, 93 Ill. 2d 59, 63 442 N.E.2d 908 (1982).

Petitioner testified that he felt onset of low back pain when he lifted a box of auto parts that weighted approximately 20 pounds on November 29, 2022. When he returned to the Franklin Park facility, he testified that he looked for a supervisor to informed him/her of the accident/injury. When he did not see anyone, he went home and used a heating pad and then returned to work the following day. The Arbitrator notes that when he returned to work the next day, he did not immediately look for a supervisor, instead he started his usual workday. The Arbitrator finds this to be inconceivable when Petitioner testified that he was in so much pain, he had to use a heating pad. He further testified that he woke up the next morning with a stiff back. Instead of informing his supervisor immediately when he arrived at work, he resumed work. He testified that as he resumed work, he felt pain in his low back and this is when he decided to inform his supervisor of the accident/injury that occurred the day before. There was no evidence as to why Petitioner did not immediately seek treatment after informing his supervisor of the accident/injury. The Arbitrator can only assume that Petitioner's injury was not as bad as he claimed during the hearing.

Three days after the accident/injury, on December 1, 2022, Petitioner presented to Gottlieb Hospital Emergency Room complaining of right-side low back pain radiating down his right leg. He was diagnosed with acute right-sided low back pain with sciatica. (PX 1 pp. 13-16) Respondent sent Petitioner to Concentra and Petitioner received treatment on December 5th and 7th of 2022. He was diagnosed with lumbar sprain and lumbar radiculopathy and treatment included pain medication (Naprosyn), activity restrictions and physical therapy. Petitioner underwent 2 sessions of physical therapy through Concentra.

Petitioner reported to Dr. Tack, Respondent's Section 12 examiner, that he was unhappy with the treatment and recommendation he received from Concentra and this was the reason why he sought a second opinion with Dr. Wojewnik. (RX 5; PX 5) An MRI was completed on December 14, 2022 that revealed a disc bulge at L4-5 causing a slight mass effect on the left subarticular zone and a diffuse disc bulge eccentric to the left with superimposed central disc protrusion effacing the ventral thecal sac which are degenerative changes. (PX 5 pp. 104-105) Petitioner was placed on off work and underwent additional 6 weeks (12 sessions) of physical therapy that did not

improve his pain. (PX 5 pp. 75-113) A recommendation for epidural steroid injection had not been approved when Petitioner met with Dr. Tack on June 14, 2023. (RX 5) After reviewing the medical records thus far and completing physical examination of Petitioner including question and answer session, Dr. Tack opined that the medical evidence supported a diagnosis of lumbar sprain/strain superimposed upon pre-existing disc degeneration of L4-5 and L5-S1 and that this lumbar sprain/strain was related to the accident that occurred on November 29, 2022. (RX 5 p. 5) He further opined that there was no objective evidence that Petitioner would benefit from further treatment, thus, Petitioner was at MMI, and returned him to work without restrictions. (RX 5 p. 5)

Dr. Wojewnik responded to Dr. Tack's initial IME report on October 29, 2022. (PX 12) He believed that Petitioner had a work-related injury, specifically a lumbar strain with radiculopathy. He believed that the work-related accident aggravated a preexisting degenerative lumbar change and his recommendation consisted of injections at L4-5 and physical therapy. He opined that Petitioner would be at MMI after the injections and that if the symptoms persisted, an FCE is needed to assess permanent restrictions. (PX 12)

On January 31, 2024, Dr. Tack prepared an addendum to his IME report after reviewing additional medical records from Dr. Wojewnik dated June 20, 2023, from Dr. Buck dated August 30, 2023, from Gotlieb Hospital Emergency Room dated October 25, 2023, and from Dr. Buck dated November 13, 2023. (RX 15) Dr. Wojewnik on June 20, 2023, recommended an injection and found that if Petitioner did not have an injection, he would be at MMI. Dr. Buck on August 30, 2023 reviewed the MRI from December 14, 2022 and after speaking to Petitioner, recommended an injection at the L4-5 level. Petitioner was transported to the Emergency Room at Gotlieb Hospital on October 25, 2023 after he reported an acute exacerbation of low back pain when reaching over a shelf at Costco. Dr. Buck on November 13, 2023, performed an epidural steroid injection at the L4-5 level on Petitioner. Dr. Tack did not alter his previous opinion that Petitioner was appropriately diagnosed with lumbar sprain/strain superimposed upon preexisting degenerative change at L4-5 and L5-S1. (RX 15 p. 3) Dr. Tack explained that the incident at Costco is "merely represents a minor lumbar sprain/strain which has no relationship to previous occupational injury." (RX 15 p. 3) He concluded that Petitioner would not benefit from further treatment and found him to be at MMI, able to return to work without restrictions. (RX 15)

Petitioner then gets a second epidural injection on February 19, 2024 from Dr. Maciukiewics. (PX 5) On March 1, 2024, Petitioner undergoes lumbar spine x-rays that reveal minimal lumbar spondylosis and no dynamic instability. Petitioner informs Dr. Wojewnik the first injection helped for 2 weeks and the second injection "is still helping some." He was doing physical therapy and had urinary incontinence and was told to follow-up with neurology for urinary issues. Dr. Wojewnik found Petitioner at MMI and recommended a FCE and follow-up with Dr. Buck for chronic pain management. March 18, 2024 FCE report placed Petitioner at sedentary work only. Petitioner met with Dr. Wojewnik on March 29, 2024 who concluded that the FCE was valid and that Petitioner was not a surgical candidate and at MMI. (PX 5 p. 301)

Petitioner met with Dr. Coleman, Respondent's Section 12 examiner, on September 10, 2024. (RX 16) Dr. Coleman detected signs of symptom magnification when Petitioner exhibited "cogwheeling and give way weakness when tested for motor strength in the lower extremities." Objectively, Dr. Coleman found that the radiographs are within normal limits, an MRI report

indicated mild-to-minimal disc bulging without significant spinal stenosis, and the neurologic exam was essentially normal. Even though Petitioner claimed he felt a pop in his low back on November 29, 2022 and delayed onset of significant right lower extremity radiating pain, Dr. Coleman found that the x-rays and the MRI did not demonstrate any evidence of an acute traumatic condition. At most, Dr. Coleman opined that Petitioner sustained a minor lumbar sprain/strain which has long since resolved. He believed Petitioner's injury should have resolved within 6 to 12 weeks from the accident date since there were no complicating factors involved. Dr. Coleman also concluded that the emergency room visit on October 25, 2023 may have been further evidence of symptom magnification because reaching over a shelf at Costco would not be a sufficient mechanism to aggravate or cause a new lumbar disc herniation. Finally, Dr. Coleman disagreed with obtaining the FCE in the first place since Petitioner did not have a significant lumbar injury and believed that Petitioner had no objective reason to have any work restriction, and the examiner was swayed by Petitioner's subjective pain complaints.

Based on the above, there is no disagreement between the treating doctors and IME doctors that Petitioner aggravated a preexisting degenerative lumbar changes and stenosis that was asymptomatic before the injury and became symptomatic after the injury. The issue is how extensive is the injury and whether the current condition of ill-being is causally related to the accident that occurred on November 29, 2022.

The Arbitrator finds that Petitioner did have a work-related accident on November 29, 2022. The Arbitrator adopts the opinions of Drs. Tack and Coleman that Petitioner sustained a minor lumbar sprain/strain that have resolved. Dr. Tack diagnosed Petitioner with a lumbar sprain/strain superimposed upon pre-existing disc degeneration at L4-5 and L5-S1. He believed that there is no objective evidence to support alternative diagnoses based on Petitioner's medical records and physical examination that he conducted. Dr. Coleman found that the radiographs are within normal limits, an MRI report indicated mild-to-minimal disc bulging without significant spinal stenosis, and the neurologic exam was essentially normal. After reviewing the initial IME report from Dr. Tack, Petitioner's treating physician, Dr. Wojewnik also agreed that Petitioner had a lumbar strain along with radiculopathy and back pain. Petitioner underwent 3 rounds of physical therapy that was not helpful according to him. On June 14, 2023, Dr. Tack concluded that there was no objective evidence that Petitioner would benefit from further treatment, that Petitioner had reached MMI and returned him to work unrestricted. Dr. Coleman concluded that any injury that Petitioner sustained from the accident that occurred on November 29, 2022 would have resolved within 6 to 12 weeks.

It is for the reasons above, the Arbitrator finds that Petitioner did sustain a causally related injury, the injury was a minor lumbar sprain/strain that would have resolved within 6 to 12 weeks from the accident, and MMI on June 14, 2023 as opined by Dr. Tack.

Issue J, whether the medical services that were provided to Petitioner were reasonable and necessary and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

The Arbitrator adopts her findings of fact and conclusions of law contained above and incorporates them by reference as though fully set forth herein.

Section 8(a) of the Act states a Respondent is responsible “...for all the necessary first aid, medical and surgical services, and all necessary medical, surgical and hospital services thereafter incurred, limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury...” A 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 (2nd Dist. 1990).

Dr. Wojewnik diagnosed Petitioner with a lumbar strain along with radiculopathy and back pain and prescribed pain medication and physical therapy. Dr. Tack diagnosed Petitioner with a lumbar sprain/strain superimposed upon pre-existing disc degeneration at L4-5 and L5-S1. On June 14, 2023, he opined that the treatment Petitioner received thus far was reasonable. He concluded that there was no objective evidence to support that Petitioner would benefit from further treatment and found him to be at MMI on June 14, 2023. Dr. Coleman opined that the radiographs are within normal limits, an MRI report indicated mild-to-minimal disc bulging without significant spinal stenosis, and the neurologic exam was essentially normal. He diagnosed Petitioner with a minor lumbar sprain/strain as a result of the accident. He detected signs of symptom magnification during the physical examination when Petitioner “clearly exhibits cogwheeling and give way weakness when tested for motor strength in the lower extremities.” He further believed that the incident at Costco did not require an emergency visit to the hospital which may be further evidence of symptom magnification on the part of Petitioner. Dr. Coleman concluded that Petitioner would have been at MMI within 6 to 12 weeks from the accident.

The Arbitrator has already found that Petitioner sustained a causally related injury that should have resolved within 6 to 12 weeks from the injury. Dr. Tack found Petitioner at MMI on June 14, 2023. As such, the Arbitrator orders Respondent to pay for any treatment that Petitioner received up to June 14, 2023, pursuant to the medical fee schedule and Section 8(a) and 8.2 of the Act.

Issue K, whether Petitioner is entitled to any prospective medical care, the Arbitrator finds as follows:

The Arbitrator adopts her findings of fact and conclusions of law contained above and incorporates them by reference as though fully set forth herein.

The Arbitrator has already found that Petitioner sustained a causally related injury that would resolve within 6 to 12 weeks from the injury. Dr. Tack found Petitioner to be at MMI on June 14, 2023. As such, the Arbitrator finds that Petitioner is not entitled to any prospective medical care as provided in Section 8(a) and 8.2 of the Act.

Issue L, whether Petitioner is entitled to temporary total disability benefits, the Arbitrator finds as follows:

The Arbitrator adopts her findings of fact and conclusions of law contained above and incorporates them by reference as though fully set forth herein.

A claimant is temporarily totally disabled from the time an injury incapacitates him from work until such time as he is as far recovered or restored as the permanent character of his injury will permit. *Westin Hotel v. Indus. Comm'n*, 372 Ill.App.3d 527, 542 (1st Dist. 2007).

In determining whether a claimant remains entitled to receiving temporary total disability benefits, the primary consideration is whether the claimant's condition has stabilized and whether she is capable of a return to the workforce. *Interstate Scaffolding, Inc. v. Illinois Workers' Comp. Comm'n*, 236 Ill.2d 132, 148 (2010). Once an injured employee's physical condition stabilizes, she is no longer eligible for temporary total disability benefits. *Archer Daniels Midland Co. v. Indus. Comm'n*, 138 Ill.2d 107, 118 (1990).

The Arbitrator has already found that Petitioner sustained a causally related injury that was minor in nature which would have resolved within 6 to 12 weeks from the accident. Petitioner was found to be at MMI on June 14, 2023 by Dr. Tack. The medical records showed that Petitioner was placed on off-work on December 5, 2022.

Based on the above, the Arbitrator finds Respondent liable for 27 3/7 weeks of temporary total disability benefits (December 5, 2022 through June 14, 2023) at a weekly rate of \$475.98 to be paid directly to Petitioner. Respondent shall be given a credit of \$19,426.77 for temporary total disability benefit already paid.

It is so ordered:

Jennifer Bae

Arbitrator Jennifer Bae

JANUARY 29 2025

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	22WC007951
Case Name	Michael E Babicki v. Wujcik Construction
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	25IWCC0488
Number of Pages of Decision	34
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Mitchell Horwitz
Respondent Attorney	Jeffrey Rusin

DATE FILED: 12/9/2025

/s/Marc Parker, Commissioner

Signature

23 WC 12692

Page 1

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)
☐ Modify	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Babicki,

Petitioner,

vs.

NO: 22 WC 7951

Wujcik Construction,

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 causal connection, medical expenses, temporary total disability, wage differential benefits, and penalties/fees, and being advised of the facts and law, corrects the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision, which is attached hereto and made a part hereof.

In paragraph 4 of the Order, Arbitrator Amarilio awarded permanent partial disability benefits for 30 weeks, commencing November 4, 2023 through May 31, 2024 at \$983.40/week, because the injuries sustained caused total incapacity from pursuing his usual and customary line of employment resulting in an average wage loss of \$1,472.60 per week. In paragraph 5 of the Order, the Arbitrator awarded permanent partial disability benefits, commencing June 1, 2024, of \$1,025.07/week until Petitioner reaches age 67 or five year from the date of the final award because the injuries sustained caused total incapacity from pursuing his usual and customary line of employment resulting in an average wage loss of earnings of \$1,537.60 per week, as provided in Section 8(d)(1).

Although the Commission agrees with the Arbitrator's benefit periods and rates, we would replace "permanent partial disability benefits" in paragraphs 4 and 5 of the Arbitrator's

23 WC 12692

Page 2

Order with “wage differential benefits,” as the benefits were awarded pursuant to Section 8(d)(1), not Section 8(d)(2) of the Act. Moreover, we would add “as provided in Section 8(d)(1) of the Act” to the end of paragraph 4.

Furthermore, the fifth and sixth sentence of paragraph 4 on page 27 of the Arbitrator’s decision, should be revised to read “The accrued amount is \$1,025.07 for 38 5/7 weeks, totaling \$39,684.85,” and “The total amount accrued wage loss benefits owed under Section 8(d)(1) through February 26, 2025, is \$69,156.88,” to reflect the proper calculations.

The Commission finds these were clerical errors and modifies the Decision to reflect same.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 28, 2025, is hereby corrected as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner wage differential benefits for 30 weeks, commencing November 4, 2023 through May 31, 2024 at \$983.40/week, because the injuries sustained caused total incapacity from pursuing his usual and customary line of employment resulting in an average wage loss of \$1,472.60 per week commencing on November 4, 2023 and continuing through May 31, 2024, as provided in Section 8(d)(1) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner wage differential benefits, commencing June 1, 2024, of \$1,025.07/week until Petitioner reached age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused total incapacity from pursuing his usual and customary line of employment resulting in an average wage loss of earnings of \$1,537.60 per week commencing on June 1, 2024 and continuing thereafter for the remainder of the duration of his disability, as provided in Section 8(d)(1) 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 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.

23 WC 12692

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DECEMBER 9 2025

MP:ns

o 11/20/25

068

/s/ Marc Parker

Marc Parker

/s/ Maria E. Portela

Maria E. Portela

/s/ Christopher A. Harris

Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	22WC007951
Case Name	Michael E Babicki v. Wujcik Construction
Consolidated Cases	
Proceeding Type	Request for Hearing
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	30
Decision Issued By	Joseph Amarilio, Arbitrator

Petitioner Attorney	Mitchell Horwitz
Respondent Attorney	Jeffrey Rusin

DATE FILED: 4/28/2025

*/s/ Joseph Amarilio, Arbitrator*_____
Signature**INTEREST RATE WEEK OF APRIL 22 2025 4.05%**

GFSTATE 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**

Michael Babicki

Employee/Petitioner

v.

Wujcik Construction

Employer/Respondent

Case # **22** WC **007951**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was electronically mailed to each party. The matter was heard by the Honorable Joseph Amarilio, Arbitrator of the Commission, in the city of Chicago, Illinois, on February 26, 2025. 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

- 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?
- 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?

FINDINGS

On 09/26/2019, 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 \$20,260; the average weekly wage was \$1,582.81.

On the date of accident, Petitioner was 54 years of age, *married* with 2 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 \$59,818.25 for TTD, \$0 for TPD, \$0 for maintenance, and \$16,613.20 for other benefits, for a total credit of \$76,431.45.

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 \$1,055.21/week for 109- 6/7 weeks, commencing September 27, 2019 through March 10, 2020 and commencing January 18, 2022 through September 12, 2023, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of \$1,055.21/week for 7-3/7 weeks, commencing September 13, 2023 through November 3, 2023, as provided in Section 8(a) of the Act.

Respondent shall pay directly to Petitioner's Attorneys the amount of \$2,832.00 to Blumenthal and Associates for vocational services as well as the reasonable and necessary medical services of \$2,654.83 to DuPage Spine & Orthopedics, PLLC, and \$323.00 to Northwestern Medicine, pursuant to the medical fee schedule and as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits for 30 weeks, commencing November 4, 2023 through May 31, 2024 at \$983.40/week, because the injuries sustained caused total incapacity from pursuing his usual and customary line of employment resulting in an average wage loss of \$1,472.60 per week commencing on November 4, 2023 and continuing through May 31, 2024.

Respondent shall pay Petitioner permanent partial disability benefits, commencing June 1, 2024, of \$1,025.07/week until Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused total incapacity from pursuing his usual and customary line of employment resulting in an average wage loss of earnings of \$1,537.60 per week commencing on June 1, 2024 and continuing thereafter for the remainder of the duration of his disability, 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; \$0, as provided in Section 19(k) of the Act; and \$0, as provided in Section 19(l) of the Act because penalties and fees 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.

/s/ *Joseph D. Amarilio*

APRIL 28 2025

Signature of Arbitrator Joseph D. Amarilio

FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. PROCEDURAL HISTORY

Mr. Michael Babicki (Petitioner), by and through his attorney, filed an Application for Adjustment of Claim for benefits under the Workers' Compensation Act ("Act") (820 ILCS 305/1 et seq. (West 2014)). Petitioner claimed that on September 26, 2019 he sustained accidental injuries that arose out of and in the course of his employment with Wujcik Construction (Respondent).

A hearing proceeded on February 26, 2025 on the following disputed issues: (1) Whether Petitioner's current condition of ill-being is causally related to the injury; (2) Whether the medical services provided to Petitioner were reasonable and necessary. (3) Whether Petitioner is entitled to temporary total disability benefits. (4) Whether Petitioner is entitled to maintenance benefits. (5). The nature and extent of the injury. (6) Whether Respondent is entitled to credit. And (7) Whether Petitioner is entitled to penalties and attorney fees. The parties mutually requested a written decision, including findings of fact and conclusions of law. (Arb. Exhibit 1).

II. FINDINGS OF FACT

Petitioner's Testimony and Medical History

Petitioner is 60 years old, and lives in Niles, Illinois with his wife and two teenage children. He was 54 years old at the time of his work accident. He completed the equivalent of one year of college over a two-year period, during which he studied architecture. (Tx. 14-15). Petitioner was introduced to carpentry by his father and has worked as a carpenter for over thirty years (Tx. 15-16). After college, he began his carpentry career in 1984 with Kaepplinger Construction, working on home construction projects (Tx. 16-17). He has been a member of Carpenters Local 58 since 1986 (Tx. 17-18). Throughout his career, Petitioner has engaged in various types of carpentry work, including commercial projects, home remodeling, finish carpentry, and new home construction (Tx. 18; Tx. 74-75).

On September 26, 2019, Petitioner was employed by Respondent (Tx. 18-19). He had been working for Respondent for several years before his work injury (Tx. 19). In the performance of his duties, Petitioner used tools such as saws, drills, wood beams, joists, plywood, and drywall to perform general rough carpentry construction work on a new home (Tx. 19-22).

Respondent employed two laborers at the construction sites, although they were rarely present, as their primary responsibilities involved transporting materials and tools to other job sites (Tx. 20; Tx. 76). As a result, carpenters were often required to take on the laborers' tasks (Tx. 20-21; Tx. 76-77; Tx. 97), including moving heavy materials such as wood, plywood, and floor joists around the site, many of which weighed between 60 and 80 pounds (Tx. 22-23). Certain materials, like trusses, were too large and heavy to be lifted by a single carpenter—some weighing hundreds of pounds (Tx. 23; Tx. 80-81). According to Petitioner, the truss that fell on his foot measured approximately 30 feet in length, two feet in height, and one foot in width, with an estimated weight of over 1,500 pounds (Tx. 23-24).

Petitioner worked a standard schedule of five days a week, Monday through Friday, for eight hours each day, totaling 40 hours per week (Tx. 21). Petitioner testified that his regular daily job duties for the Respondent involved lifting between 50 and 100 pounds. He explained that his tasks included handling two-by-sixes and two-by-fours, as well as moving trusses approximately nine feet long, made up of multiple two-by-sixes. Petitioner also stated he was required to carry bundles of plywood weighing between 60 and 80 pounds. According to Petitioner, the truss that fell on his foot measured 30 feet in length and weighed around 1,500 pounds (Tx. 22-24).

Petitioner spent most of the workday either on his feet or knees, depending on the specific task. On average, he was in these positions for about seven hours each day, with a 30-minute lunch break and two 15-minute coffee breaks (Tx. 24-25).

On September 26, 2019, Petitioner along with several other carpenters were installing large floor joists which moved by a crane. (Tx. 26). While standing on top of a low knee wall to help guide a truss into position, Petitioner observed the other four carpenters struggling to maneuver it (Tx. 26-29). In the process, they pushed the truss forward too abruptly, causing it to strike the Petitioner's shin before sliding down and crushing his foot (Tx. 30-31). The truss came to rest on the upper middle portion of his left foot (Tx. 32). Though initially trapped, the Petitioner struggled to free himself but eventually managed to pull his foot free (Tx. 32-34).

Petitioner left work and sought treatment at Physicians Immediate Care, reporting pain in the left foot following the crush injury (Tx. 37). X-rays taken on the day of the incident revealed a non-displaced fracture of the second metatarsal, a spiral fracture, an angulated fracture, a Lisfranc fracture, and associated soft tissue swelling (Tx. 37-38; Px. 3).

On September 30, 2019, Petitioner began treatment with Dr. Kevin M. Koutsky. (Tx. 38; Px. 1, 4-5). On October 28, 2019, Dr. Koutsky obtained additional X-rays of the left foot, which revealed healing fractures of the second and third metatarsals (Px. 1, 6). At that time, Dr. Koutsky removed Petitioner from work duties and prescribed the use of a CAM boot (Tx. 38, 84; Px. 1, 6).

On November 18, 2019, a third set of X-rays showed continued healing of the same metatarsals (Px. 1, 7). Later that month, Petitioner was placed on sedentary work restrictions and began physical therapy at ATI Physical Therapy (Tx. 38, 84-85; Px. 1, 7; Px. 4).

On March 9, 2020 was seen by Dr. Koutsky for a post work conditioning follow up visit.. Petitioner reported improvement in his left foot and that he has been doing exercises on his own at home after completing work conditioning. He had been released with sedentary restrictions, but he is hoping to return to work unrestricted. He still was taking anti-inflammatories on an as-needed basis. On physical examination, his left foot had minimal tenderness. Ankle range of motion was near normal with dorsiflexion and plantar flexion. He was released to unrestricted work and declared at maximum medical improvement work. Dr. Koutsky, however, prescribed a refill of anti-inflammatories and left his appointment open. (Px. 1, 11).

Petitioner returned to work following his release but experienced significant pain in his left foot (Tx. 43). After working for only a day and a half, Respondent laid him off (Tx. 43, 86). Petitioner

was fine with being laid off due to Covid as he needed some time for his foot to rest. Petitioner has not returned to work as a carpenter since that time (Tx. 43, 56).

From March 2020 until his follow-up visit in December 2021, he continued to experience pain in his foot with no noticeable improvement. He said that the pain worsened with standing and walking for extended periods of time, and as a result, he had to walk on the outside edge of his left foot to manage the discomfort (Tx. 44).

On December 21, 2021, Petitioner returned to Dr. Koutsky, reporting ongoing chronic pain in his left foot (Px. 1, 80-82). Dr. Koutsky ordered an MRI, which revealed healed fractures of the second and third metatarsals, along with advanced midfoot arthropathy and significant joint space narrowing at the tarsal-metatarsal articulations—particularly involving the first, third, and fourth TMT joints (Px. 6). Dr. Koutsky attributed these findings to the work-related injury and recommended treatment including physical therapy and orthotics (Tx. 45-46; Px. 1, 97-98).

On January 18, 2022, Petitioner was seen by Dr. Koutsky for chronic left foot pain, history of multiple metatarsal fractures stemming from a September 2019 work injury. Dr. Koutsky prescribed continuing physical therapy for range of motion and strengthening. He also prescribed custom foot orthotics and released him with sedentary/sitting restrictions. Px. 1, 90-91).

On February 15, 2022, Petitioner returned to Dr. Koutsky, who recommended restricting him to sedentary work with minimal walking (Px. 1, 99). Dr. Koutsky officially released Petitioner from his medical care in June 2022 (Tx. 47, 90; Px. 1, 80-112).

Report of Dr. Kevin M. Koutsky (Px 5) : On May 25, 2022 Dr. Koutsky authored a opinion letter at the request of Petitioner’s attorney. Dr. Koutsky noted that Petitioner was wearing his orthotics and that he prescribed an FCE once he completes his physical therapy. Petitioner sustained crush injury to the left foot involving fractures of the second and third metatarsal. The treatment included foot immobilization, physical therapy, medications, as well as custom orthotics for his feet.

Dr. Koutsky opined that Petitioner’s current condition of ill-being was causally and directly related to the work-related injury of September 26, 2019. He noted that there may have been an aggravation of some of his pre-existing degenerative conditions, however, his current condition of chronic foot pain, soft tissue injury, and fracture deformity is directly related to the work injury. Petitioner was restricted from performing his usual obligations as a carpenter from the time of the accident.

Although he was released without medical restrictions for return to work on March 9, 2020, Petitioner said he continued to experience significant pain and discomfort in his foot which precluded him from working unrestricted. Pursuant to the dictionary of occupational titles, carpenter work is considered heavy to very heavy. Dr.. Koutsky noted that although he was released without restrictions, his ongoing symptoms prevented him from performing his usual job responsibilities unrestricted. Given his ongoing complaints, he was later released with sedentary work only. The sedentary physical restrictions given were causally and directly related to the September 26, 2019 work injury. After completing the physical therapy and rehabilitation, he was

considered at maximum medical improvement. However, his condition of chronic foot pain, arthropathy continued to progress.

With regards to his current condition, Dr. Koutsky noted that the MRI scan revealed well healed metatarsal fractures with some deformity and arthropathy. Further, Petitioner complained of nerve pain in his foot due to the crush/soft tissue component of his injury. Unfortunately, chronic nerve pain cannot easily be identified objectively with testing.

With regards to future treatment, Dr. Koutsky opined that if his symptoms continued to deteriorate, he may benefit from surgical fusion of the midfoot. At the very least, he will likely require medication, courses of physical therapy, as well as regular replacement of foot orthotics. His prognosis was guarded. Assistive devices to help with activities of daily living would include his custom orthoses. Further, he may require a cane for ambulation if his symptoms continue to deteriorate. His orthotics are designed to distribute the stresses more evenly along the bottom of the foot upon standing and ambulation. Lastly, it is likely the patient has permanent physical impairment as it relates to the work injury. A functional capacity evaluation would be a reasonable tool in order to determine more accurately his functional capabilities at this time. Dr. Koutsky specifically stated that his opinions were made within reasonable degree of medical and surgical certainty. (Px 5, 9-11).

Functional Capacity Evaluation (Px7): On June 13, 2022, Petitioner underwent a Functional Capacity Evaluation (FCE) (Px. 7, Px 1 119-125). The FCE was considered valid. The evaluator concluded that Petitioner demonstrated the ability to perform within the medium physical demand category and partially into the heavy physical demand based on the definitions developed by the US Department of Labor and outlined in the Dictionary of Occupational Titles, which is below his jobs demand category. Petitioner may be able to work full time within the functional abilities within the medium physical demand category, which is below his jobs demand category. The evaluator noted his job as a Construction Worker is classified within the heavy Physical Demand Category based on the DOT description.

Based on the totality of the evidence, the Arbitrator agrees that as a construction union carpenter Petitioner's physical demand level is at the heavy demand level, as corroborated by the work he performed that caused his injury. During objective functional testing, Petitioner demonstrated consistent effort throughout 100.0% of this test which would suggest Petitioner put forth full and consistent biomechanical and evidence-based effort during this evaluation. Throughout objective functional testing, Petitioner reported reliable pain ratings 85.7% of the time, which would suggest that pain that pain could have been considered a limiting factor during testing.

The FCE evaluator determined that Petitioner qualified for work within the medium physical demand category, with the additional restriction of only occasional walking while carrying 30# weight on shoulder with tool belt (Px. 7). The FCE evaluator concluded that based on the Lower Extremity Functional Scale, Petitioner's left lower extremity function to be 55% of normal. Normal being able to hop, run and jump. Based on the FCE results, Dr. Koutsky released Petitioner to work within those specified functional limitations of the FCE findings. (Px. 7; Px. 1, 129).

Supplemental Report of Dr. Koutsky (Px 7): On July 16, 2022, Dr. Koutsky authored an supplemental report after reviewing the ATI records, the June 13, 2022 FCE report, the incident report, and a job description of a rough carpenter. Dr. Koutsky noted that after completing his treatment, Petitioner was released on March 9, 2020 to unrestricted work. But, unfortunately, over the years his foot pain and ability to function deteriorated. Dr. Koutsky adopted the restrictions outlined on the most recent functional capacity evaluation of June of 2022. Dr. Koutsky pointed out that the functional abilities of Petitioner's most recent FCE are less than his level of functioning on the March 2, 2020 ATI discharge summary. Because Petitioner's condition has deteriorated, Dr. Koutsky deferred to the most recent functional capacity evaluation of June of 2022 to outline Petitioner's functional capabilities going forward. His current restrictions are causally and directly related to his work injury. Dr. Koutsky noted that his opinions were rendered within a reasonable degree of medical and surgical certainty. (Px2, 134-135).

Report of Dr. Anish R. Kadakia (Px 11): On August 5, 2022, Dr. Kadakia authored a report at the request of Petitioner's attorney. Dr. Kadakia recorded that on November 15, 2023, Petitioner appeared before him complaining of continuing pain and looking for treatment options. Petitioner reported that a 1000-pound truss initially struck his tibia, then slid onto the dorsal aspect of his foot in 2019. During external rotation, he sustained a twisting injury to his midfoot while there was an existing dorsal load. In the records supplied, there is evidence that the stated weight is 300-400 pounds, regardless the amount of weight is significant with either amount to cause the injury described. This was further exacerbated by his foot resting on a small wood platform while sustaining the dorsal/axial load. The MRI scan of the left foot was performed on January 10, 2022. Evidence of healed fracture deformities of the second and third metatarsal shaft were noted. No acute fracture-foot arthropathy noted. Lisfranc ligament was intact. Flexor and extensor tendons were unremarkable.

On June 2, 2023, returned to Dr. Kadakia. Petitioner continued to report pain localized to the dorsal midfoot, which remained consistent with previous evaluations. His physical examination was unchanged. Dr. Kadakia has recommended a midfoot fusion involving the 1st, 2nd, and 3rd tarsometatarsal joints, utilizing two surgical approaches. He advised him that while this procedure may alleviate pain and allow for walking, biking, and use of an elliptical, he will not be able to run, jump, or engage in high-impact activities again. As with any surgical intervention, there are no guarantees of success. At this time, he remains unable to return to work, and Dr. Kadakia did not anticipate Petitioner's return to full-duty employment. If the fusion is performed, a return to light duty may be possible.

Summary of the imaging reviewed by Dr. Kadakia

MRI reviewed along with radiographs from September/October and November 2019. When reviewing of the images - the foot left side, there is clear evidence on the September x-rays of a 2nd metatarsal fracture - these are non-weightbearing. CT - there is healing of the 2nd, 1st TMT has evidence of a dorsal fracture of the 1st metatarsal - clear to see on the oblique and the lateral. November - more obvious - again non-weightbearing - so this makes a ligamentous Lisfranc impossible to evaluate. Dr. Kadakia could see the fracture of the 1st with arthritis changes already occurring. MRI was clear - Jan 22 - post-traumatic arthritis 1st/2nd/3rd with dorsal avulsion fracture 1st met and dorsal medial cuneiform. Most severe on the 1st - and when reviewing the Sept Xray -

there was no arthritis of the 1st TMT - and the only logical conclusion that can be drawn is that the trauma - resulted in a Lisfranc injury that predictably led to arthritis. Although the Lisfranc ligament was normal - there is a fracture of the 2nd - and the MRI clearly shows the changes to the 1st/2nd/3rd TMT joint with articular incongruity - subchondral cysts and post-traumatic changes.

Dr. Karakia's Report Summary

Dr. Kadakia found clear evidence of a traumatic injury to the midfoot on the left with now clear evidence of midfoot arthritis of the 1st, 2nd and 3rd tarsometatarsal joints. Evidence of the midfoot arthritis being quite clear on the current imaging and consistent with his examination. The history described is consistent with what is found in the medical records – with regards to a heavy crush injury to the foot with multiple metatarsal fractures – near the tarsometatarsal joints. The obvious fractures – of the 2nd and 3rd did not directly enter the joint.

However, when a detailed review of the x-rays are done – one can see the dorsal injury to the 1st metatarsal – there is evidence of a small intra-articular injury to the dorsal 1st metatarsal on the 10/28/2019 image. This is difficult to visualize on the September 26, 2019 images, however, the x rays are not in the same orientation. In many cases - small avulsion fractures become easier to see over time because of the natural osteolysis that occurs at a fracture.

There is lucency within the proximal 1st metatarsal consistent with an injury to that bone – that is consistent with the natural evolution of a fracture – this clearly involves the 1st TMT. More obvious on the November 18, 2019 – one can see the progression of the post-traumatic damage to the joint with spurring of the dorsal 1st TMT, with loss of the articular congruity.

Given that this was not there at the initial x rays, the only logical conclusion that can be drawn is that the damage from the truss – not only fractured the 2nd and 3rd metatarsal, but clearly injured the 1st TMT joint causing the arthritic changes that are now seen on the MRI but are also clearly seen on this set of x rays.

Even if there was some pre-existing arthritis – there is clear and rapid progression over the short course of the x rays taken with radiographic evidence of damage to the 1st metatarsal at the 1st TMT joint. The MRI of January 10, 2022 shows the extent of the arthritis of the 1st TMT, this is not in question. What can be easily seen on the sagittal imaging is the damage to the dorsal 1st metatarsal and the medial cuneiform.

The damage to the joint and the base of the 1st metatarsal correlates exactly to the findings on the Xray. Consistent with a healed fracture of the proximal 1st metatarsal now with post-traumatic arthritis. The 2nd TMT has clear evidence of arthritis – was fractured slightly distal to the joint, but the trauma injured the joint with resultant arthritis, the third TMT is arthritic as well.

Although the Lisfranc ligament is intact on the MRI, and this can be a point of confusion - a Lisfranc injury – is a description of damage to the midfoot from trauma. There are variants – and in this case from a direct trauma– there is direct damage to the joints that caused the post-traumatic arthritis and this is not from a ligamentous instability pattern.

Dr. Kadakia opined that Petitioner's current condition of ill being is causally and directly related to the work-related injury of September 26, 2019. There may have been an aggravation of some of his pre-existing degenerative conditions, however his current condition of chronic foot pain, soft tissue injury, and fracture deformity is directly related to the work injury.

Dr.. Kadakia noted that although Petitioner was released without medical restrictions for return to work in March 2020, Petitioner continued to experience significant pain and discomfort in his foot which precluded him from working unrestricted. Pursuant to the dictionary of occupational titles, carpenter work is considered heavy to very heavy..

With regards to future treatment, if his symptoms continue to deteriorate, he may benefit from surgical fusion of the midfoot. At the very least, he will likely require medication, as well as regular replacement of foot orthotics. His prognosis is guarded and further progression of the post-traumatic arthritis is expected with worsening pain and deformity (large dorsal osteophytes) that may make shoe wear more difficult. Assistive devices to help with activities of daily living would include his custom orthoses. Further, he may require a cane for ambulation if his symptoms continue to deteriorate. Dr. Kadakia noted that his opinions are to a reasonable degree of medical and surgical certainty as a board-certified orthopedic surgeon. (Px 11).

Section 12 Examination of Dr. Hythem P. Shadid: On August 29, 2022, Dr. Shadid conducted a Section 12 Examination of Petitioner at the request of Respondent. While Dr. Shadid confirmed the diagnosis of arthritis Petitioner's foot, he concluded that the arthritis was not causally related to the work accident. At the time of the evaluation, Dr. Shadid documented that Petitioner's pain rated at a 4 out of 10 and he had left mid foot pain after a couple hours of standing and walking (Rx. 5). On examination, Petitioner had a normal gait and full range of motion and strength. In regard to the mechanism of injury, Dr. Shadid agreed that the accident caused the fractures to the 2nd and 3rd metatarsals, but Dr. Shadid noted that those fractures had healed. Dr. Shadid opined that Petitioner's current complaints related to the 1st metatarsal and TMT joint are unrelated to the September 26, 2019 accident as those symptoms did not occur until approximately 652 days after Petitioner was released to return to full duty work. Dr. Shadid opined that there is no causal relationship between the current symptoms of 1st TMT degenerative joint disease and the work accident. Dr. Shadid opined that Petitioner sustained fractures to the 2nd and 3rd metatarsals which he received appropriate treatment and was discharged at maximum medical improvement with a full duty release on March 9, 2020. Dr. Shadid opined that Petitioner required no additional treatment and was capable of returning to full duty work. (Rx 5).

Dr Koutsky's review of Dr. Shadid's report: On October 17, 2022, Petitioner was seen by Dr. Koutsky for evaluation. Dr Koutsky noted that he reviewed the independent medical evaluation authored by Dr. Shadid on August 29, 2022. Dr. Koutsky annotated Dr. Shadid's report and noted that five of Dr. Shadid's conclusions were "false". (Px1, ppl 141-154)., Dr. Koutsky concluded that "Dr. Shadid's history of the patient appears to be inaccurate. There is no past medical history of hypertension, stroke, or coronary artery disease. I disagree with his opinion that the patient's diagnosis is simply first TMT joint osteoarthritis. Clearly, the patient has multiple TMT joint arthritis due to his history of multiple metatarsal fractures. Fortunately, his fractures have healed with solid union. Further, and in addition, the patient sustained a crush injury to his foot and soft

tissues which has not completely resolved. It is likely he will continue to experience pain on a permanent basis. Lastly, I disagree with Dr. Shadid's opinion that the patient can return to work unrestricted. The patient does have limitations with regards to his chronic foot pain. He is released per the functional capacity evaluation restrictions. This would be considered standard care following a crush injury to the foot, including multiple metatarsal fractures. The patient is currently using custom orthoses. The need for custom orthotics also would be considered standard care for his injury, as well as both causally and directly related to his work injury." (Px 1, 159).

On October 14, 2022, Respondent arranged a second Section 12 Examination, this time with Dr. Toolan. (Rx. 6). Dr. Toolan diagnosed Petitioner with advanced osteoarthritis in the midfoot, specifically affecting the first, third, and fourth TMT joints, and opined that the condition was not related to the work injury (Rx. 6). However, in his report, Dr. Toolan noted that a review of the X-ray and MRI images might have led him to a different conclusion (Rx. 6).

Dr. Koutsky referred Petitioner to Dr. Anish Kadakia, who evaluated him on November 15, 2022 (Tx. 46, Px. 2, 9-10). During this visit, Dr. Kadakia diagnosed the Petitioner with midfoot arthritis accompanied by post-fracture healing changes throughout the midfoot and noted a widening at the Lisfranc joint (Px. 2, 9-10). He attributed the arthritis to fractures in the tarsometatarsal (TMT) joints, including the Lisfranc joint, as well as fractures in the first through fourth metatarsals (Px. 2, 9). Notably, Dr. Kadakia was the first physician to identify a fracture in the first metatarsal upon reviewing the initial x-rays taken at the time of and following the accident.

Dr. Kadakia discussed both surgical and non-surgical treatment options, including recommending a midfoot fusion (Tx. 49, Px. 2, 9-10). Petitioner chose not to undergo surgery (Tx. 49-50), and Dr. Kadakia subsequently cleared him for sedentary work (Tx. 50).

Currently, Petitioner is only able to stand for approximately one-third of the day (Tx. 51). When he exceeds this limit, the pain in his left foot increases significantly, prompting him to rest. (Tx. 51-52). Prior to September 2019, Petitioner had not sustained any serious injuries to his left foot and was capable of performing strenuous manual labor (Tx. 55-56). He has not experienced any reinjury to the left foot since the initial incident in September 2019 (Tx. 56).

Respondent's Section 12 Examinations by Dr. Brian Toolan

Quick Report of Dr. Toolan (Px 8) dated 10/31/2023): In his quick report, Dr. Toolan rendered his provisional diagnosis of post traumatic left midfoot arthritis and left foot post-traumatic foot deformity. He opined that Petitioner was able to return to work on a secondary duty basis and had not reached maximum medical improvement. He further opined that Petitioner's diagnosis and treatment were causally related to his work accident. He recommended a CT scan of Petitioner's left foot and opined that a midfoot arthrodesis (fusion surgery) was possible.

First Report of Dr. Toolan (Rx 6): Dr. Toolan examined Petitioner for the first time on October 14, 2022. Unlike his quick report, Dr. Toolan opined that Petitioner's current condition of ill-being was advanced osteoarthritis of the midfoot unrelated to the accident.. Dr. Toolan opined that the tarsometatarsal joint arthritis is not causally related to the work accident. Dr. Toolan opined that the absence of documentation of any tarsometatarsal joint injury after the 9/26/19 is

significant. Dr. Toolan noted the absence of complaints nor physical examination findings related to the tarsometatarsal joint. Dr. Toolan noted that there is no documentation of complaints, physical examination findings, or radiographic evidence of an injury or pathology to the 1st tarsometatarsal joint. Further, Dr. Toolan opined that based upon the FCE, Petitioner would be capable of returning to full duty work as a carpenter (Rx. 6).

Second Report of Dr. Toolan (Rx 7):

Dr. Toolan conducted a follow-up examination of Petitioner on October 31, 2023 (Rx. 7). Dr. Toolan recorded that on September 26, 2019, Petitioner injured his left foot while building out the second floor of a building. He was participating in the placement of a large truss to be the foundation of the second floor of the building. Petitioner reported that the truss struck the medial upper aspect of his left leg and subsequently shifted and fell on top of his left forefoot. His left foot was pinned beneath the truss and against a 2" x 6" temporary floor beam he was standing on to place the truss. Only his forefoot was standing on this 2" x 6" beam and only his forefoot was pinned. Petitioner reported that he was able to gradually pull and slide his foot out from beneath the truss and, in the process, felt a crack in his left forefoot.

Dr. Toolan noted that weightbearing x-rays of the left ankle 3 views, and left foot 4 views were obtained at this encounter of October 31, 2023.. The x rays demonstrated severe arthritis of the 1st tarsometatarsal joint and mild arthritis of the 2nd and 3rd tarsometatarsal joints and healed fractures of the 2nd and 3rd metatarsals. The ankle x-rays demonstrated a well-preserved ankle articular surface without appreciable arthritis. Dr. Toolan also noted a bony exostosis at the medial malleolus which may represent the sequelae of a superficial deltoid ligament.

At Respondent's request, Dr. Toolan attempted to obtain a detailed history from Petitioner regarding his duties and requirements as a carpenter. Dr. Toolan reported that Petitioner provided limited information. He did not quantify the specific amount or frequency of the things he lifted at work or specific tasks that he performed as a carpenter. Petitioner acknowledged that he was working as a carpenter prior to his work-related injury and returned to work as a carpenter when he was released on March 9, 2020 for two days. .

Dr. Toolan diagnosed Petitioner with healed fractures of the 2nd and 3rd metatarsals, along with degenerative arthritis of the 1st tarsometatarsal (TMT) joint. He reiterated his opinion that the 1st TMT joint arthritis was not caused by the work-related incident. Dr. Toolan reviewed certain medical records but he did not review of the prior the x-ray or MRI images of the left foot reviewed by Dr. Kadakia. Dr. Toolan found it significant that Dr. Koutsky had released Petitioner to return to full-duty work at maximum medical improvement (MMI), and that Petitioner did in fact resume work as a carpenter in March 2020—stopping two days later due to the onset of the COVID-19 pandemic (Rx. 7).

Dr. Toolan responded to Dr. Kaz' report and detailed his disagreements with Dr. Kaz' conclusions on causation and pathology, offering an anatomical and pathological analysis to support his own views. After reviewing Dr. Kaz' report, Dr. Toolan maintained that Petitioner's current 1st TMT arthritis is not causally related to the original injury.(Rx8)

Specifically, Dr. Toolan disputed Dr. Kaz’ assertion that Petitioner sustained a crush injury. Dr. Toolan defined a crush injury as resulting from a high-energy, high-load compressive force that severely disrupts the bones and joint structures, as well as the arches of the foot, leading to immediate deformity and functional loss. Dr. Toolan reiterated his prior opinion that Petitioner did not sustain such an injury.

Consistent with his October 2023 report, Dr. Toolan , unlike Dr. Shadid, and like Dr. Koutsky, Dr. Kaz and Dr. Kadakia, concluded that Petitioner was not fit to return to full-duty work—whether at medium or heavy physical demand levels. He opined that Petitioner had not reached MMI and recommended an arthrodesis of the tarsometatarsal joints, followed by postoperative physical therapy and work conditioning, after which Petitioner’s work capacity should be reassessed. (Rx8).

Video Surveillance –Respondent Exhibit 10: Petitioner confirmed that he was the individual shown in the surveillance footage. The Arbitrator reviewed six days of surveillance recorded in August and October 2024 most of which were in the morning and notes that Petitioner did not appear to display any significant gait abnormalities or pain-related behavior. However, the surveillance clips are brief and depict only a limited range of activities of daily living. On October 5, 2024, Petitioner was observed standing for over 50 minutes while watching his son’s soccer game. During this period, he moved around the soccer field area without showing any obvious signs of difficulty or physical limitation. And yet, none of the videos contradict the findings of the FCE or Petitioner’s testimony about experiencing foot pain after prolonged standing. Furthermore, no footage shows Petitioner standing or walking continuously for an extended period. The FCE evaluator noted that Petitioner complained of left foot pain after standing and walking after one-third of the day.

As a warning the viewer, parts of the video may be challenging to watch for those prone to motion sickness due to its unsteady, jerky camera movement—reminiscent of the filming style in *The Blair Witch Project*. Despite this, the Arbitrator carefully reviewed the video surveillance in its entirety and would have been grateful if the Respondent’s investigator had utilized camera stabilization to prevent the jittery video motion.

Vocational Counselors: In November 2023, Petitioner met with vocational counselor Steven Blumenthal, who opined that Petitioner no longer possesses the physical capabilities to be a carpenter (Tx. 57). Since the accident, Petitioner has not applied for other jobs, as he has struggled to find a position allowing him to sit for most of the day (Tx. 61; Tx. 95). It was Petitioner’s intention to continue working with and retire as a union Carpenter (Tx. 57). Had Petitioner been able to continue his career as a carpenter he would have earned \$52.01 an hour from June 1, 2022 to May 31, 2023, \$53.51 an hour from June 1, 2023 to May 31, 2024, and \$55.11 an hour from June 1, 2024 to May 31, 2025, according to the Carpenters' Wage Scale from the Mid-American Carpenters Regional Council (Px. 18, Tx. 58-60). *See infra*.

Petitioner also appeared before Jacqueline Bethell, a vocational expert, at Respondent’s request. Ms. Bethell generated two labor market surveys as reviewed further *infra*.

Current Condition: In his daily routine, the Petitioner has noticed that his foot shows no signs of improvement. He continues to experience persistent pain that extends from his ankle to his foot

after prolonged periods of standing, with the discomfort worsening the longer he remains on his feet (Tx. 61-62). To manage the pain, he relies on custom orthotics, adjusts his walking by using his heel or the edge of his foot, shifts most of his body weight onto his right foot, and takes breaks as necessary (Tx. 63-64; Tx. 95).

Before his work accident, the Petitioner was an avid runner and regularly did household chores (Tx. 67-68). However, since the accident, he is unable to perform many of the physical tasks he previously could (Tx. 67-68). Today, if he attempted to engage in similar activities, the Petitioner mentioned, "I probably wouldn't move much the following day" (Tx. 68-69).

Evidence Deposition of Dr. Anish Kadakia

The evidence deposition of Dr. Anish Kadakia proceeded on September 12, 2023 (Px. 12, 1:10-18). Dr. Kadakia is a board-certified orthopedic surgeon with a specialized practice in foot and ankle care. He is a full-time professor of Orthopedic Surgery and Fellowship Director of Foot and Ankle Orthopedics at Northwestern's Feinberg School of Medicine (Px. 12, 5-7:20-5, Px Dep. Ex. 1).

Dr. Kadakia evaluated Petitioner on two occasions, on November 15, 2022 and June 2, 2023, and reviewed all relevant x-rays and medical records to author a narrative report dated August 5th, 2023 (Px. 12, 14-15:7-9).

Dr. Kadakia reviewed the x-ray images from September, October and November 2019 and marked them with his findings. The x-ray images show the healing progression of a second metatarsal fracture, a fracture on the dorsal aspect of the cuneiform, and a fracture fragment on the first TMT joint (Px. 12, 16-18:11-14). He explained that the increase in bone density and callus formation at the second metatarsal and first cuneiform indicate new bone growth and early signs of healing from a trauma injury (Px. 12, 19-22:19-18). Dr. Kadakia explained that if there was no injury, there would be no changes or obvious signs of healing in the X-ray images (Px. 12, 18:15-21).

Petitioner's first metatarsal injury is intra-articular Lisfranc injury, which refers to an injury within the joint and affects the stability of the joint (Px. 12, 22-25:19-2). The injury affects the Lisfranc complex which consists of two bones, the medial cuneiform and the first metatarsal (Px. 12, 24:2-9). Dr. Kadakia clarified that the second metatarsal injury is not a Lisfranc injury since it is extra-articular, describing it as a metatarsal shaft fracture that does not affect the joint (Px. 12, 25:3-13). While Petitioner's treating physician Dr. Koutsky and an MRI from January 2020 identify a second and third metatarsal fracture, Dr. Kadakia does not note any fracture on the third metatarsal (Px. 12, 25-26:14-6; Px. 12, 31-33:21-5; Px. 12, 33-34:13-24). Although he does not specifically mention a fracture, Dr. Kadakia notes damage to the third TMT joint (Px. 12, 35:16-22). This damage likely suggests a small, healed injury to the lateral cuneiform, accompanied by arthritic changes in the area (Px. 12, 35-36:22-2).

In the October 28, 2019 X-ray images, Dr. Kadakia observed healing in the second metatarsal fracture with callus formation (Px. 12, 28:2-11). He also noted callus formation in the first metatarsal, clearly indicating an injury in that area, as the new bone growth is a natural response

and not present elsewhere in the body (Px. 12, 28:12-22). Dr. Kadakia identified osteolysis at the base of the first and second metatarsals, which show a healing fracture (Px. 12, 29:1-20).

Dr. Kadakia found articular incongruity at the joints, indicating an abnormal joint shape often resulting from trauma (Px. 12, 36-37:12-2). Dr. Kadakia opined that the trauma sustained by the Petitioner's foot is a contributing factor to the articular incongruity he observed (Px. 12, 37-38:13-13).

Dr. Karakia's diagnosed Petitioner with post-traumatic arthritis to the midfoot including the first, second, third and fourth TMT joints, which he stated is related to the work accident on September 26, 2019 (Px. 12, 41-42:13-5; Px. 12, 94:8-12). Dr. Kadakia opined that the progression of the arthritis and changes in the X-rays from the initial injury until 2022 confirm the diagnosis is from a traumatic injury to the joint and the bones at the first, second, third and fourth TMT joint (Px. 12, 42:6-15; Px. 12, 91:9-16). The arthritis was not present when the injury occurred, and likely developed due to the articular incongruity in the Lisfranc area (Px. 12, 38-39:5-16). Dr. Kadakia explained that the location of the pain and tenderness correlates directly with where the imaging shows post-traumatic arthritis (Px. 12, 90-91:22-8). While it took time for the post-traumatic arthritis to develop, that is consistent with the nature of post-traumatic arthritis in a Lisfranc injury (Px. 12, 93-94:12-7).

Dr. Kadakia prescribed permanent restrictions of sedentary duty (Px. 12, 44:14-19). Upon review of the FCE, it was Dr. Karakia's opinion that sedentary duty accurately reflects Petitioner's capabilities (Px. 12, 44-45:20-19). Although Petitioner can perform medium-duty work on a good day, his foot deformity and pain make it more appropriate for him to have sedentary restrictions (Px. 12, 45:8-12).

Dr. Kadakia reviewed Dr. Shadid's Section 12 Examination report, where Dr. Shadid stated that the left foot joint osteoarthritis is unrelated to the September work accident, as the injury affected a different area of the foot, not the first TMT joint (Px. 12, 46: 2-11). Dr. Kadakia disagreed, calling it disingenuous to claim that the second and third TMT joints are in a different region, as they are only millimeters apart and part of the same foot complex (Px. 12, 47:1-16). While arthritis can be a degenerative and idiopathic condition, Dr. Kadakia stated that the X-rays do not indicate degenerative arthritis, as it would have been visible in the 2019 X-rays (Px. 12, 48-50:21-14; Px. 12, 68:19-22). Dr. Kadakia clarified that Dr. Shadid's claim—"there is no medical basis that metatarsal fractures cause TMT arthritis"—is incorrect (Px. 12, 51:12-16). While this may apply to extra-articular fractures, the first metatarsal injury was intra-articular (Px. 12, 51-52:17-18).

Dr. Kadakia states that all medical treatment Petitioner has received to date has been reasonable, necessary, and related to the accident of September 26, 2019 (Px. 12, 42:16-23). Regarding future treatment Dr. Kadakia recommended a fusion would be appropriate surgical treatment should Petitioner seek that option (Px. 12, 43-44:3-5).

Evidence Deposition of Dr. Ari Kaz

The deposition of Dr. Ari Kaz proceeded on February 19, 2025 (Px. 14, 1:10-16). Dr. Kaz is a board-certified orthopedic surgeon (Px. 14, 5:1-5). Dr. Kaz completed a residency in orthopedic

surgery and a fellowship in orthopedic foot and ankle surgery; he dedicates much of his practice to foot and ankle orthopedic treatment (Px. 14, 6:11-18).

Dr. Kaz has treated patients with metatarsal fractures, which are bones located in the middle of the foot, linking the toes to the rest of the foot (Px. 14, 4-9). These bones aid in transferring weight from the ankle to the front of the foot, contributing to stability and propulsion during weight-bearing activities (Px. 14, 8:10-15). A metatarsal fracture can result from crush injuries, twisting injuries, or falls (Px. 14, 8:16-22). Dr. Kaz typically diagnoses fractures with a plain x-ray and will treat fractures either with immobilization and protection of the fracture with a boot or cast, or with surgery (Px. 14, 9:2-19).

Dr. Kaz prepared a narrative report regarding his opinions on the treatment of Petitioner on January 6, 2025 (Px. 14, 14-15:5-18). Dr. Kaz reviewed the X-ray images from September, October, and November 2019 and explained that the September 2019 X-ray clearly showed a mildly displaced fracture in the proximal shaft of the first, second and third metatarsal, and a nondisplaced third metatarsal shaft fracture (Px. 14, 18-19:19-22). In the oblique view, he identified a second metatarsal shaft fracture and an abnormal finding of a spur or fracture on the first cuneiform (Px. 14, 19-20:24-9).

In the October 2019 X-ray images, Dr. Kaz observed callous formation at the second metatarsal, increased density in the first metatarsal, and in increased bone formation in the second metatarsal (Px. 14, 22-23:23-15). The October X-ray oblique view clearly shows a difference in the bone density in the first metatarsal, which reflects the early stages of a healing fracture (Px. 14, 24-25:21-12).

In the X-ray from November 18, 2019, Dr. Kaz noted increased callus formation at the fracture site on the second metatarsal, osteolysis on the medial side of the middle cuneiform, changes in bone density of the first metatarsal, and a cortical break on the dorsal aspect at the base of the first metatarsal - all indicative of a healing fracture (Px. 14, 25-27:24-5).

Dr. Kaz stated that the provided images show evidence of a healing second metatarsal fracture, and more subtle evidence of a healing injury at the base of the first metatarsal (Px. 14, 27-28:21-2). Dr. Kaz' findings of a fracture at the base of the first metatarsal was shared by Dr. Kadakia (Px. 14, 36-37:19-2; Px. 14, 49-50:10-11; Px. 14, 51:18-21).

After reviewing the MRI of the left foot from January 2022, Dr. Kaz found healed fracture deformities in the second and third metatarsal, advanced midfoot arthropathy and significant narrowing at the tarsal-metatarsal joints of the first, third, and fourth metatarsals. He diagnosed midfoot arthritis (Px. 14, 28:8-17). Dr. Kaz expected Petitioner would have increased pain on the outside of his foot due to increased weightbearing on it (Px. 43:3-15).

The arthritis shown in the January 2022 MRI did not exist at the time the x-rays were taken in 2019 (Px. 14, 28:18-20). Dr. Kaz opined that the arthritis present in Petitioner's left foot is causally related to his work accident (Px. 14, 28-29:21-1).

Dr. Kaz explained that Petitioner experienced a significant injury, clearly resulting in the fracture to the second metatarsal, and damage to the articular surface at the base of the first metatarsal (Px. 14, 29:2-20). Over time, Petitioner developed advanced midfoot arthropathy with notable narrowing of the TMT joints, particularly at the first, third, and fourth joints *Id.* The MRI also showed attenuation (stretching) of the Plantar Lisfranc ligament and inner cuneiform, all of which were caused by the traumatic injury the patient sustained (*Id.*; Px. 14, 43-44:16-11).

Dr. Kaz found no evidence to suggest that Petitioner had arthritis prior to his injury (Px. 29-30:21-7; Px. 14, 33-34:15-9). Dr. Kaz stated that the images and radiology reports all coincide with a significant Lisfranc injury, which resulted in post-traumatic arthritis of the midfoot (Px. 14, 44:16-20).

Dr. Kaz opined that all treatment has been reasonable, necessary, and related to the work accident on September 26, 2019 (Px. 14, 30:8-12). For future treatment, Dr. Kaz recommended that the Petitioner may require a midfoot arthrodesis, along with non-surgical options such as orthotics and pain management (Px. 14, 30:13-23).

Evidence Deposition of Steven Blumenthal

The deposition of Steven Blumenthal proceeded on August 8, 2024 (Px. 16, 1:8-16). Mr. Blumenthal has been a vocational rehabilitation counselor for over forty years and has managed his own practice, Blumenthal & Associates, for the past twenty-two years (Px. 16, 5-6:9-2).

Mr. Blumenthal met with Petitioner to complete a vocational rehabilitation interview, achievement and aptitude testing, and interest testing to develop a vocational rehabilitation plan and report (Px. 16, 6-7:11-1). Mr. Blumenthal reviewed Petitioner's education history, work injury, work history and medical treatment by Dr. Kadakia (Px. 16, 8:5-13; Px. 16, 24:4-8). Mr. Blumenthal noted that Petitioner was treating with Dr. Kadakia for his left foot injury (Px. 16, 8-9:14-1). Petitioner is independent in his activities of daily living but was given sedentary work restrictions by Dr. Kadakia (Px. 16, 9:10-24). Mr. Blumenthal highlighted that Petitioner has had a singular work history as a carpenter and has not performed other jobs that would allow him to develop other aptitudes (Px 16, 11:9-15).

Petitioner has permanent restrictions of sedentary duty (Px. 16, 11-12:19-6). The Department of Labor defines sedentary work as performing a majority of work in a seated position with only limited standing or walking, and instruction to not lift more than ten pounds (Px. 16, 12-7-12).

Mr. Blumenthal performed various vocational tests on Petitioner and noted that he generally performed average to above average for all aptitudes tested (Px. 16, 13-14:22-13). A transferrable skills analysis showed various clerk positions as potential careers but noted that they would require additional training in computer office skills training, and data entry which may not be recommended for someone who is 59 years old (Px. 16, 16-17:4-1). It is likely Petitioner will face difficulties in the job placement as he will be competing with younger individuals who have office experience (Px. 16, 17:2-17).

Mr. Blumenthal explained the wage data for Petitioner reflected that if he were to obtain employment in any of the recommended sedentary positions, he would earn in the range of \$16.00 per hour to \$21.00 per hour (Px. 16, 18:7-24). This range was made with the understanding that Petitioner has no prior office-based work and would require training to work at an entry level (Px. 16, 18-19:24-5). This is significantly different than the wages reflected in the wage data from Petitioner's former union which documented that he would be able to earn \$53.51 an hour (Px. 16, 19:6-15).

Mr. Blumenthal reviewed Jacqueline Bethell's February 18, 2024 report, vocational rehabilitation assessment, and labor market survey report (Px. 16, 20:10-14). Mr. Blumenthal and Ms. Bethell both agree that sedentary work wages are between \$16.00 per hour and \$21.00 per hour (Px. 16, 21:4-16). During cross examination, Mr. Blumenthal was asked about an FCE which found Petitioner was able to function in the medium physical demand level (Px. 16, 25-26:23-1). Mr. Blumenthal disagrees with this categorization (Px. 16, 26:2-8). The Department of Labor considers heavy level of work to include the ability to lift a hundred pounds at all levels, and medium level of work to include the ability to lift fifty pounds at all levels (Px. 16, 26:2-8). Petitioner was unable to do (Px. 16, 26:6-8). The FCE documents that he could only occasionally walk, which often indicates a sedentary classification (Px. 16, 26-27:14-7; 28:3-24). Although the Petitioner's job as a carpenter may involve a variety of tasks, it is generally expected that carpenters should be able to perform work classified as heavy duty (Px. 16, 27-28:8-2; 29:1-16).

Mr. Blumenthal clarified that while the FCE may state that Petitioner can lift a certain weight, that is a secondary consideration to how much they can stand and walk, simply stating "if they have to be seated more than standing or walking, how much they can lift is moot" (Px. 16, 29-30:17-19). Mr. Blumenthal recommended training with an accredited school in Illinois to develop the computer skills necessary to be competitive in the job market (Px. 16, 37-39:15-5). Petitioner can complete job readiness training while working, or while searching for a position (Px. 16, 39:12-21).

Evidence Deposition of Jacqueline Bethell

The deposition of Jacqueline Bethell proceeded on August 13, 2024 (Rx. 9, 1:12-18). Ms. Bethell has been a certified rehabilitation counselor for approximately 12 years and is currently employed by MedVoc Rehabilitation (Rx. 9, 4:14-23).

Ms. Bethell prepared a labor market survey and authored a report based on her findings (Rx. 9, 6:9-17). Ms. Bethell reviewed records pertaining to Petitioner's education, work history, select medical records, documented physical capabilities, and Mr. Blumenthal's Vocational Rehabilitation Report (Rx. 9, 6-8:21-19). The medical records provided to Ms. Bethell included an FCE, medical records from Dr. Koutsky, and the Section 12 reports of Dr. Shadid and Dr. Toolan (Rx. 9, 8:1-14). The Section 12 reports were provided despite a lack of treating relationship established between both doctors and Petitioner, and an absence of treating physician records (Rx. 9, 19-20:8-4; 20-21:22-12). Ms. Bethell drafted two labor market surveys – one using the restrictions of the treating doctor and one using medium demand work (Rx. 9, 9:2-8; 22:11-23).

The first Labor Market Survey examined the job market for Petitioner if he were able to work at the medium demand level. It found that Petitioner could perform specific types of carpentry work and work as a construction equipment salesclerk, despite restrictions to walking no more than two and a half hours during the day (Rx. 9, 10-11:17-4; 20:7-17). Ms. Bethell claimed that 15 of 39 contacted employers for the survey indicated that Petitioner would be qualified for work based on his work history and accommodations at an average wage of \$25.40 per hour (Rx. 9, 11-12:21-22).

The second Labor Market Survey examined the job market for Petitioner if he were able to work at the sedentary demand level, which is what his treating physician Dr. Kadakia placed him at (Rx. 9, 13:7-16). Ms. Bethell reported that 15 of the 43 employers indicated that Petitioner would be qualified for work given his work history and sedentary work restrictions, with an average wage of \$16.67 per hour (Rx. 9, 13:7-24). However, during cross-examination, Ms. Bethell testified that while the employers said that Petitioner was qualified for a role, none of the employers extended a job offer to Petitioner (Rx. 9, 25-26:23-14). Furthermore, Ms. Bethell could not confirm whether each employer who deemed the Petitioner qualified was fully aware and understood the restrictions they would be required to accommodate (Rx. 9, 26-27:10-13).

Ms. Bethell suggested that while Petitioner may be employable in some desk positions, given his lack of computer skills, he would require computer training to assist (Rx. 9, 14:15-20). Ms. Bethell testified that Petitioner is a candidate for vocational planning and training as his age may be an obstacle, but that if Petitioner presents himself well and has impressive qualifications, he should find a job (Rx. 9, 14-15:21-23).

Ms. Bethell opined that Petitioner is employable as a trade show carpenter, trim carpenter, and material construction equipment sales, with anticipated earnings of \$25.40 per hour (Rx. 9, 14:3-15). This opinion was made with the knowledge that these roles require more than occasional walking, which is outside of Petitioner's restrictions (Rx. 9, 20:5-17; 28:7-17; 29:9-21). Ms. Bethell opined that Petitioner has lost access to the occupation of carpenter laborer and agrees with Mr. Blumenthal's opinion regarding Petitioner's earning potential at sedentary restrictions (Rx. 9, 37-38:11-10).

III. CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below. Section 1(b)3(d) of the Act provides that, to obtain compensation under the Act, Petitioner bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d).

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his or her claim, including that there is some causal relationship between the employment and the injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 2d 52, 63 (1989). And yet, it also is well established that the Act is humane law of remedial nature and is to be liberally construed to affect the purpose of the Act that the burdens of caring for the casualties of industry should be borne by the industry and not by the

individuals who misfortunes arise out of the industry, nor by public. *Shell Oil v Industrial Commission*, 2 III 2nd 590, 603 (1954).

The Act should be liberally construed to provide financial protection for injured workers. *McAllister v Illinois Workers' Compensation Commission*. 2020 IL 124848 1 32. The Act's provisions are to be read in harmony to achieve that goal. *Vaught v Industrial Commission*, 52 Ill. 2d 158,165 (1972). Workers are entitled to "prompt, sure and definite compensation, together with a quick and efficient remedy" with industry bearing the "costs of such industries: rather than the injured worker. *O'Brien v Rautenbush*, 10 Ill.2d 167, 174 (1956). Decisions of an arbitrator shall be based exclusively on stipulation of the parties, the evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1(b)3(d).

Credibility finding: The Arbitrator, as a trier of fact in this case, has the responsibility to observe the witnesses testify, judge their credibility, and determine how much weight to afford their testimony and the other evidence presented. *Walker v Chicago Housing Authority*, 2015 IL App (15) 133788, 147. The Arbitrator observed Petitioner during the hearing and finds him to be a credible witness.. Petitioner's description of the accident and subsequent physical complaints remained consistent throughout. The Arbitrator compared Petitioner's testimony with the totality of the evidence submitted and did not find any material contradictions that would deem the witness unreliable.

The Arbitrator finds that the evidence deposition testimony of Dr. Kaz and Dr. Kadakia to be more persuasive and reliable than that the evidence testimony of Dr. Toolan. The Arbitrator further finds the evidence deposition testimony of Mr. Blumenthal to be more persuasive than Ms. Bethell.

WITH RESPECT TO ISSUE (F), WHETHER PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds Petitioner has proven by the preponderance of the credible evidence that his current left foot condition is causally related to his work accident of September 26, 2019 based on the chain of events and the persuasive medical opinions of Dr. Koutsky, Dr. Kaz and Dr. Kadakia.

In a workers' compensation case every natural consequence that flows from an injury that arose out of and in the course of the claimant's employment is compensable unless caused by an independent intervening accident that breaks the chain of causation between a work-related injury and an ensuing disability or injury." *Vogel v. Illinois Workers' Compensation Comm'n*, 354 Ill. App. 3d 780 (2005). To obtain compensation under the Act, a claimant must prove that some act or phase of his employment was a causative factor in his ensuing injuries. A work-related injury need not be the sole or principal 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).

An employer takes its employees as it finds them. *St. Elizabeth Hospital v Worker's Compensation Comm'n*, 371 Ill. App 3d 882, 888 (2007). A claimant with a pre-existing condition may recover where the employment aggravates or accelerates that condition. *Caterpillar Tractor Co. v*

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Industrial Commission, 92 Ill.2d 30, 36 (1982). That the claimant had a pre-existing condition does not preclude the use of a chain of events analysis. *Schroeder v Illinois Worker's Compensation Commission*, 2017 Ill. App.(4th) 160192 WC (2017); *Corn Belt Energy Corp. v Illinois Worker's Compensation Commission*, 2016 Ill. App (3d) 150311 WC.

The Arbitrator finds the recent case of *Tazewell County v. Illinois Workers' Compensation Comm'n IWCC* (Dora Potts) 2025 IL App (4th) 230754WC, a case of first impression, to be instructive. The *Tazewell* Court held that work activity that results solely in pain from a preexisting non-work-related condition is compensable under the Act in the absence of a concomitant worsening of the underlying non-work-related condition. If the aggravation is work-related and solely causes pain, the pain suffered is, in and of itself, a compensable aggravation of the preexisting condition. The Court held that pain by itself is a compensable condition under the Act. The Court further held that an aggravation or acceleration of a preexisting condition caused by work-related activity is compensable even in the absence of an organic or structural change in the preexisting condition. In instant case, is undisputed that Petitioner sustained a work-related accident that resulted in persistent pain since then which progressed over time as post traumatic arthritic changes at the midfoot progressed.

Even if the Arbitrator were to find that Petitioner's condition was pre-existing as it related to the left foot, this accident clearly worsened Petitioner's condition resulting in medical treatment, off work notes and a surgical recommendation - none of which were present on the date of accident. Furthermore, the persuasive evidence established that the arthritic changes that developed in Petitioner's foot were as a consequence that flowed from Petitioner's injury. There is no evidence that any other incident has broken the chain of causation..

The Arbitrator notes that Respondent voiced no complaints about Petitioner's pre-accident work performance. No mention was made that Petitioner missed time off work because of his preexisting left foot issues, no mention was made that he requested any work accommodation because of a preexisting condition. No evidence was introduced that Petitioner required or received any medical treatment to his left foot before his accident. Petitioner's job was physically demanding as demonstrated by the facts of the accident where a 30-foot wood truss crushed his left foot for which he had to struggle in pulling free. Following his work accident, Petitioner could no longer work, was taken off work by his doctors, had significant foot pain and limitations. No persuasive evidence was presented of intervening or subsequent injuries to foot that could explain Petitioner's injuries and current condition.

The medical histories in the record demonstrate a consistent history as to the onset of Petitioner's foot injury. The Arbitrator finds based on the weight of the credible evidence in this record, Petitioner's current condition of ill-being is causally related to the work accident based on the chain of events as well as based on the persuasive findings and opinions of Dr. Koutsy, Dr. Kadakia and Dr. Katz and not simply the result of a normal degenerative process. The Arbitrator is mindful and finds it significant that no evidence was introduced that Petitioner had any degenerative changes in the right foot.

It is undisputed that Petitioner suffered a work-injury on September 26, 2019 where a heavy truss fell onto his left foot, crushing it while he struggled to free himself. At the outset of his injury, Petitioner underwent treatment with Dr. Kevin Koutsy for fractures at the second and third

metatarsals. In the few months following the injury no physician that read the x-rays diagnosed a first metatarsal fracture in the left foot. Petitioner was released to return to work; however, his return to work was cut short by continued pain to his left foot and the onset of the COVID-19 pandemic.

The Arbitrator acknowledges that Petitioner was initially cleared by Dr. Koutsky to return to work at the medium demand level based on a valid FCE. However, as his post-traumatic arthritis advanced significantly, the FCE findings and work release became outdated and no longer applicable, ultimately leading to a recommendation for fusion by Dr. Koutsky, Dr. Kaz, Dr. Kadakia and even Dr. Toolan. Additionally, the Arbitrator notes that Dr. Kaz later adjusted the work release to light duty in response to the progression of arthritic changes.

The pivotal issue in this claim for benefits is whether his severe left foot arthritis is related to the injury and whether there was a fracture of the first metatarsal in the left foot. Dr. Koutsky, a general orthopedist, reviewed the initial x-rays. He concluded that the current condition of ill-being in the left foot is causally related to the accident. He said there may have been an aggravation of some of his pre-existing degenerative conditions; however, his current condition of chronic foot pain, soft tissue injury, and fracture deformity is directly related to the work injury. Petitioner continued to have significant pain and discomfort in his foot which precluded him from working unrestricted. His left foot condition continued to the point where a surgical fusion involving the fractured bones was recommended. (Px. 9). The only physicians who have reviewed the x-rays taken at the time of the injury are the doctors at Physicians Immediate Care, Dr. Koutsky, Dr. Kadakia, and Dr. Kaz. The only board-certified foot and ankle physicians to review the first three sets of X-rays performed in 2019 were Dr. Kadakia and Dr. Kaz. Both foot and ankle surgeons found a fracture of the first metatarsal that was not diagnosed by the doctors reviewing the images at the time. The Arbitrator notes that Respondent's two Section 12 experts, Dr. Shadid and Dr. Toolan, a board-certified foot and ankle surgeon, were not provided access to the original X-rays, depriving them from viewing, examining and comprehending material and relevant information.

Dr. Kadakia, as Petitioner's treating physician, found that Petitioner suffers from diffuse midfoot arthritis with post fracture healing changes throughout the midfoot and widening at the Lisfranc joint. He relates this condition to the original crush injury sustained by Petitioner on September 26, 2019. During his deposition, Dr. Kadakia marked up the initial x-rays from September 26, 2019 that clearly show a fracture to the first metatarsal. Following x-rays also show bone changes to the first tarsometatarsal joint. Dr. Kaz reviewed these x-rays during his deposition and had the same findings. Neither Dr. Shadid nor Dr. Toolan viewed or addressed the x-ray marked by Dr. Kadakia showing the first metatarsal fracture.

These findings are important due to their impact on the joints. Dr. Kadakia noted that imaging studies reveal the Petitioner is now experiencing end-stage arthritis in his left foot. He further explained:

"So based on his mechanism of injury, something hits the top of your foot. That's one of the most described mechanisms for a Lisfranc injury. He had a fracture in that area. He had pain in that area. He had fracture of that first metatarsal and medial cuneiform that you can easily see on the oblique x-rays, and so, more likely

than not, the cause of his current joint condition is that trauma, and you can see progression over time where the arthritis wasn't there on the initial injury. There's no other logical explanation for why it has now end-stage arthritis where it wasn't there before the trauma, and I know that because you don't see it on the x-ray." (Px. 21, 37-38:22-24, 1-13).

Dr. Kaz agreed. Upon review of the imaging, he opined that the arthritis was not present on the post-accident x-rays, but a review of the MRI taken in January 2022 showed advanced midfoot arthropathy with significant narrowing of the tarsometatarsal articulations, most pronounced at the first, third, and fourth TMT joints. According to Dr. Kaz, there is no reason to believe that Petitioner had arthritis prior to the injury, he clearly has arthritis after the injury, he clearly sustained an injury to the midfoot, and it is much more likely than not that the injury he sustained to the midfoot caused the midfoot arthritis (Px. 14, 30:1-7).

Dr. Toolan also found diffuse midfoot arthritis. He opined that the x rays which he took demonstrated severe arthritis of the 1st tarsometatarsal joint and mild arthritis of the 2nd and 3rd tarsometatarsal joints and healed fractures of the 2nd and 3rd metatarsals.

Respondent retained Dr. Toolan and Dr. Shadid for Section 12 examinations. Neither of these doctors reviewed the x-rays taken after the accident. Dr. Toolan, a foot and ankle surgeon, authored a report dated January 22, 2025 in response to the report of Dr. Kaz where he voices his disagreement. However, Respondent continued to withhold or simply failed to provide the x-ray images from the year 2019 from Dr. Toolan to review. These x-rays are foundational in determining whether Petitioner's left midfoot arthritis is related to the crush injury from September 26, 2019. The causation opinions of Dr. Toolan are given little to no weight as the x-rays that Dr. Kadakia and Dr. Kaz reviewed were not provided to Dr. Toolan by Respondent, and Dr. Toolan gave conflicting opinions. (Px. 8). Dr. Toolan in his quick report unequivocally opined that Petitioner left foot condition of ill-being was work related. In his subsequent reports, Dr. Toolan failed to explain why he changed his mind, the failure of which deprived the Arbitrator of explaining his contradictory opinions. He acted as though his quick report did not exist.

Dr. Shadid, a general orthopedist retained by Respondent, opined that Petitioner did not sustain an injury to the first tarsal metatarsal on September 26, 2019. He also was not supplied the x-ray imaging from the time of injury. Little to no weight can be given to his report. Additionally, Dr. Koutsky showed that at least five of Dr. Shadid's opinions were false and, therefore, unreliable.

Respondent argues that the Petitioner's condition was not a natural consequence that flowed from the original injury. For an employer to be relieved of liability by virtue of an intervening cause, the intervening cause must completely break the causal chain between the original work-related injury and the ensuing condition. *Global Products v. Illinois Workers' Compensation Comm'n* 392 Ill.App3d 408, 411-412. (2009). The claimant's employment needs only to remain a cause, not the sole cause or even the principal cause, of his condition. "So long as a 'but-for' relationship exists between the original event and the subsequent condition, the employer remains liable." *Id.* The courts have repeatedly held that employers take employees as they find them and that the "chain of events" principle does not apply solely to workers in pristine health. *See, e.g., St. Elizabeth's*

Hospital v. Industrial Commission, 371 Ill.App.3d 882, 888 (2007) and *Schroeder v. Illinois Workers' Compensation Commission*, 2017 IL App (4th) 160192WC.

Here, the Arbitrator finds that Petitioner sustained a work-related accidental injury that flowed from the original injury. Petitioner's current condition of ill-being is causally connected to the work-related injury and not simply the result of a normal degenerative process of the pre-existing condition. The Arbitrator finds that the testimony of Dr. Kaz and Dr. Kadakia and the opinions of Dr. Koutsky to be more persuasive than the testimony of Dr. Toolan and the unreliable opinions of Dr. Shadid.

Having carefully considered all of the evidence, the Arbitrator concludes that the current condition of ill-being in Petitioner's left foot is related to the accident of September 26, 2019. A very heavy weight, a 30-foot wood truss, landed directly on the top of his midfoot, resulting in several fractures. The end stage arthritis is located where the injury occurred.

The Arbitrator finds it significant that at the time of the Petitioner's injury, the x-rays showed that he did not have left midfoot arthritis. By 2022, imaging studies revealed the presence of arthritis in the left midfoot. An MRI of January 2022 confirmed the arthritis at the midfoot, appearing just 28 months after the crush injury. The Arbitrator also recognizes that there is no indication of arthritis in the right foot. The combination of these objective findings supports the medical opinions regarding the progression the arthritic changes in the left foot are post-traumatic. .

The chain of events shows a simple cause and effect. Additionally, two board-certified foot and ankle surgeons, Dr. Kadakia and Dr. Kaz, persuasively explained that the first metatarsal was fractured at the TMT joint. It was subtle, but nonetheless fractured, disrupting the tarsal metatarsal joint, leading to a Lisfranc injury and the development of midfoot arthritis from the fallout of the trauma. It is a significant injury. While Respondent retained two experts, neither of their experts reviewed the actual images from the time of injury.

The Arbitrator gives great weight to the opinions of Dr. Kadakia and Dr. Kaz as they are both qualified foot and ankle experts, they read the images, and they both testified and explained the nature and progression of the injury. Dr. Toolan and Dr. Shadid were not supplied the x-rays. Dr. Kadakia's and Dr. Kaz' readings of the x-rays and explanation are the only reasonable explanation that appears in this record. The opinions of Dr. Toolan and Dr. Shadid are not given weight by the Arbitrator as they did not review the most relevant evidence in this case -- the initial x-rays that showed the first metatarsal fracture, which was missed by Dr. Koutsky.

Given the persuasive opinions of Dr. Kadakia and Dr. Kaz as well as Dr. Koutsky, the Arbitrator finds that Petitioner's current condition of ill-being of left midfoot arthritis is related to the work accident of September 26, 2019. The Arbitrator concludes there was a crush injury to his left foot that resulted in a Lisfranc injury, fractures of the second and third metatarsals, and a left foot first metatarsal fracture at the tarsometatarsal joint, which became arthritic. The Arbitrator concludes the medical need for the left mid-foot fusion suggested by Dr. Kadakia is reasonable, necessary, and related to this accident.

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 Arbitrator has found that Petitioner's current condition of ill-being is related to his September 26, 2019 work accident. Petitioner's treating physicians agree that the medical services administered were reasonable, related, and necessary. Given the above, the Arbitrator finds that Respondent is liable for the unpaid medical bills.

Petitioner submitted bills for causally related medical treatment and vocational rehabilitation as part of Petitioner Exhibit 23. The total amount of these unpaid bills is \$5,809.83. Respondent submitted a payment ledger as Respondent Exhibit 1. The Arbitrator reviewed this ledger and does not see that it shows payments made in full for any bills that Petitioner alleges are due in Petitioner Exhibit 23.

Petitioner submitted \$2,832.00 in unpaid bills for vocational services rendered from Blumenthal and Associates LLC. Petitioner underwent vocational interview and testing with Steven Blumenthal of Blumenthal and Associates LLC. Respondent's payment ledger does not show that they made any payments to Blumenthal and Associates LLC. As these bills are for reasonable, necessary, and related vocational rehabilitation services, Respondent owes \$2,832.00 to be paid for the bills outstanding with Blumenthal and Associates LLC.

Petitioner submitted \$2,654.83 in unpaid bills from DuPage Spine & Orthopedics, PLLC. These bills cover services from December 21, 2021 through July 24, 2023 for Petitioner's treatment with Dr. Koutsky. These bills match up to dates of service from Petitioner's reasonable, necessary, and related medical treatment with Dr. Koutsky. Respondent's ledger shows some dates of payment that match up to bills claimed by Petitioner, but these payments do not cover the totals for the outstanding charges. These are partial payments. Given that Petitioner's billing statements are dated later than Respondent's payment dates, the Arbitrator finds that Respondent is liable for unpaid bills to DuPage Spine and Orthopaedics, PLLC in the amount of \$2,654.83.

Lastly, Petitioner submitted bills from Northwestern Medicine totaling \$323.00. The bills from Northwestern Medicine for treatment are reasonable, necessary, and related. Petitioner alleges that the office visit dated November 15, 2022 is unpaid. Respondent's ledger shows that no payments were made for this date of service. Therefore, the Arbitrator finds that Respondent is liable for unpaid bills to Northwestern Medicine in the amount of \$323.00.

Respondent shall pay all outstanding medical bills for Petitioner's reasonable and necessary medical treatment for his left foot, pursuant to Sections 8(a) and 8.2 of the Act. In summary, Respondent shall pay \$2,654.83 to DuPage Spine & Orthopedics, PLLC, and \$323.00 to Northwestern Medicine and \$2,832.00 to Blumenthal and Associates, LLC, \$2,654.83. Respondent shall make this payment directly to Petitioner's attorney in accordance with Section 9080.20 of the Rules Governing Practice before the Illinois Workers' Compensation Commission

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY AND MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Petitioner is entitled to TTD from September 27, 2019 through March 10, 2020 and from January 18, 2022 through September 12, 2023. The Arbitrator finds that Petitioner is entitled to maintenance from September 13, 2023 through November 3, 2023.

To be entitled to TTD, the claimant must show not only that he or she did not work but also that he or she was unable to work. *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission*, 236 Ill.2d 132 (2010).

Petitioner alleges that he is entitled to TTD for a total of 109-6/7 weeks. During the alleged periods of disability, Petitioner was taken off of work by his treating physicians. He was not accommodated or offered light duty work by his employer. As the Arbitrator has already found the opinions of his treating physicians more persuasive than the opinions of the Section 12 examiners, the Arbitrator awards the 109- 6/7 weeks of TTD with a credit for any benefits paid.

Dr. Kadakia testified on September 12, 2023 that Petitioner should be released to work with permanent restrictions of sedentary duty. As of September 13, 2023, Petitioner is owed maintenance payments. Petitioner obtained a vocational opinion from Steve Blumenthal on November 3, 2023 outlining Petitioner's earning capacity. Petitioner has not engaged in a job search or plan of vocational rehabilitation since this day and therefore is owed maintenance payments only up until November 3, 2023. Again, given that the Arbitrator finds the opinions of Petitioner's treating physicians more persuasive than those of Respondent's experts and has already found that the current condition of ill-being is related to the work accident, the Arbitrator awards the 7-3/7 weeks of maintenance claimed by Petitioner.

The Arbitrator finds that Petitioner is entitled to 117-2/7 weeks of TTD and maintenance benefits to be paid at a rate of \$1,055.21 per week based on his average weekly wage of \$1,582.81, totaling \$123,761.06. Respondent is due a credit of \$76,431.45 based on their payment ledger, Respondent's Exhibit 1. The net unpaid TTD and maintenance owed after Respondent's credit is \$47,329.61.

WITH RESPECT TO ISSUE (N), WHETHER RESPONDENT IS DUE ANY CREDIT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Respondent is due credit for TTD payments demonstrated in their ledger and has not demonstrated an 8(j) credit. The Arbitrator finds that Respondent is owed credit for TTD in the amount of \$59,818.25. The Arbitrator finds that Respondent is not owed any credit under Section 8(j) of the Act. The Arbitrator finds that Respondent is owed an additional credit of \$16,613.20 towards TTD, maintenance, and PPD based on other payments made and noted in their ledger.

In the event the injured employee receives benefits, including medical, surgical or hospital benefits under any group plan covering non-occupational disabilities contributed to wholly or partially by

the employer, which benefits should not have been payable if any rights of recovery existed under this Act, then such amounts so paid to the employee from any such group plan as shall be consistent with, and limited to, the provisions of paragraph 2 hereof, shall be credited to or against any compensation payment for temporary total incapacity for work or any medical, surgical or hospital benefits made or to be made under this Act. 820 ILCS 305/8(j).

In the instant matter, Respondent has provided a medical payment ledger to show what medical billing they have made payment for. On the Request for Hearing Form, Arbitrator's Exhibit 1, Respondent alleges that it is eligible for medical bills through the group plan as laid out in their exhibit 1. Upon review of Respondent's Exhibit 1, that ledger does not show any group plan payments. The Arbitrator takes note of the ledger as evidence of payment for medical bills in this case by Respondent's insurance carrier, but the ledger does not provide evidence of payments under Section 8(j) of the Act.

Respondent's indemnity payment ledger is also demonstrated in Respondent's Exhibit 1. This ledger matches up with Respondent's allegations for their credit on the Request for Hearing form. Wherefore, the Arbitrator finds that Respondent is owed a total credit against TTD, maintenance, and PPD of \$76,431.45.

WITH RESPECT TO ISSUE (L), THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

After reviewing all evidence and testimony in this case, the Arbitrator hereby finds that Petitioner is entitled to a wage differential award pursuant to Section 8(d)(1) of the Act.

Under section 8(d)(1), an impaired worker is entitled to a wage differential award when (1) he is "partially incapacitated from pursuing his usual and customary line of employment" and (2) there is a "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." (Emphasis added.) 820 ILCS 305/8(d)(1) (West 2012). To qualify for wage loss benefits, the claimant must show that the disability has caused both a partial incapacity that prevents him from pursuing his usual and customary line of employment and that there has been an impairment of earnings. *Albrecht v. Industrial Commission*, 271 Ill.App.3d 756 (1995).

In a claim such as this one, where the parties do not dispute that the Petitioner is incapacitated from pursuing their usual and customary line of employment, a percentage-of-the-person-as-a-whole award under Section 8(d)(2) would be appropriate *only* if the claimant has suffered no loss in "earning capacity," or having suffered a loss in "earning capacity," has elected to wave the right to an award under 8(d)(1). *Jackson Park Hospital v. Illinois Workers' Compensation Comm'n*, 2016 IL App (1st) 142431WC, ¶ 45, citing *Lenhart v. Illinois Workers' Compensation Comm'n*, 2015 IL App (3d) 130743, ¶ 48.

The Act prefers an award under Section 8(d)(1) when there is a loss of earnings. There is no affirmative requirement under 8(d)(1) that a claimant even conduct a job search; he simply must demonstrate an impairment of earnings. *Gallianetti v. Industrial Comm'n*, 315 Ill. App. 3d 721,

731 (3rd Dist. 2000). A lack of effort in finding employment is not a demonstration of a suitable occupation; the Commission must find an occupation and average wage based on the evidence to determine the amount of wage loss. *Crittenden v. Illinois Workers' Compensation Comm'n*, 2017 IL App (1st) 160002WC, ¶ 25. In *Gallianetti*, the court held that “the plain language of section 8(d) prohibits the Commission from awarding a percentage-of-the-person-as-a-whole award where the claimant has presented sufficient evidence to show a loss of earning capacity.” *Gallianetti*, 315 Ill. App. 3d at 728.

The Arbitrator has previously determined that Petitioner’s current condition of ill-being is causally connected his work-related accident. Based on the persuasive testimony provided by Dr. Koutsky, Dr. Kadakia, Dr. Kaz, the Arbitrator concludes that the Petitioner is capable of performing sedentary work. While Dr. Toolan disputed the issue of causation, his testimony still supported Petitioner is limited to sedentary duties.

The Arbitrator reviewed video surveillance of the Petitioner. The video depicts him standing on grass watching a child’s soccer game, as well as walking and driving short distances—primarily in the morning. The footage does not suggest that he is capable of activity beyond a sedentary level. Considering the nature of the trauma he sustained, the resulting post-traumatic arthritis, and the medical consensus that the condition at the injury site is severe enough to warrant a fusion as a reasonable treatment, the Arbitrator concludes that a sedentary work restriction is most appropriate. This finding is consistent with Dr. Karakia’s medical records, report and testimony. The remaining question in determining eligibility for an award under Section 8(d)(1) is whether the Petitioner has sustained a loss of earning capacity and, if so, to what extent.

Petitioner underwent vocational testing conducted by Steven Blumenthal, CRC. Mr. Blumenthal administered the tests, reviewed medical records and the Petitioner’s work history, and assessed the potential earnings the Petitioner could achieve within a stable labor market. Based on the sedentary work restrictions provided by Dr. Kadakia, Mr. Blumenthal concluded that the Petitioner could earn between \$16 and \$21 per hour—significantly less than his previous union wage of \$55.11 per hour as a union carpenter—provided he completes computer office skills training and job placement services. (Px. 16, 19:1-5).

Respondent engaged Jacqueline Bethell to conduct a vocational rehabilitation assessment and labor market survey. Ms. Bethell produced two labor market surveys: one evaluating employment opportunities at the medium physical demand level and another considering positions within the sedentary restrictions set by Dr. Kadakia, the treating physician.

In the first survey, Ms. Bethell determined that Petitioner could potentially earn \$25.40 per hour in a stable labor market if he were capable of functioning at the medium demand level. However, the Arbitrator finds this assessment unreliable, as Petitioner is not currently functioning at that level. In the second survey, Ms. Bethell found that at the sedentary physical demand level, Petitioner could earn \$16.67 per hour in a stable labor market.

Ms. Bethell concurred with Mr. Blumenthal that Petitioner would benefit from computer skills training and job readiness programs. Both experts agree that, irrespective of whether Petitioner

qualifies for medium or sedentary-level work, he has experienced a loss of earning capacity and would benefit from vocational rehabilitation to maximize his earning potential.

The Arbitrator has determined that Petitioner has permanent sedentary restrictions, relying on the persuasive testimony of Dr. Kadakia. Based on these restrictions, Mr. Blumenthal estimates Petitioner's earning capacity at the lower range of \$16 to \$21 per hour, while Ms. Bethell calculates an average earning capacity of \$16.67 per hour.

These labor market surveys function as evidence of Petitioner's earning capacity and what he would be able and qualified to earn in suitable employment. Both vocational counselors identified that Petitioner could work with training, as an office clerk. The job of office clerk was identified by Blumenthal as one of the lower wage possibilities in his wage range and Bethell identified several 'information clerk/concierge' positions in her labor market survey. Both agree that Petitioner would benefit from vocational rehabilitation. Several of the opportunities identified by Bethell provide on the job computer training, which would satisfy Petitioner's vocational needs.

Petitioner described his job for Respondent at the heavy physical demand level.. His accident substantiates this claim, as he sustained injuries while maneuvering a 30-foot wood truss that required crane to move it to the work site. In addition to his carpenter work duties, he also carried out laborer duties. The Arbitrator determines that Petitioner is unable to resume work as a construction or rough carpenter and is incapable of performing his full job functions as outlined in Section 8(d)(1) of the Act.

The Arbitrator finds that Petitioner has suffered a loss of earning capacity. Petitioner is unable to return to his pre-injury job and both vocational experts find that his earning capacity has been greatly reduced in light of his disability, age, education, and prior training.

Given that the testimony of the experts agrees that Petitioner could find employment in this clerking role and that they agree on a wage range, the Arbitrator finds that Petitioner is able to earn \$16.67 per hour in a stable labor market under Section 8(d)(1) of the Act.

Petitioner has not engaged in a job search. Engaging in a job search is not a requirement to obtain a wage loss award under Section 8(d)(1). Engaging in a job search is one way in which Petitioner could show that a labor market exists but is not required under the Act or the case law. Petitioner's lack of job search does not weigh into his wage loss benefits.

Given the totality of the testimony and the opinions of the vocational experts, the Arbitrator finds that an award under Section 8(d)(1) is appropriate. The start date of this award is the date of Steve Blumenthal's report, November 3, 2023.

The only remaining issue is to determine what Petitioner would be earning were he not to have suffered a loss of earning capacity. Petitioner's Exhibit 18 is the current wage scale of the Carpenters. Petitioner credibly testified that it was not his intention to retire as a member of the Carpenters. He wanted to continue working as long as he could. On the date of accident, Petitioner was only 54 years of age, married, with two dependent children.

In the full performance of his duties, Petitioner would currently be earning \$55.11 per hour based on the wage scale for the period of June 30, 2024 through May 31, 2025 (Px. 18).

Given the testimony of all witnesses, including both vocational experts, in the instant matter, the Arbitrator finds that there is suitable employment where Petitioner is able to earn \$16.67 per hour. He would also need to complete some vocational training. The vocational experts concluded he is trainable, so he is employable.

The Arbitrator finds that Petitioner is owed payments for wage differential under 8(d)(1) beginning on November 4, 2023. Petitioner would have earned \$53.51 per hour, or \$2,140.40 per 40-hour week, in the full performance of his duties from November 4, 2023 through May 31, 2024. He is able to earn \$16.67 per hour, or \$666.80 per 40-hour week. For this period the weekly wage loss is \$1,472.60.

The rate owed under Section 8(d)(1) for the period is \$983.40 per week for 30 weeks, or \$29,472. He would earn \$55.11 per hour or, \$2,204.40 per 40-hour week, in the full performance of his duties from June 1, 2024 through February 26, 2025. He can earn \$666.80 per week yielding a wage loss of \$1,537.60 per week. The rate under Section 8(d)(1) owed for this period is \$1,025.07 per week through February 26, 2025. The accrued amount is \$1,025.07 for 38 5/7 weeks, totaling \$39,680.46. The total amount accrued wage loss benefits owed under Section 8(d)(1) through February 26, 2025 is \$66,152.46.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES UNDER SECTIONS 19(k), 19(l) AND ATTORNEY FEES UNDER SECTION 16 BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner has filed petition for penalties under sections 16, 19(k), and 19(l) (Px. 20). At trial, Respondent denied liability to penalties and fees. Although the Arbitrator was unpersuaded by Dr. Shadid and Dr. Toulan's conclusions—particularly his assertion that Petitioner did not suffer a crushing injury, which the Arbitrator finds to be contrary the facts, contrary to common sense and contrary to the accepted definition of such an injury—the overall assessment is that Respondent's reliance on Dr. Toolan's opinions was misguided. However, it was not so unreasonable as to justify the imposition of penalties. Based on the totality of the evidence, the Arbitrator concludes that Respondent came close to crossing the threshold for imposition of penalties. Respondent waded into the waters of the Rubicon but did not cross it. Accordingly, penalties and fees are denied.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	23WC012692
Case Name	Shannon Tonkin v. Rivian
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	25IWCC0489
Number of Pages of Decision	20
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Todd Strong
Respondent Attorney	Nicholas Rubino

DATE FILED: 12/9/2025

DISSENT

/s/Marc Parker, Commissioner

Signature

23 WC 12692

Page 1

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)
☐ Modify	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Shannon Tonkin,

Petitioner,

vs.

NO: 23 WC 12692

Rivian,

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, causal connection, medical expenses, prospective medical treatment, permanent partial disability, and 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 May 14, 2024, 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.

23 WC 12692

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The bond requirement in Section 19(f)(2) of the Act is only applicable when the Commission has entered an award for the payment of money. Therefore, no bond is set by the Commission. 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.

DECEMBER 9 2025

MP:yl

o 11/6/25

68

/s/ Maria E. Portela

Maria E. Portela

/s/ Christopher A. Harris

Christopher A. Harris

DISSENT

I respectfully dissent from the decision of the Majority. I would have reversed the Arbitrator's decision and found Petitioner sustained an accident that arose out of and in the course of her employment under *McAllister v. Illinois Workers Comp Comm'n*, 181 N.E.3d 656, 450 Ill. Dec. 309 (2020), and under a neutral risk analysis.

Injuries resulting from risks distinctly associated with the employment are compensable. *McAllister*, 450 Ill. Dec. at 315. A risk is distinctly associated with the employee's employment if the employee was performing acts he was instructed to perform by his employer, acts which he 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. *Id.* at 316.

Here, I believe the employee's use of the shuttle was an act that she might reasonably be expected to perform incident to her assigned duties. The shuttle was provided by the employer. I do not believe the fact that the employee was not inside the facility renders *McCallister* inapplicable.

Even if *McCallister* was inapplicable, I would find a compensable injury under a neutral risk analysis. Injuries resulting from a neutral risk are compensable when the employee was exposed to the risk to a greater degree than the general public. *Springfield Urban League v. Illinois Workers' Compensation Comm'n*, 2013 IL App (4th) 120219WC. "Such an increased risk may be either qualitative, such as some aspect of the employment which contributes to the risk, or quantitative, such as when the employee is exposed to a common risk more frequently than the public." *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers'*

23 WC 12692

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Compensation Comm'n, 407 Ill. App. 3d 1010, 1014 (2011). In my view, the Petitioner having to navigate a 15.5-inch step is not a risk faced by the general public. The “general public” in Normal, Illinois does not regularly use shuttles. I would have found Petitioner’s accident to be compensable and awarded benefits.

For the foregoing reasons, I respectfully dissent from the Majority’s decision.

/s/ Marc Parker

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	23WC012692
Case Name	Shannon Tonkin v. Rivian
Consolidated Cases	
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	16
Decision Issued By	Maureen Pulia, Arbitrator

Petitioner Attorney	Hania Sohail
Respondent Attorney	Nicholas Rubino

DATE FILED: 5/14/2024

/s/ Maureen Pulia, Arbitrator

Signature**INTEREST RATE WEEK OF MAY 14, 2024 5.165%**

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)

SHANNON TONKIN

Employee/Petitioner
 v.

Case # **23** WC **12692**

Consolidated cases: _____

RIVIAN

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 **Maureen Pulia**, Arbitrator of the Commission, in the city of **Peoria**, on **4/12/24**. 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, **4/19/23**, 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 **\$11,448.29**; the average weekly wage was **\$954.02**.

On the date of accident, Petitioner was **39** years of age, *single* with **3** dependent children.

Respondent *has* paid all reasonable and necessary 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 any bills paid under Section 8(j) of the Act.

ORDER

The petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left knee that arose out of and in the course of her employment by respondent on 4/19/23. The petitioner's claim for compensation is denied.

In no instance shall this award be a bar to a 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 14, 2024

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 39 year old Team Member, alleges she sustained an accidental injury to her left knee that arose out of and in the course of her employment by respondent on 4/19/23. Respondent disputes. The issues in dispute are accident, as well as causal connection, medical, temporary total disability, and prospective medical expenses as they relate to liability.

Petitioner began working for respondent in January of 2022, through Entegee, a staffing company. In January of 2023 petitioner became an employee of Rivian. Petitioner works in the Body Division, working on the skateboard where they work on the frame of the Rivian vehicle. Petitioner underwent training and orientation when she became an employee of Rivian.

Rivian has 5 parking lots: A, N, North, South, and East. The only parking lot with a shuttle bus to and from the plant is the North lot. Anyone, including the public, can park in the North lot. Petitioner also has keycard access to park in the East lot. To enter the plant the employees can enter Entrances A, B, and C with their ID, and anyone, including the public, can enter through the Main Entrance and go through security at that point. Rivian has no security gates at any of the roads that lead to the plant or its plant parking lots that are not Badge Access only. Anyone, including the public, can drive in and park in the North lot. Much discussion was had about trespassers on the property, but it was agreed that anyone with business at the Rivian plant, whether it be vendors, employees, other professional that have meetings at the plant, and the members of the public that may have business at Rivian or are simply there to pick up their vehicle, can park in any parking spot or lot that does not have Badge Access only, including the North lot. Petitioner testified that employees were encouraged to park in the North lot.

Petitioner testified that she worked in the plant that is behind Building C. For that reason, petitioner testified that she enters the plant through the C Entrance. Petitioner works the 3rd shift, which is from 6:00 pm to 7:00 am. Petitioner testified that she can park in front of the plant, if a spot is available, or park in the East lot and the North lot. Petitioner testified that she preferred to park in the North lot because it had a shuttle bus that picks her up and drops her off at the C Entrance. Petitioner stated that she did not like to park in the East lot because there was no shuttle bus, and she would have to walk to the C Entrance. Petitioner stated that there is a walking path from the North and East parking lots to the plant if people would like to walk to the plant instead of taking the shuttle bus. Petitioner testified that the North lot is 1 ½ miles to the plant. Matthew Christopher, Senior Manager of Claims Operations and Strategy, testified that the North lot is about ½ mile from the plant.

Petitioner testified that she is not required to park in a specific parking lot, and is not required to take the shuttle bus from the parking lot to the C entrance. Petitioner testified that the East parking lot is closer to the plant than the North lot, but more dangerous because of the trucks. Petitioner testified that she has used the East lot when it is not full.

On 4/19/23 petitioner arrived for work and parked her vehicle in the North Parking lot and took the shuttle bus to the C entrance at the plant. Petitioner then proceeded to the Body Division, where she works. Petitioner testified that while working that day she developed swelling in her legs and left knee. At the end of her shift, after bending and lifting a lot, petitioner noticed that her left knee was swollen and painful. Petitioner testified that she had been working a lot and her legs were hurting. She also testified that she had bought insoles for her shoes due to the pain in her legs.

After her shift, petitioner got onto the shuttle bus to return to her vehicle which was parked in the North lot. Petitioner testified that the shuttle bus she got on was similar to the Proterra Catalyst E2 bus depicted in Respondent's Exhibit 4. This bus is similar to a city bus. The maximum step height for the front door is 15.5".

Petitioner testified that when the shuttle bus arrived at the vestibule near her vehicle (Shuttle Stop 3) she exited the front door of the shuttle bus. There were a few people who got off before here, and there was one person behind her. Petitioner did not feel rushed getting off the shuttle bus, and was not carrying anything work related. Petitioner testified that as she stepped out of the bus to the ground (about a foot) she twisted her left knee, and felt a pop in her left knee. Petitioner testified that after that, the bus had already left, so she headed to her vehicle, which was right in front of her. She stated that she did not look at her knee until she got into her car. She noted that it was swollen. Petitioner testified that she was not aware that the bus could "kneel down" or lower to let people off.

Petitioner testified that it was not snowing, or raining, and the ground she stepped onto was not wet. She also testified that the ground was level, and there was no debris on the ground where she stepped off the shuttle bus. Petitioner stated that there was no defect in the bus stairs, or debris on them. She testified that she was not claiming that the weather on 4/19/23 contributed to her injury that day.

After leaving work on 4/19/23, petitioner presented to OSF Glen Park to be seen for her left knee. Petitioner reported that she was seeking care for an injury that occurred at her place of employment. She stated that her supervisor was aware of her injury, but did not send her to seek treatment or request any testing. Petitioner reported that her left knee problems started at work that day. She denied any injury, but stated that her left knee just started swelling up at work that day. She thought it was due to standing,

because they are not allowed to sit at work. Petitioner then reported that as she stepped off the bus to go to her car she heard a pop in her left knee. She rated her pain at a 5/10. She initially complained of posterior knee pain, but than was experiencing anterior knee pain. An examination revealed tenderness to palpation; no tenderness of the joint line, popliteal fossa, and patella; normal patellar motion, knee extension, and knee flexion; no crepitus or ligament laxity; negative Lachman's test and Homan's test; and, normal calf muscles and gait. An x-ray of the left knee revealed a small to moderate suprapatellar joint effusion without acute osseous abnormality, and mild degenerative changes of the left knee. It was noted that if the pain persisted an MRI should be considered. Petitioner was prescribed Naproxen for pain, and given an ACE wrap.

On 4/20/23 petitioner presented to HCHC Knoxville for her left knee. She reported that her pain began a day ago. She noted that the pain was located both medially and laterally. She described her pain as throbbing. She reported that the knee has given out or felt unstable. Petitioner gave a history of working 12 hours and feeling pain in her left knee. She noted that the left knee was swollen. She reported that when she was going down the bus stairs her left knee popped. Following an examination and review of the x-rays, petitioner was assessed with patellar tendinitis of the left knee. Petitioner was restricted from lifting greater than 10 pounds. She was given a knee brace and prednisone pack.

On 5/8/23 petitioner was seen by Dr. Oliver at HCHC Knoxville. Petitioner gave a history that on 4/19/23 she noticed that during the day her left knee was starting to swell and was a little bit painful. She then reported that at the end of the day she got on the shuttle bus to go back to her car, and as she was getting off of the bus she twisted on her left knee and felt a pop in her left knee. She reported that her left knee pain greatly intensified after that, and there was subsequent worsening over the next 3-4 days. She reported minimal improvement in her pain, but noted that her swelling had improved. She noted that her left knee locks and catches on her, which it had not done previously. Following an examination, Dr. Oliver assessed acute pain of the left knee, and ordered an MRI of the left knee. Petitioner was restricted to light duty work.

On 5/24/23 petitioner underwent an MRI of the left knee. The impression was Grade 3 anterior cruciate ligament sprain; complex tearing of medial meniscus body, posterior horn and posterior root; radial tear of lateral meniscus posterior root; early osteoarthritis; and, popliteal cyst.

On 6/22/23 petitioner presented to OSF PIA Orthopedics for her left knee. She gave a history of getting off the shuttle bus and her left knee gave out on her. She stated that she felt and heard a pop in her left knee. Petitioner was seen by Dr. Jordan Meiss. Dr. Meiss was of the opinion that petitioner had a complete ACL tear with medial and lateral meniscal tearing, somewhat complicated by the presence of

some underlying medial compartment osteoarthritis. Petitioner complained of a painful knee that was unstable and gives out. Dr. Meiss was of the opinion that living with meniscal tearing, as well as instability, may only lead to the progression of her underlying osteoarthritis. Dr. Meiss examined petitioner and assessed a complete tear of the left anterior cruciate ligament; acute pain of the left knee; complete tear of the medial meniscus of the left knee; other tear of the left knee lateral meniscus; and, primary osteoarthritis of the left knee. Due to the risk of ongoing instability and progressive arthritis, Dr. Meiss recommended an ACL allograft reconstruction, as well as meniscal correction surgery. Dr. Meiss was of the opinion that the surgery would help stabilize the knee and promote healing, and lessen the progression of osteoarthritis. Petitioner informed Dr. Meiss that she wanted to undergo the recommended surgery.

On 10/13/23 respondent sent a denial letter to petitioner's attorney regarding petitioner's claim.

On 10/18/23 petitioner was seen in Dr. Blair Rhode's office, on the recommendation of her attorney. She was examined by Dr. Rhode's PA, Lori Welke. She gave a history of working the line on 4/19/23 by herself. She noted that she normally worked with one other person, but none were present that day. She reported that while walking back and forth picking up large heavy boxes of parts weighing 20-30 pounds, her legs became painful and swollen, as they had done before. She also reported that as she was getting off the shuttle bus her left leg just gave out from under her and she collapsed. She was unable to walk or bear weight on it. She noted that she had leg pain from all the hours of standing she did days prior to 4/19/23, so she had been wearing compression socks to help. She denied any prior injuries or problems. She reported that her left knee continued to be painful and popped, and it was unstable. Following a physical examination and record review, Welke noted that petitioner has a job where she is on her feet 72-80 hours per week; she described a particularly painful day with excessive left knee swelling and her left knee gave out causing her to collapse and be unable to walk; and, she has had pain and instability since. Welke recommended surgery to repair her ACL, as well as her medial and lateral meniscus tears. She gave petitioner medications, a hinged knee brace, and an infrared heat pad wrap. Welke took petitioner off work and instructed her to return in a week to discuss surgical options with Dr. Rhode.

On 10/25/23 petitioner presented to Dr. Rhode for reevaluation of her left knee. Petitioner related that she was working as a loader at reman and working long hours; that she was required to repetitively lift 20 pound objects; that she assembles approximately 100 skateboards per shift; that she is required to bend approximately 2 times per skateboard; that her left knee popped; and, that her left knee gave way. Dr. Rhode examined petitioner and reviewed the diagnostic tests. Dr. Rhode assessed a medial meniscus

tear with an ACL tear. Dr. Rhode was of the opinion that petitioner would likely require an arthroscopic ACL reconstruction to restore her stability. Dr. Rhode performed an intra-articular injection for diagnostic and therapeutic purposes. He continued petitioner off work.

Petitioner returned to Dr. Rhode's office on 11/29/23. Petitioner reported that the injection had helped with her pain, but she still had popping in her left knee. Following a physical examination, Welke prescribed physical therapy. Petitioner was released to sedentary work, with a maximum 10 pounds or less lift/carry, and occasional lift/carry. Petitioner underwent 3 physical therapy sessions on 11/30/23, 12/6/23 and 12/11/23.

Petitioner followed up with Dr. Rhode on 1/2/24. Following an examination, petitioner reported that she wanted to undergo the ACL reconstruction with a hamstring allograft and a partial medial meniscectomy recommended by Dr. Rhode. Dr. Rhode continued petitioner on light duty.

On 1/31/24 the evidence deposition of Dr. Blair Rhode, an orthopedic surgeon, was taken on behalf of the petitioner. Dr. Rhode is board certified in orthopedic surgery and sports medicine. Dr. Rhode testified that he was recommending an ACL reconstruction and partial medial meniscectomy. Dr. Rhode opined, based on petitioner's denial of a preexisting knee condition, followed by a competent mechanism of injury to her left knee giving way and popping, that there is a causal connection to her ACL tear and meniscal tear. He opined that the ACL and medial meniscus were torn secondary to the knee giving away with a twisting maneuver. Dr. Rhode also opined that petitioner's job exposure, and the repetitive nature of it, could have been a causative for the swelling. Dr. Rhode opined that the recommended surgery is causally related to the work accident petitioner was involved in on 4/19/23. Dr. Rhode noted that following the surgery petitioner would need 8-12 weeks of physical therapy, and could return to modified work 3-4 months postop, and full duty 5-6 months postop. Dr. Rhode opined that all his medical treatment of petitioner was reasonable and necessary, and that his recommended treatment is also reasonable and necessary.

On cross-examination Dr. Rhode was of the opinion that none of the repetitive job duties, or general job duties described by petitioner were the cause of her ACL or medial meniscus injury. When asked if the swelling in petitioner's knee, if it existed on 4/19/23 before she stepped off the bus, caused or contributed to the ACL, Dr. Rhode testified that "other than the repetitive nature of her job causing fatigue on that leg which predisposed her knee to give way getting off the bus, but it is still my opinion that the twisting injury was causative to both the ACL and the meniscus." Dr. Rhode agreed that the swelling in petitioner's left knee prior to stepping off the shuttle bus was complicated by the fact that the repetitive nature of her job irritated the left medial compartment. Dr. Rhode agreed that petitioner could

have had the presence of underlying osteoarthritis which may have been temporarily exacerbated or aggravated by her work tasks, but then not suffer an ACL injury. He also agreed that the ACL injury was really caused by the twisting event on 4/19/23 when she stepped off the shuttle bus. Dr. Rhode testified that he was unaware that petitioner was involved in a motor vehicle accident on 10/11/23.

Although there is no office note for 2/7/24, there is a return to work note continuing petitioner's sedentary light duty work restrictions.

Matthew Christopher, Senior Manager of Claims Operations and Strategy, was called as a witness on behalf of respondent. His duties include overseeing all Claims Operations on the Corporate side, including workers' compensation. Christopher stated that he was familiar with the Normal Rivian grounds, and that he travels to Normal 1-2 times a week to visit the plant. Christopher is aware of the operations at the plant. He also makes and keeps documents on the Grounds and Bus Operations, including maps. Christopher became aware of petitioner's workers' compensation claim as part of his duties.

Christopher testified that anyone, including the general public with business at the plant, can pull into the North lot and take the shuttle to the Main Entrance to enter the plant. Christopher testified that most employees use the North lot for parking because it is the largest. He further testified that no employee is mandated to use the North lot, or the shuttle bus to take them to the plant. He stated that there is a walking path from the North parking lot. If someone was to take the walking path it to the C Entrance it would take about 12 minutes to walk. Christopher stated that the parking lot is paved, and the walking path is patted down gravel.

Christopher testified that he would be notified if there were any problems with the parking lots or buses. He testified that the buses are regularly serviced and inspected. The buses are operated by Transwest. No bus goes into service without being inspected. If there is a problem the bus is taken out of service.

Christopher testified that there was a process in place for employees to report any problems or defects that they see, by reporting it through Benchmark. Once it is received by Benchmark, the appropriate teams are alerted to address the issue reported. Christopher testified that he was not aware of any defects or problems with Vestibule 3 in the North parking lot on 4/19/23, or problems with any of the shuttle buses in operation on 4/19/23 that operated in the North parking lot. Christopher stated that on 4/19/23, three Proterra Catalyst 2 buses, and one Arboc Equess shuttle bus were in operation from the North parking lot to the plant.

On cross-examination Christopher testified that customers can set up pickup of their new Rivian vehicle at the Rivian plant in Normal, right behind the production plant. In order to pick up the vehicle, the customer must check in at the main entrance. Such customers could park in the North lot and take the shuttle bus to the main entrance. Christopher testified that anyone from the general public can come and park in the North parking lot and take the shuttle bus to the Rivian plant, but should have business with Rivian. Christopher testified that people not there for a business reason might be considered trespassers and asked to leave. Christopher testified that he was not made aware of the injury until more than 30 days following the alleged injury. As a result, there was no video for him to review, given that the video is only saved for 30 days. Christopher testified that the distance from the North parking lot to the C Entrance is about ½ a mile. Christopher said a lot of people come to Rivian in Normal that are not employees, who are allowed to use the North parking lot and take the shuttle bus to the Main Entrance.

Petitioner testified that currently her left knee pops and hurts, and it hurts when she gets up and down. She further testified that she has two braces, and wears the one from Dr. Rhode all the time. She stated that the brace keeps her left knee in place. She testified that if she is not wearing her brace, her left knee jerks and she could lose her footing. Petitioner testified that she has not returned to work since the date of injury. She denied any problems with, or treatment for, her left knee prior to the injury. She also denied any new injuries since 4/19/23.

Petitioner testified that she was not in a motor vehicle accident on 10/11/23, but rather her car was hit while on the side of the road, and a rock was thrown at it. Petitioner testified that she was not in the car when the damage occurred. She only filed a property damage claim.

Petitioner testified that she emailed Cornell on the date of injury. Email conversations between petitioner and Cornell were offered into evidence. RX6. On 4/16/23 petitioner texted that she was in the emergency room since last night. Some reports were sent that are illegible. On 4/19/23 petitioner sent a report from OSF Medical that is illegible. On 4/20/23 petitioner sent a text asking if Cornell had received her doctor note indicating that she injured her knee and needed to stay off it. Cornell responded that he did. He also asked petitioner how and when she injured herself at work. Petitioner responded that “I was leaving on the 19th when I went to get off the bus my leg gave out and I heard a popping sound then I couldn’t walk on it. I went to prompt care that morning.” She also text “I hadn’t told Brandon my leg was bothering me that’s why I was having troubles.” Petitioner testified that she did not tell Cornell that she had any problems with her left knee at work prior to the injury on 4/19/23.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Whether or not an accident occurred that arose out of and in the course of petitioner's employment by respondent on 4/19/23 is the threshold issue in this case. Petitioner claims that she was involved in a work-related accident on 4/19/23, that arose out of and in the course of her employment by respondent. Alternatively, respondent claims petitioner failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left knee that arose out of and in the course of her employment by respondent on 4/19/23.

Petitioner testified that while working for respondent on 4/19/23 she developed swelling in her legs and her left knee. She further testified that by the end of her shift, after bending and lifting a lot, she noticed that her left knee was swollen and painful after working a lot. Once petitioner's shift ended, she got on the shuttle bus (similar to a city bus) and headed back to the North Lot where she had parked her car. When the bus arrived at Vestibule 3 Shuttle stop in the North Lot, petitioner disembarked the bus. She stated that she did not feel rushed getting off the bus. Petitioner testified that as she stepped off the bus to the ground (about a foot) she twisted her left knee and felt a pop. Petitioner stated that the bus had already left, so she headed to her vehicle which was right in front of her. Once she got in her car, she looked at her left knee and noted that it was swollen. The arbitrator notes that at the time petitioner completed her shift on 4/9/13 her left knee was already swollen and painful after working a lot that day.

In order for an injury to be compensable under the Act it must arise out of and in the course of the petitioner's employment by respondent. In the case at bar, the parties stipulate that the injury occurred in the course of the petitioner's employment by respondent. The dispute is whether or not petitioner's injury arose out of her employment by respondent on 4/9/13.

Arising out of the employment refers to the origin or cause of the claimant's injury. *Caterpillar Tractor Co. v Industrial Comm'n*, 129 Ill. 2d 52 (1989). Specifically, for an injury to "arise out of" one's employment, its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. Typically, an injury arises out of one's employment if the employee was performing acts he was instructed to perform by his employer, acts which he 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. 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*, 129 Ill. 2d at 58.

In recent years, the court has carved out a further means for an accident to “arise out of” one’s employment in the matter of *McAllister v. Illinois Workers’ Comp. Comm’n*, 2020 IL 124848. When addressing the three categories of risk in Illinois, the Supreme Court readdressed the *Caterpillar Tractor* standard concerning risk associated with employment and the specific provision regarding “an act that the employee might be reasonably expected to perform incident to his or her assigned duties.” *McAllister*, 2020 IL 124848, citing to *Caterpillar Tractor*, 129 Ill. 2d. at 58; *The Venture – Newberg-Perini, Stone & Webster v Illinois Workers’ Compensation Comm’n*, 2013 IL 115728 ¶18; *Sisbro*, 207 Ill. 2d at 204. Further, in that case, the claimant’s act of kneeling, while alone was a common bodily movement, was a function of the foreseeable, known, and admitted job duty of using the walk-in cooler to complete his job tasks for the employer. *McAllister*, 2020 IL 124848.

The “common bodily movement” rule from *McAllister* still required that the common bodily movement was related to a foreseeable task, duty, or activity incident to his employment. *McAllister*, 2020 IL 124848. In *McAllister* the Supreme Court did not rule that any common bodily movement performed on the employer’s premise was a compensable accident, as the court specifically held the claimant’s injury was an employment specific risk. *McAllister*, 2020 IL 124848. The arbitrator notes that the law and rules regarding the assessment of the three types of risk, and the laws regarding the application of “neutral risks” were not overturned by the *McAllister* decision, 2020 IL 124848. Under its assessment of “D. Injuries Caused by Common Bodily Movements”, the Supreme Court specifically held that:

“*Caterpillar Tractor* prescribes the proper test to analyzing whether an injury “arises out of” a claimant’s employment when the claimant is injured performing job duties involving common bodily movements or routine “everyday activities.” In analyzing whether an injury resulting from an everyday activity or common bodily movement arises out of a claimant’s employment it must first be determined whether the employee was injured performing one of the three categories of employment-related acts delineated in *Caterpillar Tractor*, 129 Ill. 2d at 58, see also *The Venture-Newburg-Perini, Stone & Webster*, 2013 IL 115728 ¶ 18; *Sisbro*, 207 Ill. 2d at 204... *Caterpillar Tractor* has not been overruled and remains the starting point for analyzing “arising out of” injuries, even those that involve common bodily movements and everyday activities. Only if it is established that the risk of injury for a worker who was on the job does fall within one of the three categories of employment-related acts delineated in *Caterpillar Tractor* should the Commission consider applying a neutral-risk analysis.” *McAllister*, 2020 IL 124848.

The three-part *Caterpillar Tractor* test finds that a risk is distinctly associated with an employee’s employment if, at the time of the occurrence, the employee was performing (1) acts he or she was instructed to perform by the employer, (2) acts that he or she had a common-law or statutory duty to perform, or (3) acts that the employee might be reasonably expected to perform incident to his or her assigned duties, 129 Ill. 2d at 58.

With respect to part one (acts he or she was instructed to perform by the employer), both parties agree that petitioner was not mandated to park in the North Lot. However, the materials employees were given noted that the North Lot was encouraged, due to the fact that it was the largest parking lot. In addition to being encouraged to park in the North Lot, petitioner testified that she had keycard access to the East Lot. Petitioner stated that the East Lot is closer to the plant than the North Lot, and she had parked in this lot when it was not full. In addition to the North Lot and the East Lot, petitioner testified that she could even park in front of the plant if there was a space available. Petitioner testified that she was not required to park in any specific Lot, and was not required to take the bus from the parking lot to the C entrance.

The arbitrator notes that when parking in the North Lot, in addition to taking the shuttle bus to the plant entrances, there is a walking path available to those who choose to bypass the shuttle bus and walk from the North lot to the plant entrances. Christopher estimated that the time to walk from the North Lot to the C entrance (1/2 mile) was about 12 minutes.

The arbitrator also notes that the North Lot was not for the exclusive use of respondent's employees. All respondent parking lots without keycard access were open to anyone that came to Rivian. The North Lot did not require keycard access. In fact, anyone, including the general public, can drive in and park in the North Lot and take a bus, or walk to the plant. This includes vendors, employees, other professionals that may have meetings at the plant, members of the general public that may have business at Rivian, and members of the general public that are simply there to pick up their vehicle. There was much discussion regarding trespassers in the North Lot, but it was agreed that anyone with business at the plant could park in the North Lot. The arbitrator finds that anyone can access the North Lot and get on the bus, or walk from the North Lot to the plant. It is not until the person arrives at the plant that they would encounter any security.

With respect to part two of the test (acts that he or she had a common-law or statutory duty to perform) the arbitrator finds petitioner failed to offer any credible evidence to support a finding that she had a common-law or statutory duty to ride the bus between the North Lot and the C entrance.

With regards to the third, and last part of the test (acts that the employee might be reasonably expected to perform incident to his or her assigned duties), the arbitrator finds that although it is foreseeable that petitioner would use the shuttle bus from the North Lot before and after her shift to get to and from the plant, riding the shuttle bus was not an act the employee might reasonably be expected to perform incident to his or her assigned duties given that riding the shuttle bus had nothing to do with petitioner's assigned duties. In fact, the arbitrator finds it significant that unlike in the *McAllister* case petitioner had already completed her assigned duties for the day, her shift had ended, and she was heading home. Although the petitioner chose to park in the North Lot, the arbitrator finds it significant that petitioner had alternate sources of parking available to her that were closer to

the plant and did not involve the use of a shuttle bus to get to the plant. Additionally, the arbitrator notes that the petitioner also had the option of walking from the North Lot to the plant.

Based on the above, the arbitrator finds the petitioner did not meet the threshold test under *Caterpillar Tractor*. The arbitrator further finds petitioner's simple act of stepping off a bus step after she had completed her shift was not a risk associated with her employment for respondent, and therefore, the *McAllister* rule does not apply to petitioner's claim.

In determining whether a claimant's injury arose out of his or her employment Illinois courts recognize three categories of risks: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and, neutral risks. *McAllister*, 2020 IL 124848.

"Injuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public." *Springfield Urban League v Illinois Workers' Compensation Comm'n*, 2013 IL App (4th) 120219WC ¶ 27. "Such an increased risk may be either qualitative, such as some aspect of the employment which contributes to the risk, or quantitative such as when the employee is exposed to a common risk more frequently than the general public." *Metropolitan Water Reclamation District of Greater Chicago v Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1014 (2011).

A fall that occurs while traversing stairs is normally a neutral risk that generally does not arise out of the employment. *Village of Villa Park v. Illinois Workers' Compensation Comm'n*, 2013 IL App (2d) 130038WC (citing Ill. Consol. Tel. Co., 314 Ill. App. 3d at 353). However, the court in this case did assert traversing stairs can be a quantitatively increased risk if the stairs were ascended or descending a significantly increased amount. *Id.* at ¶ 21. In that case, the Petitioner ascended and descended stairs over six time per day, every day, and the staircase was a total of approximately twenty stairs each time. *Id.* at ¶¶ 4; 5; and 21.

In contrast, the petitioner in this case only got in and out of the bus at most, on 2 occasions a day. The arbitrator finds the petitioner's act of stepping into and out of the shuttle bus was not a quantitatively increased risk from the general public. The arbitrator finds this case distinguishable from *Village of Villa Park*, given that petitioner's act of stepping into and out of the shuttle bus was at most 2 times per day, and petitioner was not required to park in the North Lot, and was not required to take the shuttle bus to and from the plant. Petitioner clearly testified that she had other means of ingress and egress to the plant that did not require her to access the shuttle bus, namely parking in the East Lot or in front of the plant, or walking from the North Lot to the plant entrance.

If an employee is holding an object connected to their employment (*Knox County YMCA*, 311 Ill. App. 3d at 885), or if someone was in a hurry or rushed due to their employment (*Cf William G Ceas & Co. v Industrial Comm'n*, 261 Ill. App. 3d 630, 636-37 (1994)), a risk may be qualitatively increased from that of the general public. However, the petitioner in this case specifically testified that she was not carrying an object connected to her employment, nor was she in a hurry or rushed to disembark the bus.

Specifically, the arbitrator notes that the Commission has twice addressed the mere act of stepping off a bus. The Commission has twice addressed the mere act of stepping off a bus. *Carrillo v Chicago Transit Authority*, 17 IWCC 668, and *Totten v Pace Bus Transportation*, 2010 Ill. Wrk. Comp LEXIS 637. Neither decision cited to a higher court on their bases for the opinion, but both specifically state the mere act of stepping off a bus does not create a risk greater than that of the general public. *Id.* Both take this position almost as a given, with the *Carrillo* decision stating, “many people ride buses daily, to and from work or just to get around a city for site seeing. They step on and off buses on a regular basis.” *Carrillo*, at ¶21.

Given that petitioner testified that at most she stepped on the bus once per day, and stepped off the bus once per day, the arbitrator finds the petitioner was no greater risk than the general public that ride the bus to and from work each day, or anyone that steps on and off a bus as their means of getting around the city, or tourists who may get on and off a bus as a means of site seeing. Additionally, the arbitrator finds, based on the credible evidence, that the shuttle bus petitioner took between the North Lot and the plant each day was similar to the buses that are used all over for public transportation. The arbitrator further finds that the bus system respondent provided to the North Lot included bus options almost identical to the city buses, with the use of similar buses, and bus stops. The arbitrator also finds it significant that the North Lot was not a secure lot for the exclusive use of employees, but rather it was a parking lot open to anyone who had business at Rivian, including the general public. Therefore, the arbitrator finds petitioner’s act of stepping on and off the bus each day did not create a risk greater for petitioner than the general public.

The arbitrator also finds it significant that the petitioner testified that it was not snowing or raining, and the ground she stepped onto was not wet. She further testified that the ground was level and there was no debris on the ground when she stepped off the shuttle bus. Petitioner also testified that there was no defect in the bus stairs, and there was no debris on them. In summary, petitioner testified that she was not claiming that the weather on 4/19/23 contributed to her injury. Petitioner also testified that her left knee was swollen and painful when she stepped off the bus. She reported that her left knee swelled up and was painful at work that day, but denied any injury.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left knee that arose

out of and in the course of her employment by respondent on 4/19/23. The arbitrator finds petitioner failed to establish that her risk of injury fell within one of the three established categories of employment-related acts delineated in *Caterpillar Tractor*. The arbitrator further finds the “common bodily movement” or “routine everyday activity” provisions created by the *McAllister* decision are not applicable to the case at bar.

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?

K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

L. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Having found the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left knee that arose out of and in the course of her employment by respondent on 4/19/23, the arbitrator finds these remaining issues moot.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC002031
Case Name	Jean Ellis, Administrator of the Estate of Jon Ellis v. Haag Landscape & Stonework
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	25IWCC0490
Number of Pages of Decision	23
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Thomas Crosby, Stephen Stone
Respondent Attorney	Casey Fitzgerald

DATE FILED: 12/10/2025

/s/Stephen Mathis, Commissioner

Signature

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 JEFFERSON)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☒ Modify	☐ PTD/Fatal denied
		☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jean Ellis, Administrator of the Estate of Jon Ellis,

Petitioner,

vs.

No. 19 WC 02031

Haag Landscape & Stonework, and
Illinois State Treasurer as Ex-Officio Custodian of the Injured Workers' Benefit Fund,

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent Injured Workers' Benefit Fund (IWBF) and notice given to all parties, the Commission, after considering the issues of employment relationship, accident, temporary disability, medical expenses, permanent disability and liability of IWBF, 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 January 14, 2019, Jon Ellis (hereinafter Decedent), by a former attorney, filed an application for adjustment of claim against Haag & Haag Landscape & Stonework alleging that on March 14, 2018, he sustained an accident "within scope of employment while lifting railroad tie for landscaping." Decedent alleged a back injury. On April 22, 2019, Decedent amended his application for adjustment of claim to add as co-Respondent the Illinois State Treasurer, without mentioning IWBF. On December 5, 2023, Decedent further amended the application for adjustment of claim by changing the date of accident to March 21, 2018.

On May 14, 2024, the Arbitrator filed a Decision finding the claim compensable and awarding temporary total disability, medical and permanent partial disability benefits.

On June 4, 2024, IWBF timely filed a Petition for Review.

On July 24, 2024, Decedent's (second) attorney filed a "Suggestion of Death" "suggest[ing], on information and belief, that the petitioner, Jon Nathan Ellis, died on or about July 6, 2024." On June 17, 2025, Decedent's estate, by a successor (third) attorney, filed an amended application for adjustment of claim substituting the estate as Petitioner, changing Respondent-employer's name to Haag Landscape & Stonework, and properly naming IWBF as co-Respondent.

The main arbitration hearing took place on December 5, 2023. A second hearing was needed because IWBF was not present during the main hearing. IWBF adduced additional evidence and ratified the transcript of the main hearing.

Decedent, who was still living at the time of the arbitration hearing, testified on direct examination that he was 42 years old at the time of the alleged accident on March 21, 2018. He worked for Respondent-employer as a landscaping laborer. The accident occurred at Pheasant Hollow Winery in Whittington, Illinois. Decedent drove to the job site and began to work at "8 or 9." "We had a stone wall to do, but we also had to tear down a railroad tie [retaining] wall." Decedent performed the work with Tom Haag, the owner of Respondent-employer. Decedent described the accident as follows:

"We had a 4-foot space, maybe, and we had to take apart the railroad tie wall. Tom had insisted to lay the first row of block on the ground because he wanted it to set up. I didn't think it was a good idea because it took our foot space away.

Anyway, we laid the first row of block. I was on the inside towards the wall when we lifted—you had to lift the railroad tie up off the steel, so my legs were spreading because of the row of block. And when I turned, I felt immense pain."

Decedent felt the pain in his low back and stomach. Decedent immediately told Mr. Haag while they were both holding the railroad tie. Mr. Haag dropped his end of the railroad tie. Decedent continued: "Upon dropping, I said the word, No, and then I went to all fours on the ground. It was immense pain, kind of hard to breathe." Decedent told Mr. Haag that he had to go to the hospital. Mr. Haag did not say anything. Decedent denied prior low back problems.

Decedent further testified that he received emergency treatment at Heartland Regional Medical Center. Decedent texted Mr. Haag about his emergency room visit and resulting medical bill. Mr. Haag said he would take care of the bill. Next time Decedent sought treatment for his injury was a month later, on April 26, 2018, when he presented at Harrisburg Medical Center. He was given medication and discharged. Three days later, on April 29, 2018, Decedent returned to Harrisburg Medical Center because he was not improving.

Decedent further testified that he also saw Physician's Assistant Curt Morris at Christopher Rural Health Clinic. PA Morris referred Decedent to the Orthopaedic Institute of Southern

Illinois, where Dr. Swastik Sinha assumed his care. Ultimately, Dr. Sinha performed fusion surgery at L5-S1. After the surgery, Decedent felt “not well,” with “[c]ontinued pain, lack of motion.” Decedent followed up with Dr. Sinha, “for a little bit,” through March of 2019, until Decedent moved to Nashville, Tennessee. Decedent continued to suffer from low back pain with radiation down the left leg.

Decedent further testified that on September 25, 2019, he received some treatment at Vanderbilt Medical Center. In January of 2020, Decedent came under the care of Dr. Ivan Stoev. Decedent acknowledged being in a car accident in January of 2020. He described the car accident as minor, although he did seek medical treatment. He denied the car accident made his condition worse.

On July 16, 2020, Dr. Stoev performed a revision surgery. Decedent stated that until the revision surgery, he had constant back pain and was unable to work because of the work accident. The revision surgery helped the back pain, but did not take it away. The revision surgery took away the leg pain. A month after the surgery, on August 19, 2020, Dr. Stoev instructed Decedent to follow up as needed. Decedent has not treated since.

In 2021, Decedent moved back to Illinois. He did not work or look for work, explaining: “I don’t know what job they’re going to give me that will let me sit down when I need to or lay down when I need to.” Decedent was a high school graduate with a work history as a heavy laborer. At the time of the arbitration hearing, Decedent still had low back pain. The pain was always there, a 4-5/10. Decedent stated he did not take medication for the pain. He did not return to the workforce, other than attempting to work as a delivery driver for UberEats on and off for a year.

On cross-examination, Decedent testified that he did not have regular employment. Decedent worked for Mr. Haag only occasionally. Decedent generally reported to the job site at 8:30 a.m. When shown a picture of a block wall being built, Decedent stated that Mr. Haag continued to build it after he left for the hospital. Only one row was done when the accident occurred. The railroad ties used to be directly behind where the block wall was being built. Decedent was asked about his start time the day of the accident. Decedent stated he got there early. Mr. Haag arrived no later than Decedent. They immediately began to work. The railroad tie wall was approximately 3 ½ feet high, but could have been 4 ½ to 5 feet tall because it was on higher ground. The railroad ties were fastened together by rebar. The railroad ties measured “about 8 ½ inch square,” 8 feet long, and made of oak wood. The first task of the day was to disassemble the railroad tie wall. Decedent and Mr. Haag were standing “on concrete” when they lifted the first railroad tie.

Decedent admitted abusing painkillers. After Decedent tested positive for cocaine, Christopher Rural Health refused to fill any more prescriptions for controlled substances.

Thomas Haag testified on direct examination that he was the owner of an LLC landscaping and stonework company. Decedent worked for Mr. Haag as a laborer on as-needed basis. In 2018, Decedent worked for Mr. Haag four full days. Wage records in evidence confirm the casual nature of the employment.

Mr. Haag further testified that the Pheasant Hollow Winery project involved removing an old retaining wall made of railroad ties and replacing it with a stone wall. The railroad ties were 8 inch by 8 inch square, approximately 8 feet long, and made of solid oak. They weighed up to 150 pounds. The railroad ties had to be removed before a new wall could be constructed. The railroad tie wall was secured with heavy rebar. The wall was 5 feet tall and 30 feet long. The railroad tie wall could not be dismantled by two people lifting the railroad ties. Rather, Mr. Haag used a skid steer (Bobcat machine) to dismantle the wall.

On March 21, 2018, Mr. Haag arrived at the job site at around 8:20 a.m. Decedent's vehicle was already there, but he was not in the vehicle. "I walked around to the back where the wall was being built, and [Decedent] was leaning up against the building, and he said, I think I hurt my back. Okay. You know, What happened? He said he was lifting on a tie." Mr. Haag denied telling Decedent to lift a tie; he did not believe Decedent. Mr. Haag offered to take Decedent to urgent care, so that a drug test could be performed. Decedent responded that he would rather go home and rest. After Decedent went to the hospital, he and Mr. Haag texted back and forth. On March 27, 2018, Decedent asked if Mr. Haag had more work for him. Mr. Haag had completed the wall and did not have any more work for Decedent.

On cross-examination, Mr. Haag testified that he dismantled the railroad tie wall by himself using the skid steer. Mr. Haag did not explain why he needed Decedent to come to work on March 21, 2018. Mr. Haag reiterated that he wanted Decedent tested for drugs because he suspected Decedent was a drug user. However, Mr. Haag never saw Decedent "under the influence."

In evidence are photographs of the scene of the alleged accident and salvaged railroad ties after the railroad tie wall was dismantled. There is also a drawing of the railroad tie wall. Also in evidence are text exchanges between Decedent and Mr. Haag. On March 21, 2018, Decedent texted that he had "[s]evere muscle strain" and was "not supposed to move for couple days." The following day, Mr. Haag texted a picture of a partially completed block wall. Decedent texted that a doctor's note said he could return to work "after sat." On March 23, 2018, Decedent made arrangements to pick up his paycheck and drop off the work status note. The work status note, which is in evidence, released Decedent to return to work on March 24, 2018. On March 27, 2018, Decedent texted about returning to work. Mr. Haag asked Decedent to send the medical bill and stated that he did not need any help that week. On April 11, 2018, Mr. Haag again asked for the medical bill and stated that he did not need any help that week.

The attorneys for Decedent and Respondent-employer represented that Respondent-employer did not have workers' compensation insurance, and "[t]here is a companion civil case against the broker that let the policy lapse." The attorneys further represented that IWBF had been "served." The Arbitrator ruled: "They [IWBF] are not part of this claim on any pieces of evidence that you have admitted here today, not one. This case cannot proceed without [IWBF] representative here." As noted, a second hearing was held. IWBF adduced additional evidence and ratified the transcript of the first hearing. However, there is no certification in evidence from the National Council on Compensation Insurance (NCCI) showing Respondent-employer was uninsured.

The medical records in evidence show that on March 21, 2018, Decedent arrived at Heartland Regional Medical Center at 10:47 a.m. and complained of back pain. "The symptoms/episode began/occurred 1 hour(s) ago. Pt complains of low back pain after pulling on railroad ties at work approx 1 hour ago. *** Pain is rated 10/10." The attending physician diagnosed a sprain/strain. The staff administered Norflex, Toradol and Valium. "ED course: Pt reports pain improved from 11/10 down to 7/10." Decedent was prescribed medication and released to return to work full duty on March 24, 2018.

On April 26, 2018, Decedent sought treatment at Harrisburg Medical Center. The triage nurse noted: "Patient sustained a back injury approx one month ago while at work, pulling a railroad tie out of the ground and twisted back." "The patient describes the pain as 10/10." "The symptoms have worsened in the last 2 day(s)." The staff administered medication and discharged Decedent home. On April 29, 2018, Decedent returned, requesting pain medication and rating the pain a 10/10. The staff administered medication, including Fentanyl and Norco. A CT scan of the lumbar spine showed "[c]hronic findings at L5-S1 including bilateral pars defects at L5, anterolisthesis of L5-S1, and degenerative disc disease at L5-S1." Decedent was advised that "the ER could not give additional narcotic pain medication so it is urgent that he follow up with Dr. Koth and if unable he will have to go to his family provider for pain control."

On May 1, 2018, Decedent sought treatment at Christopher Rural Health. "[A]bout 5 weeks ago he was lifting a railroad tie and twisted wrong and instantly felt shooting [*sic*] pain across the lower abdomen and lower back. It made him drop to his knees. He went about a week ago, because he couldn't take the pain any longer, to HMC ER and saw a doctor that didn't do much went back on the 29th and saw [a nurse practitioner] at HMC ER ***. In a lot of pain in a wheelchair to assist with ambulating, unable to do so on his own with ease at this time." Decedent was taking ibuprofen and Vicodin for pain control. PA Morris prescribed Norco and ordered an MRI. On May 7, May 9 and May 11, 2018, Decedent requested refills of his pain medication. Norco was refilled on May 11, 2018. An MRI performed May 14, 2018, showed moderate to severe findings at L5-S1. On May 15, 2018, Decedent was referred to a neurosurgeon. Decedent requested another refill of Norco. The staff refilled Norco.

On May 25, 2018, Decedent came under the care of Dr. Sinha at the Orthopaedic Institute of Southern Illinois. Dr. Sinha initially recommended injections.

On May 29, 2018, Decedent returned to Christopher Rural Health and asked for another refill of Norco. On June 1, July 2 and August 1, 2018, Decedent presented for refills of Norco. He was examined, and Norco was refilled. On August 27, 2018, Decedent complained of worsened symptoms after turning wrong and requested a refill of his "pain pills." The staff refilled Norco and again referred Decedent to a neurosurgeon. On September 26, 2018, Decedent returned for his monthly refill for Norco, rating the pain an 8-9/10. Decedent reported being scheduled for surgery. "[T]he pt states that his surgeon recommends his norco be increased to 10/325 as pt c/o's unable to sleep @ noc with the pain." The staff refilled Norco for one week, "as the surgeon should be responsible for post operative pain management."

On October 2, 2018, Dr. Sinha performed fusion surgery at L5-S1. Postoperatively, Decedent continued to complain of pain, and Dr. Sinha prescribed Norco. On January 25, 2019, Dr. Sinha recommended an epidural steroid injection, which was performed on March 6, 2019. In the meantime, on February 19, 2019, Dr. Sinha began tapering Decedent off Norco. For the next ten days, Decedent or his wife repeatedly called for refills of Norco.

On February 28, 2019, Decedent returned to Christopher Rural Health, complaining of increasing back pain post surgery and physical therapy. "Patient states that the ortho doctor only gives him 10 days of pain medication at a time." Decedent wanted "at least a month supply at a time." The staff noted: "Last refill, according to PMP, was 2/20 and states he is currently out of medication (2/28). Pt stated that he was on 7.5 norco but when questioned, he did admit to being reduced to 5mg norco. Pt refused Toradol injection as it might make him 'too sleepy' and he had 'to play the drums tonight during a studio recording for his band's album.' Pt also refused any muscle relaxer as they give him 'restless arms.' Pt refused ibuprofen 800 mg as well." The staff did not prescribe or refill any pain medication. On March 1, 2019, Decedent returned, requesting pain medication. "Patient was asked to submit a UDS for drug screen and refused due to going to have cocaine in his system and marijuana." Decedent evidently changed his mind, and drug testing was performed (results came in later). It was positive for Benzoylcegonine, marijuana and cocaine. On March 8, 2019, the clinic notified Decedent it would no longer prescribe any controlled substances "due to the findings of Cocaine in his system."

There are no further treatment records until September 25, 2019, when Decedent sought treatment for his low back condition at Vanderbilt Medical Center Primary Care. The attending physician requested Decedent's medical records. Decedent did not return.

On January 3, 2020, Decedent came under the care of Dr. Stoev at Nashville Neurosurgery Associates for continuing low back complaints.

On January 13, 2020, Decedent received emergency care after being involved in a motor vehicle accident. Decedent complained of back pain. X-rays showed no acute abnormalities. Decedent was instructed to follow up with his orthopedist.

A CT scan ordered by Dr. Stoev showed failed fusion and loosening of hardware. On July 16, 2020, Dr. Stoev performed a revision fusion surgery. Decedent's only follow-up visit was on August 19, 2020. Decedent reported his leg pain had resolved, but he still had postoperative back pain. Dr. Stoev instructed Decedent to follow up as needed.

Most of Decedent's medical bills were paid by various medical insurance carriers, apparently through the employer(s) of Decedent's wife.

The Arbitrator found the claim compensable and awarded: temporary total disability benefits from March 21, 2018 through August 19, 2020; medical bills of \$287,371.70, without any reference to the applicable fee schedule or lower negotiated rate; and permanent partial disability benefits representing 20 percent disability to the person as a whole.

The Commission affirms the Arbitrator on the issues of compensability of the claim and liability of IWBF. Regarding employment relationship, the Commission adds to the Arbitrator's analysis that Mr. Haag admitted Decedent worked for him as a laborer on an as-needed basis. The record shows that on March 21, 2018, Decedent performed unskilled labor work under Mr. Haag's direction and control. Regarding accident, the Commission affirms the Arbitrator. Regarding liability of IWBF, the Commission adds to the Arbitrator's analysis that the attorneys for Decedent and Respondent-employer represented that Respondent-employer did not have workers' compensation insurance, and "[t]here is a companion civil case against the broker that let the policy lapse." During the pendency of this matter on review, Decedent's estate filed an amended application for adjustment of claim properly naming IWBF as co-Respondent.

The Commission modifies the Arbitrator's award with respect to temporary total disability and medical benefits. The Commission awards temporary total disability benefits from April 26, 2018 through March 6, 2019, during which time Decedent actively treated for his low back injury, underwent surgery, and received five months of post-operative care. After March 6, 2019, Decedent stopped treating and moved to Tennessee. There is no credible evidence he was unable to work. The Commission further awards temporary total disability benefits from July 16, 2020 through August 19, 2020, when Decedent underwent a revision surgery and postoperative care. Turning to medical expenses, the Commission awards the medical bills in evidence **pursuant to §§8(a) and 8.2 of the Act.**

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 14, 2024, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondents shall pay to Petitioner the sum of \$253.00 per week for a period of 50 weeks, from April 26, 2018 through March 6, 2019, and from July 16, 2020 through August 19, 2020, those being the periods of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondents shall pay the medical bills in evidence pursuant to §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondents shall pay to Petitioner the sum of \$253.00 per week for a further period of 100 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability to the extent of 20 percent of the person as a whole.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondents 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-employer is hereby fixed at the sum of \$75,000.00. Pursuant to section 19(f)(2)(1) of the Act, Respondent IWBF is exempt from the bonding requirement. 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.

December 10, 2025

SJM/sk

o-11/4/2025

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/s/ *Stephen J. Mathis*

Stephen J. Mathis

/s/ *Amylee H. Simonovich*

Amylee H. Simonovich

/s/ *Kathryn A. Doerries*

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC002031
Case Name	Jon Nathan Ellis v. Haag & Haag Landscape & Stonework & IWBf
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	14
Decision Issued By	Bradley Gillespie, Arbitrator

Petitioner Attorney	Thomas Crosby, Kelly Phelps
Respondent Attorney	Casey Fitzgerald

DATE FILED: 5/14/2024

/s/Bradley Gillespie, Arbitrator
Signature

INTEREST RATE WEEK OF MAY 14, 2024 5.165%

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**

JON NATHAN ELLIS

Employee/Petitioner

Case # **19 WC 02031**

v.

Consolidated cases: _____

**HAAG & HAAG LANDSCAPE & STONework, LLC, and MICHAEL W. FRERICHS, STATE
 TREASURER and 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 **Bradley Gillespie**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **March 22, 2024**. 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 Employer have workers' compensation insurance coverage for the date of accident?**

FINDINGS

On **3/21/2018**, 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 **\$11,593.40**; the average weekly wage was **\$222.95**.

On the date of accident, Petitioner was **42** 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 **\$0.00** 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

RESPONDENT SHALL PAY REASONABLE AND NECESSARY MEDICAL SERVICES OF **\$ 287,371.70**, AS PROVIDED IN SECTION 8(A) OF THE ACT.

RESPONDENT SHALL PAY PETITIONER TEMPORARY TOTAL DISABILITY BENEFITS OF **\$253.00** /WEEK FOR 126 WEEKS, COMMENCING 3/21/2018 THROUGH 8/19/2020, AS PROVIDED IN SECTION 8(B) 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 LANDSCAPER AT THE TIME OF THE ACCIDENT AND THAT HE TESTIFIED THAT HE IS NOT ABLE TO RETURN TO WORK IN HIS PRIOR CAPACITY AS A RESULT OF SAID INJURY. THE ARBITRATOR NOTES PETITIONER WAS RELEASED WITH NO RESTRICTIONS; THEREFORE, THE ARBITRATOR GIVES LESSER WEIGHT TO THIS FACTOR.

WITH REGARD TO SUBSECTION (III) OF §8.1B(B), THE ARBITRATOR NOTES THAT PETITIONER WAS 42 YEARS OLD AT THE TIME OF THE ACCIDENT. BECAUSE OF HIS LONGER WORK LIFE EXPECTANCY, 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 PETITIONER WAS RELEASED WITHOUT RESTRICTIONS AND HAS NOT PERFORMED A JOB SEARCH, THEREFORE, THE ARBITRATOR GIVES LESSER 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 PETITIONER UNDERWENT 2 LUMBAR FUSION PROCEDURES AND HIS TESTIMONY REGARDING HIS CONSTANT LOW BACK PAIN IS CREDIBLE, 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 20% LOSS OF USE OF THE PERSON PURSUANT TO §8(D)2) OF THE ACT. THEREFORE, RESPONDENT SHALL PAY PERMANENT PARTIAL DISABILITY BENEFITS OF \$253.00/WEEK FOR 100 WEEKS.

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.

Bradley D. Gillespie

Signature of Arbitrator

MAY 14, 2024

off of the steel. *Id.* He testified that when he turned, he felt immense pain. *Id.* The railroad ties were held together with rebar. (Arb. Ex. B p. 13) Petitioner indicated that you had to go up with the tie before you could turn. *Id.* He stated that the railroad tie was over his head. *Id.* Petitioner described feeling pain in his stomach and back. *Id.* He indicated that he and Haag both had the railroad tie in hand when he advised Haag that he thought he hurt himself and then Haag dropped his end of the railroad tie. (Arb. Ex. B pp. 13-14) Petitioner testified that he then dropped to the ground due to the pain. (Arb. Ex. B p. 14) He indicated that they had not been working very long when the incident occurred. *Id.* Petitioner was not able to continue working due to pain. (Arb. Ex. B p. 15) He told Haag he needed to go to the hospital. Petitioner said that it took him 15 minutes to walk back to his truck. He got in his car and drove to Heartland Regional Medical Center in Marion, Illinois.

Petitioner presented to the emergency room of Heartland Regional Medical Center at 10:47 am. (PX 1). He gave a history of developing acute low back pain after pulling on railroad ties at work approximately 1 hour ago. His pain was radiating around to both hips. He rated his pain 10/10. A physical examination was performed. He was diagnosed with a lumbosacral sprain. He was given an injection of Norflex and Toradol, and Valium orally in the emergency room. He was also given a prescription for Norflex, Naprosyn, and Ultram. He was discharged to home.

Petitioner testified that he communicated with Haag via text messages after his trip to the emergency room. (Arb. Ex. B p. 17 & RX 1) The text messages confirm that Respondent was aware of the accident. Moreover, it is interesting that Haag does not express doubt or disbelief that Petitioner had sustained injuries. Petitioner testified that he received a medical bill associated with his emergency room visit at Heartland Regional Medical Center. (Arb. Ex. B p. 19) He testified that he texted Haag after receiving the bill. *Id.* Petitioner indicated that Respondent asked him to send the bill. (Arb. Ex. B p. 20)

Petitioner's pain did not improve. He was not able to return to work. He next sought medical treatment on April 26, 2018, at the emergency room of Harrisburg Medical Center. (PX 2). Petitioner gave a history of sustaining a back injury approximately one month ago at work pulling a railroad tie out of the ground and twisting his back. A physical examination was performed. He was diagnosed with lumbago. He was given an injection of Norflex and Solumedrol, and Norco orally. He was discharged to home. Petitioner denied any new injuries prior to going to Harrisburg Medical Center. (Arb. Ex. B p. 20) No explanation was provided for the one month gap in treatment, nor was there any testimony about the delay in seeking additional care. No off work slip was submitted for the dates between March 21, 2018, and April 26, 2018.

Petitioner's low back pain continued and he returned to the emergency room of Harrisburg Medical Center on April 29, 2018. (PX 2). He reported that he was not able to get an appointment scheduled with his primary care provider until May 1 but had run out of pain medication. He reiterated the history of his work injury. He described his low back pain as aching, sharp, stabbing, and throbbing. He also complained of numbness. A physical examination was performed. CT scans of the thoracic spine, lumbar spine and pelvis were also obtained. The lumbar CT scan revealed chronic findings at L5-S1, including bilateral pars defect at L5, anterolisthesis of L5-S1 and degenerative disc disease at L5-S1. He was given several medications for pain. He was

diagnosed with lumbosacral back pain. He was told to follow up with Dr. Koth (HMC orthopedic surgeon) or his primary care provider for pain control.

On May 1, 2018, Petitioner presented to the Christopher Rural Health Clinic in Eldorado, Illinois, for treatment. He was evaluated by Curt Morris, a physician's assistant. Petitioner gave a history that about 5 weeks ago he was lifting a railroad tie and twisted wrong and instantly felt shooting pain across the lower abdomen and lower back. (PX 3). Morris performed a physical examination. Petitioner was diagnosed with acute bilateral low back pain without sciatica. Morris prescribed Norco and ordered an MRI.

A lumbar MRI was performed on May 14, 2018, at Saline Valley Radiology. (PX 4). It was interpreted as showing (1) minimal annular disc bulge and minimal spinal stenosis at L2-3 with minimal annular disc bulge L4-5 and moderate annular disc bulge at L5-S1; (2) moderate to severe bilateral neural foraminal stenosis at L5-S1 with impingement of the exiting L5 nerve roots bilaterally; (3) mild to moderate lumbar spondylosis becoming severe at L5-S1; and (4) grade 1 spondylolisthesis at L5-S1 due to chronic spondylosis.

After the MRI, Petitioner was referred by PA Morris to the Orthopaedic Institute of Southern Illinois. (PX 3). Petitioner returned to PA Morris a few times after the referral was made for pain medication - June 1, 2018; July 2, 2018; August 1, 2018; August 27, 2018; and September 26, 2018.

On May 25, 2018, Petitioner presented to the Orthopaedic Institute for treatment and was examined by Dr. Swastik Sinha. (PX 6). Dr. Sinha performed a physical examination and reviewed the MRI. He diagnosed petitioner with L5-S1 grade 2 listhesis with moderate foraminal stenosis. Dr. Sinha recommended aggressive non-operative treatment and prescribed an LSO back brace. (PX 6).

Petitioner returned to the Orthopaedic Institute on September 5, 2018. (PX 6). He was examined by Meshia Reed, physician's assistant. He gave a history of low back pain since March after helping lift a railroad tie. Petitioner reported that his pain was so bad that he wanted to proceed with surgery.

Dr. Sinha performed surgery on petitioner on October 2, 2018, at Herrin Hospital. (PX 5). The surgery consisted of (1) L5-S1 arthrodesis, posterior lumbar interbody fusion; (2) L5-S1 posterior lumbar instrumentation; (3) PEEK cage placement L5-S1; and (4) L5-S1 discectomy, laminectomy, and foraminotomy. The post-operative diagnoses were (1) L5-S1 lateral disc herniation with foraminal, extraforaminal narrowing on the left; (2) L5-S1 lateral recess stenosis on the left; (3) L5 and S1 foraminal stenosis; and (4) lumbar degenerative disc disease at L5-S1.

Dr. Sinha saw petitioner post-operatively on October 17, 2018. (PX 6). He reported some improvement with his pain but noticed some numbness and tingling to the dorsal surface of the left foot. He was referred to physical therapy.

Petitioner returned to Dr. Sinha on December 17, 2018. (PX 6). He reported persistent numbness and tingling in his left lateral foot. He was starting physical therapy next week.

Petitioner had physical therapy at the Orthopaedic Institute on December 19, 2018; December 21, 2018; December 27, 2018, and January 3, 2019. (PX 6).

On January 25, 2019, Petitioner was again examined by Dr. Sinha. (PX 6). He was experiencing symptoms to his left SI joint. Dr. Sinha ordered a left SI joint injection.

A left SI joint injection was performed by Dr. Tennyson Lee at the Orthopaedic Institute on March 6, 2019. (PX 6).

Petitioner continued to experience low back pain and left leg pain after the left SI joint injection. He had moved to Nashville.

On September 25, 2019, Petitioner presented to Vanderbilt University Medical Center - Primary Care, in Nashville, Tennessee. (PX 7). He was complaining of chronic low back pain. He gave a history of injuring his back at work in Illinois while lifting a railroad tie in March 2018. A physical examination was performed. He was diagnosed with chronic left-sided low back pain with sciatica and paresthesia of the left foot.

Petitioner was next treated for his low back pain and left foot numbness on January 3, 2020, at Nashville Neurosurgery Associates. (PX 9). He was examined by Dr. Ivan Stoev. Dr. Stoev ordered an MRI and CT scan of the lumbar spine so as to investigate the integrity of the instrumentation from his previous surgery.

On January 13, 2020, Petitioner was involved in a minor motor vehicle accident. He was treated at the emergency room of Southern Hills Medical Center. (PX 8). The records for this examination do not identify any new injury or change in his condition.

The MRI ordered by Dr. Stoev was obtained on January 14, 2020. (PX 9). Dr. Stoev saw Petitioner at his office on January 17, 2020. (PX 9). He reviewed the MRI findings with Petitioner and wanted to review the CT scan after it was completed. He also wanted Petitioner to get an EMG/NCV study to check for radiculopathy and nerve injury.

The CT scan was performed on May 8, 2020. (PX 9). Dr. Stoev saw Petitioner at his office on May 11, 2020, and reviewed the CT scan findings with him. (PX 9). Dr. Stoev thought the CT scan suggested some loosening of the S1 screw. As a result, he thought Petitioner may require a revision of his fusion. He wanted Petitioner to complete the EMG/NCV study.

The EMG/NCV study was completed on June 2, 2020. (PX 9). It was consistent for mild chronic left L4 lumbar radiculopathy.

Dr. Stoev re-examined Petitioner on June 5, 2020. (PX 9). He reviewed the results of the EMG/NCV. Because of Petitioner's ongoing symptoms, he recommended a revision of his fusion.

Dr. Stoev saw Petitioner on July 15, 2020, for a pre-operative examination. (PX 9). On July 16, 2020, Dr. Stoev performed the revision of Petitioner's posterior lumbar interbody fusion

at L5-S1. (PX 8). During the procedure, Dr. Stoev confirmed that the S1 screw on the left was loose.

On August 19, 2020, Petitioner was seen post-operatively by Dr. Stoev. (PX 9). Petitioner was experiencing some post-operative pain, but Dr. Stoev thought this was to be expected. Petitioner was able to ambulate better since the surgery. He was released from Dr. Stoev's care on an as needed basis.

Petitioner has not received any additional treatment since he was released by Dr. Stoev. (Arb. Ex. B p. 30) He testified that he still experiences constant low back pain at a level of 4 or 5 on a scale of 10. (Arb. Ex. B pp. 30-31) Movement, such as walking, helps alleviate his pain. Arb. Ex. B pp. 31-32)

Petitioner has not worked since his accident on March 21, 2018. (Arb. Ex. B p.32) He did try delivering food for Uber Eats when he lived in Nashville. *Id.* He moved back to Illinois in 2021. (Arb. Ex. B p. 33) Petitioner has not worked anywhere nor has he applied for any jobs since moving back to Illinois. (Arb. Ex. B pp. 33-34) He is a high school graduate. (Arb. Ex. B p. 34) His past work history consists primarily of working in the masonry field. *Id.* He was 42 years old at the time of his accident. (Arb. Ex. B p. 35)

Petitioner testified that he did not necessarily work 40 hours every week. (Arb. Ex. B p. 37) On cross-examination, Petitioner confirmed that the tasks which they were performing on the date of accident were building a block wall and tearing down the railroad tie retaining wall. (Arb. Ex. B pp. 38-39) Petitioner testified that the first row of blocks had been laid when he sustained his injury. (Arb. Ex. B p. 41)

Petitioner testified that he arrived at the job site before the 8:30 a.m. start time. (Arb. Ex. B p. 45) He indicated that he did not recall where he was when Haag arrived and who arrived first. (Arb. Ex. B p. 46) Petitioner looked at photographs of the scene and described where he was in relationship to those pictures. (Arb. Ex. B pp. 39-53) Petitioner stated that the railroad tie wall was approximately 4-5 feet in height. (Arb. Ex. B p. 59) He stated that they had to lift the railroad tie above the level of the rebar which was drilled through it. (Arb. Ex. B p. 60) Petitioner testified that the railroad tie "slid over the rebar pretty easily." (Arb. Ex. B p. 66)

Petitioner admitted to using cocaine and Oxycontin regularly following the injury. (Arb. Ex. B p. 72) He stated that he lost his way because he was unable to pursue his normal work and could no longer drum. *Id.* Petitioner testified that he was living in pain. (Arb. Ex. B p. 73) Petitioner testified that Haag did not say a word to him after he reported having back pain. (Arb. Ex. B pp. 73-74) He confirmed that he communicated with Haag via text messages following his visit to the emergency room and various times thereafter.

Testimony of Thomas Haag

Haag testified that he owned the company and that the company performs landscaping and stonework. (Arb. Ex. B p. 82) Haag testified that he came to an agreement with Pheasant Hollow Winery to do a project consisting of removing an old leaning retaining wall made of railroad ties

and replacing it with a stone wall. (Arb. Ex. B pp. 82-83) He identified the picture of the railroad ties to be the ones he removed at the job. (Arb. Ex. B p. 83) Haag claimed that the railroad ties were eight inches by eight inches in diameter and 8 feet in length. (Arb. Ex. B p. 84) He estimated that the ties weighed approximately 150 pounds. *Id.* Haag testified that Petitioner worked for him on an as needed basis. *Id.*

Haag testified that he arrived at the job site about 8:20 a.m. (Arb. Ex. B p. 85) He claimed that Petitioner's vehicle was at the job site when he arrived. *Id.* Haag claimed that Petitioner was not in his vehicle and that the few times he had arrived at a job site prior to him, he would wait in his vehicle. (Arb. Ex. B p. 86) He indicated that he had not given Petitioner any instructions prior to his arrival at the job site. *Id.*

Haag testified extensively about the location, dimensions and location of the railroad tie wall in relationship to the existing structure and the eventual block wall. He stated that the railroad tie wall was five feet tall. (Arb. Ex. B p. 97) He claimed that the railroad tie was 30 feet in length. *Id.* Haag denied laying the first course of block before taking down the railroad tie wall. (Arb. Ex. B p. 99) He claimed that there was no way they could have lifted the ties by hand. (Arb. Ex. B p. 100) Haag testified that he removed the railroad tie wall using a skid steer with a hydraulic bucket. (Arb. Ex. B pp. 100-101) He claimed that when he came around to the work area, Petitioner was leaning up against the building and informed him that he hurt his back lifting on a tie. (Arb. Ex. B p. 104) Haag testified that he offered to take Petitioner to Urgent Care to have his back looked at and Petitioner declined and said he would just go home and put his feet up. (Arb. Ex. B p. 106) He said that he told Petitioner to take the day off and if he need to have his back looked at to let him know and he would take him to Urgent Care or meet him there. *Id.* Haag wanted to make sure Petitioner was drug tested. *Id.* He denied Petitioner's account of the accident. (Arb. Ex. B p. 107) Haag claimed that he has not worked for Respondent since the date of accident. (Arb. Ex. B p. 116)

On cross-examination, Haag testified that he offered to take Petitioner to the Urgent Care because he was concerned for Petitioner, and he wanted him drug tested. (Arb. Ex. B p. 123) Haag said he always suspected Petitioner of using drugs. *Id.* He admitted that the work involved the use of sharp tools and machinery. (Arb. Ex. B pp. 124-25)

CONCLUSIONS OF LAW

A. Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

Based on the testimony presented at arbitration, the Arbitrator finds that Respondent was operating under and subject to the Illinois Workers' Compensation Act. Haag testified that his business involved the use of sharp tools and machinery. This is the type of work that brings the Respondent under the jurisdiction and subject to the Act pursuant to Section 3 of the Act.

B. Was there an employee-employer relationship?

The uncontroverted evidence presented at arbitration establishes that an employee-employer relationship existed between Petitioner and Respondent at the time of the work accident on March 21, 2018.

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

Haag disputes that an accident occurred that arose out of and in the course of Petitioner's employment by him. Specifically, Haag disputes the mechanism of injury claimed by Petitioner, i.e., lifting the railroad tie. Haag testified that he was going to use a skid steer to lift the railroad ties because it was not possible for two men to lift them off the rebar. He testified that Petitioner and he were scheduled to start dismantling the railroad tie retaining wall at 8:30 am. He testified that Petitioner was already at the job site when he arrived at 8:20 am. When Haag encountered Petitioner that morning, he reported to Haag that he hurt his back trying to lift a railroad tie. Haag offered to take Petitioner to Urgent Care, but Petitioner told him he just needed to go home and put his feet up. Petitioner then left the job site.

Haag's testimony does not disprove that Petitioner suffered an injury that arose out of and in the course of his employment. It just establishes that Petitioner was performing his job in a manner that was different than Haag had planned. The job that day was to dismantle the railroad retaining wall. Petitioner claims he hurt his back lifting a railroad tie as part of the job to dismantle the retaining wall. There was no evidence offered at arbitration to dispute that Petitioner hurt his back lifting a railroad tie. However, the Arbitrator notes that the accounts of injury presented by Petitioner and Respondent differ radically and calls into question the credibility of both parties.

The emergency room record of Heartland Regional Medical Center on the day of the accident also questions the credibility of Haag's testimony. (PX 1). The emergency room record shows that Petitioner presented for treatment at 10:47 am on March 21, 2018. The job site was in Whittington, Illinois. Heartland Regional Medical Center is in Marion, Illinois. There is less than 30 miles between Whittington and Marion. According to Haag, petitioner had already injured himself when he arrived at the job site at 8:20 am. Per Haag, petitioner left the job site shortly after Haag arrived at 8:20 am. Petitioner testified, however, that he and Haag had been working for a period of time laying a row of block before he got hurt. The history contained in the emergency room record for Heartland Regional Medical Center states that Petitioner injured his back pulling on railroad ties at work approximately an hour ago. (PX 1). If Petitioner left the job site in Whittington around 8:20 am, as Haag testified, Petitioner would have arrived at Heartland Regional Medical Center in Marion, Illinois, much earlier than 10:47 am. Petitioner's arrival time noted in the emergency room record for Heartland Regional Medical Center corroborates Petitioner's testimony that he and Haag had been working for a period of time before he got hurt. The ER arrival time casts doubt on Haag's testimony regarding the accident.

In further corroboration of Petitioner's testimony, the medical records show that he gave a consistent history of his accident to his medical providers.

Based on the foregoing, the Arbitrator finds and concludes that Petitioner sustained an accident occurred that arose out of and in the course of petitioner's employment by Respondent.

D. What was the date of accident?

The Arbitrator finds that the date of accident was March 21, 2018, based on Petitioner's testimony and as reported in the submitted medical records.

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

The Arbitrator finds that timely notice of the accident was given to Respondent. Respondent was present at the work site when Petitioner told him that he injured himself.

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

Petitioner's testimony and the medical records support that petitioner gave an accurate and consistent history of his accident to his medical providers. The medical records also establish that Petitioner experienced continuous low back pain from the day of the accident and throughout the course of his treatment. Petitioner's testimony and the medical records further establish that his low back injury necessitated the fusion surgery on October 2, 2018. Petitioner's low back pain continued after this surgery and he developed left sided radiculopathy. These symptoms required a revision of the fusion on July 16, 2020. The revision surgery showed that the S1 screw on the left had loosened. There is no evidence that Petitioner experienced low back pain or symptoms prior to the accident on March 21, 2018.

Based on the foregoing, the Arbitrator finds that petitioner's current condition of ill-being is causally related to the injury.

G: What were Petitioner's earnings?

The Arbitrator finds that the petitioner's average weekly wage while working for respondent was \$222.95. Based on petitioner's marital status, he would be at the minimum TTD/PPD rate of \$253.00.

H: What was Petitioner's age at the time of the accident?

The Arbitrator finds that petitioner was 42 years old at the time of injury, based on Petitioner's testimony.

I. What was Petitioner's marital status at the time of the accident?

The Arbitrator finds that Petitioner was married at the time of injury based on Petitioner's testimony.

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 all medical services provided to petitioner were reasonable and necessary. Respondent has not paid for any of petitioner's medical treatment. Based on the Arbitrator's findings on accident and causal connection, the Arbitrator finds that respondent shall pay the charges for petitioner's medical treatment admitted into evidence and itemized in petitioner's exhibit number 10 (PX 10), which totals \$287,371.70.

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

Petitioner's testimony and the medical records establish that he was unable to work and did not achieve maximum medical improvement until he was released from Dr. Stoev's care on August 19, 2020. Therefore, the Arbitrator finds that petitioner is entitled to temporary total disability benefits from March 21, 2018, through August 19, 2020, or 126 weeks, because the injury did arise out of and in the course of petitioner's employment.

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

The Arbitrator finds that petitioner suffered permanent partial disability as a result of his work injury. Pursuant to Section 8.1b(b) of the Act, the Arbitrator makes the following findings:

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 doing landscaping and stonework at the time of the accident. He is a high school graduate with a work history basically in masonry. He was released from Dr. Stoev's care without any restrictions. Petitioner testified that he does not feel that he is able to return to work in his prior capacity as a result of said injury but he has not performed a job search. The Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that petitioner was 42 years old at the time of the accident. Because petitioner has a longer work life expectancy, 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 that Petitioner has been released without restrictions. Although Petitioner testified that he does not believe he is able to return to work in his prior capacity, he has not performed a job search or made a consistent effort at a job search. The Arbitrator, therefore, gives lesser 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 Petitioner underwent 2 lumbar fusion procedures. The Arbitrator also finds Petitioner's testimony credible that he still experiences constant low back pain at a level of 4 or 5 on a scale of 10. The Arbitrator, therefore, gives greater weight to this factor.

Based on the above factors, petitioner's testimony, and the medical records, the Arbitrator finds that petitioner suffered permanent partial disability to the extent of 20% loss of the person as a whole pursuant to Section 8(d)(2) of the Act, or permanent partial disability benefits of \$253.00/week for 100 weeks.

O: Did Respondent Employer Haag & Haag Landscape & Stonework, LLC, have Workers' Compensation Insurance Coverage for the Date of Injury?

The Arbitrator finds that respondent, Haag & Haag Landscape & Stonework, LLC, did not have the required workers' compensation insurance coverage on the date of injury.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	22WC025216
Case Name	Jared West v. Patton
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	25IWCC0491
Number of Pages of Decision	21
Decision Issued By	Frank Soto, Commissioner

Petitioner Attorney	Casey VanWinkle
Respondent Attorney	Julie Webb

DATE FILED: 12/16/2025

/s/Frank Soto, Commissioner

Signature

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: Occupational disease	☐ Second Injury Fund (§8(e)18)
☐ Modify:	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JARED WEST,

Petitioner,

vs.

NO: 22 WC 25216

PATTON MINING, LLC,

Respondent.

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 all issues, and being advised of the facts and law, reverses the Decision of the Arbitrator and finds that Petitioner failed to prove that he suffered from an occupational lung disease that arose out of and in the course of his coalmine employment.

I. FINDINGS OF FACT

a. Petitioner's Testimony

Petitioner, a former coal miner, alleged that he developed coal workers' pneumoconiosis (hereafter, "CWP") due to coal dust inhalation over his approximately nine years of employment in the coal mines, all of which were spent underground. In addition to coal dust, Petitioner was regularly exposed to silica dust, roof bolting glue fumes, and diesel fumes.

Petitioner began working in the coal mines in 2005 with Freeman United at the Crown 2 Mine in Virden, Illinois. Following a short two-week period as an "out by" laborer, Petitioner moved to coal production, which was considered "in by." In the "out by" position, Petitioner rock dusted, set props, replaced roof bolts, and conformed to MSHA regulations. After his transfer to an "in by" position shortly thereafter, Petitioner worked the rest of his career down in the face of the mine where the coal was being extracted.

Petitioner's first "in by" laborer position was as a ram car operator. In this role, Petitioner sat approximately 25 feet behind the continuous miner machine as it was cutting coal and then

transported the coal from the extraction point to where it exited the mine. Petitioner remained a ram car operator for six months before moving to a roof bolter position. As a roof bolter, Petitioner went into places that had been mined to install conventional or resin roof support bolts. The resin bolts had to be glued into place, and when the glue pens broke, Petitioner noticed a strong odor.

After six to eight months as a roof bolter, Petitioner became a continuous miner operator, which required him to stand in the face of the mine and operate the continuous miner machine by remote control. Petitioner stood approximately 30 feet from the face of the mine when he started cutting the coal, and by the time he was done operating the machine, he would be 60 feet from the face. Petitioner testified that he was exposed to quite a bit of coal dust when he ran the machine.

The Crown 2 Mine eventually closed in August of 2007. As a result, Petitioner left mining for a short period of time and went to work at a fertilizer plant from March of 2008 to February of 2011. He returned to mining as a roof bolter at Moriah Mining on February 7, 2011. Petitioner testified that he had more exposure to coal dust at this mine, because the roof bolting was performed on the downside of the mine and he caught all of the return air off the machine. Petitioner worked for nine months at Moriah Mining until November of 2019.

Petitioner then transferred to Respondent's sister mine and remained working there until he left mining. Petitioner described Respondent's mine as a dustier environment, since they cut limestone tops that produced more rock and limestone dust. Petitioner worked as a miner operator there for two years before taking a foreman position. As a foreman, Petitioner worked nights moving the belt and power to keep up with the continuous miner machine. He also rock dusted the whole area before the crews arrived. Then, in January of 2016, Respondent decided to let its foremen go after its mine had caught fire. Petitioner was later called back and asked to return as a continuous miner operator in 2019. He worked in that position from January of 2019 until September 19, 2019, which was the last day he worked in Respondent's mine and was exposed to coal dust.

Petitioner, who was 41 years old on the hearing date, left mining when he was 36 years old to be a highway maintainer for Montgomery County Highway Department. Petitioner testified that he left mining to pursue a better quality of life for his family and to stop the rotating shifts at the mine. However, Petitioner testified that halfway through his mining career, he noticed he would get short of breath when walking and carrying his heavy mining gear and he would produce a black substance when he coughed or blew his nose. Petitioner testified that these symptoms stayed the same until he left mining, and by the time of the hearing, he still had some shortness of breath when he played basketball with his daughter. Otherwise, Petitioner did not have any issues performing his current highway maintainer job duties, which he described as heavy manual labor, except for when he had to rake patches. Petitioner testified that he became winded after five to ten minutes of raking patches and would have to catch his breath before continuing.

Petitioner was a former smoker having smoked one pack every four days from the ages of 17 to 20. At the time of the hearing, Petitioner had not had a cigarette in 21 years. Petitioner testified that his only other health condition for which he took medication was anxiety. He also had Covid-19 once after he left the mines.

b. Testimony of Dr. Suhail Istanbuly

The parties deposed Dr. Istanbuly on January 23, 2024. Dr. Istanbuly is a pulmonologist who currently works at Hines VA in Chicago and maintains satellite clinics in Southern Illinois, where he previously practiced from 2003 to 2019. While in Southern Illinois, 10% to 20% of Dr. Istanbuly's practice consisted of the treatment of coal miners. However, Dr. Istanbuly is not a certified B-reader, and as such, he did not provide profusion ratings on the films he interpreted for black lung. Dr. Istanbuly agreed that he could not say whether Petitioner's chest X-ray dated August 5, 2022 had a profusion rating of 1/0 or 0/1.

After examining Petitioner on December 13, 2022, and reviewing Petitioner's spirometry testing results as well as Dr. Henry Smith's B-reading report, Dr. Istanbuly's assessment was simple CWP (early stage) related to long-term coal dust inhalation. Dr. Istanbuly found that it was highly likely that long-term coal dust inhalation significantly contributed to Petitioner's respiratory symptoms, which included an intermittent cough, nocturnal dyspnea, and exertional dyspnea. He recommended Petitioner avoid future coal dust inhalation to halt the progression of the disease. Dr. Istanbuly further testified that Petitioner's position as mine machine operator presented a higher risk of exposure to silica dust, which made the time of exposure Petitioner had more dangerous for mine-related lung disease than if he had only been around pure coal dust.

Nevertheless, Dr. Istanbuly testified that Petitioner's pulse oximetry was normal at 100% and his physical examination had revealed no respiratory disease. Dr. Istanbuly further testified that Petitioner's spirometry testing was normal with a FVC of 91.7% of predicted, FEV of 88% of predicted, and FEV1/FVC ratio of 77.29%. He agreed that based on AMA Guides' Six Edition, Petitioner had a Class 0 impairment per his pulmonary function testing.

c. B-reading Report of Dr. Henry Smith

Dr. Smith, a board-certified radiologist and certified B-reader, provided a B-reading of Petitioner's chest X-ray taken on August 5, 2022. Dr. Smith's impression was minimal simple CWP of classification p/p, bilateral mid and lower zones involved of profusion 1/0. The parties did not depose Dr. Smith regarding this report.

d. Testimony of Dr. Cristopher Meyer

Dr. Meyer is a board certified radiologist who has held his B-reader certification since 1999. He averages 50 to 100 B-readings per month. Dr. Meyer is also the co-director of the ACR B-reader course and a member of the ACR Pneumoconiosis Task Force. In this role, Dr. Meyer helped create the new syllabus for the B-reader course and designed the B-reader examination that was delivered to NIOSH. Dr. Meyer was deposed by the parties on June 7, 2024 regarding his B-reading of Petitioner's chest X-ray dated August 5, 2022. Dr. Meyer found the X-ray to be of diagnostic quality and normal with no findings of CWP.

Dr. Meyer explained that profusion ratings in B-readings defined the concentration of small opacities in the lung with a normal film having a profusion rating of 0 and the most severely abnormal film having a profusion rating of 3. He testified that profusion was further described in

fractioned terms with the numerator implying the profusion value it was thought to be and the denominator implying the next closest possible value. Dr. Meyer testified that the particular profusion distinction of 0/1 versus 1/0 was a critical component of the B-reader examination that often tripped up non-radiologists. Dr. Meyer indicated there could even be disagreement amongst B-readers as to whether X-rays had small opacities or not, which made the distinction between 0/1 and 1/0 opacities one of the most difficult on the B-reader form.

Nevertheless, Dr. Meyer agreed that the gold standard for confirming the existence of lung disease was pathologic review of the tissue itself rather than radiology. He acknowledged that it was possible for a miner to have pneumoconiosis determined by pathology or autopsy that was not found on a radiographic study. As such, Dr. Meyer testified that a negative X-ray did not necessarily rule out pneumoconiosis pathologically.

e. Testimony of Dr. David Rosenberg

Dr. Rosenberg is a B-reader who holds board certifications in internal medicine, pulmonary disease, and occupational medicine. In his clinical practice, Dr. Rosenberg also treated black lung patients. The parties deposed Dr. Rosenberg on April 15, 2024 regarding his B-reading of Petitioner's chest X-ray from August 5, 2022. Dr. Rosenberg concluded that the X-ray films were negative for the presence of pneumoconiosis with a 0/0 profusion rating. He further opined that Petitioner had normal diffusing capacity measurements with no impairment, obstruction, or restriction. Dr. Rosenberg thus found that Petitioner had Class 0 impairment and was not disabled from performing his previous coal mining job. He further concluded that Petitioner did not have any other condition whatsoever related to his past coal mine dust exposure.

Dr. Rosenberg also reviewed records from Community Medical Center, the B-readings from Dr. Smith and Dr. Meyer, Dr. Istambouly's report, and pulmonary function testing conducted on April 14, 2023. He found that these records did not contain any diagnoses of chronic bronchitis or respiratory disease. Dr. Rosenberg further testified that Petitioner's pulmonary testing results were normal. He agreed that the results would fall in a Class 0 or no impairment category. Dr. Rosenberg opined that Petitioner was capable of heavy manual labor from a respiratory standpoint.

Dr. Rosenberg, nevertheless, acknowledged that it was possible to have diseased or impaired lungs despite normal pulmonary function testing or a negative chest X-ray. Dr. Rosenberg explained that CWP was a chronic disorder, and to prevent its progression, he recommended minimizing one's ongoing exposure to coal dust. He noted that other exposures in a coal mine could also result in lung disease, including but not limited to, silica, diesel fumes, and fumes from roof bolting glues.

f. Treatment Records

The earliest submitted treatment record was for a physical examination Petitioner underwent at Community Medical Center on March 7, 2013. At that time, Petitioner expressed no complaints and demonstrated normal excursion with symmetric chest walls, normal breathing sounds, and no adventitious sounds. Dr. Debra Anklam categorized his examination as normal. Several years later, on December 5, 2018, Petitioner underwent another physical examination and

again expressed no complaints. Examination of the chest and lungs revealed quite, easy, and even respiratory effort on auscultation with no use of accessory muscles, normal breath sounds, no adventitious sounds, and normal vocal resonance. Dr. Walter Cunningham found that Petitioner was well overall, yet mildly overweight. Dr. Cunningham also noted that Petitioner had quit smoking cigarettes in 2003.

On January 21, 2019, Petitioner returned to Dr. Cunningham complaining of cold symptoms, including fatigue, nasal congestion, a stuffy and runny nose, bilateral ear pain, and a productive cough. Examination of the chest and lungs demonstrated normal excursion with symmetric chest walls, quiet and even respiratory effort on auscultation and with no use of accessory muscles, normal breath sounds, no adventitious sounds, and normal vocal resonance. Dr. Cunningham diagnosed Petitioner with a sinus infection and prescribed antibiotics.

Dr. Cunningham thereafter performed a Department of Transportation physical on March 18, 2019, at which time he cleared Petitioner from a medical standpoint for two years. Almost two years later, on January 18, 2021, Petitioner returned for a wellness examination and reported the worsening of his short-term memory. Petitioner otherwise denied any shortness of breath, and his lungs on examination were clear to auscultation with non-labored respiration. Dr. Cunningham found that Petitioner was generally very healthy overall despite experiencing some mild memory disturbance. A few days later, on January 25, 2021, Dr. Cunningham conducted another Department of Transportation physical and cleared Petitioner medically for another two years.

On April 12, 2021, Petitioner returned to Dr. Cunningham and reported feeling anxious for six years. Nevertheless, Petitioner denied any shortness of breath and his lungs upon examination were again clear to auscultation with non-labored respirations. Dr. Cunningham diagnosed Petitioner with generalized anxiety disorder and prescribed Lexapro. At his follow-up appointment on May 12, 2021, Petitioner reported that his anxiety was improving with the medication. Petitioner again denied shortness of breath, and his examination again showed his lungs to be clear to auscultation with non-labored respirations.

On June 19, 2021, Petitioner presented to Community Medical Center's urgent care for a rash on his bilateral arms, legs, and neck. Petitioner denied shortness of breath, coughing, or wheezing at that time. On examination, Petitioner's lungs were again clear to auscultation with non-labored respirations. NP Nichole McMillen diagnosed Petitioner with contact dermatitis.

Petitioner next followed up for his anxiety on August 2, 2021. He reported being stable on Lexapro and denied experiencing any shortness of breath. Upon examination, Petitioner's lungs were again found to be clear to auscultation with non-labored respirations. Several months later, on January 18, 2022, Petitioner returned to Community Medical Group's urgent care for treatment of Covid-19. Petitioner complained of a cough at that time but otherwise denied any shortness of breath. Dr. Cunningham's examination found Petitioner's lungs to be clear to auscultation with non-labored respirations.

On February 28, 2022, Petitioner returned to Dr. Cunningham with complaints of worsening snoring. Petitioner's ongoing problem list at this time included excessive daytime sleepiness, generalized anxiety disorder, and mild memory disturbance. Nevertheless, Petitioner continued to

deny any shortness of breath, and his lungs were again clear to auscultation with non-labored respirations. Dr. Cunningham's assessment was excessive daytime sleepiness and generalized anxiety disorder. He ordered a sleep study to determine the appropriateness of a CPAP machine. Petitioner next followed up for his snoring issues on September 12, 2022, at which time he reported waking up two times in the past few weeks gasping for air. Dr. Cunningham noted that a sleep study had been performed and was negative for sleep apnea, although it did show decreased sleep efficiency and possible bruxism. Dr. Cunningham recommended consultation with a sleep specialist. Petitioner again reported no shortness of breath at this visit, and the examination of his lungs were clear to auscultation with non-labored respirations.

Petitioner thereafter returned for another Department of Transportation physical with Dr. Cunningham on January 24, 2023. Petitioner's past medical history was noted to include Covid-19, excessive daytime sleepiness, and tobacco use. Following the examination, Dr. Cunningham cleared Petitioner medically for another two years.

Petitioner last treated with Community Medical Clinic on January 10, 2024 for right elbow and shoulder pain. At that time, Petitioner reported that his snoring had improved sometime after a recent weight loss. Examination of Petitioner's respiratory system revealed non-labored respirations with bilateral chest expansion, clear breath sounds in all lung fields bilaterally, and no adventitious sounds. Petitioner again denied shortness of breath, as well as a cough, at this visit.

II. CONCLUSIONS OF LAW

Following a careful review of the entire record, the Commission reverses the Decision of the Arbitrator and finds that Petitioner failed to prove that he suffered from CWP or any other lung disease that was causally related to his work in the coalmines.

Although both Dr. Istambouly and Dr. Smith determined that Petitioner's chest X-ray was consistent with a CWP diagnosis, the Commission finds that Dr. Istambouly's opinion lacks persuasiveness since he is not a certified B-reader. As such, Dr. Istambouly did not assign profusion ratings to films and could not say whether the profusion rating on Petitioner's film was 0/1 or 1/0, which the Commission recognizes as an important distinction.

Of Petitioner's experts, Dr. Smith offered a more persuasive opinion, as he is a certified B-reader. Dr. Smith interpreted Petitioner's chest X-ray as showing minimal simple CWP of classification p/p, bilateral mid and lower zones involved of profusion 1/0. In contrast to the opinions of Dr. Istambouly and Dr. Smith, Dr. Meyer and Dr. Rosenberg, both of whom are certified B-readers, opined that Petitioner's X-ray findings were inconsistent with a CWP diagnosis. Dr. Meyer also possessed the added distinction of being the co-director of the ACR B-reader course who helped create the B-reader syllabus and designed the B-reader examination used by NIOSH. Dr. Meyer explained that there could be disagreement even among seasoned B-readers as to whether a profusion rating on a film was normal at 0/1 or abnormal at 1/0. If qualified B-readers nevertheless struggled with this nuanced distinction, it is presumably even harder for those without B-reader certification, like Dr. Istambouly, to correctly identify it.

The Commission acknowledges that there is a consensus among the experts that a negative

X-ray did not necessarily rule out the presence of CWP. However, based on the record in its entirety, the Commission places greater weight on the opinions of certified B-readers, Drs. Meyer and Rosenberg, who opined that there was no CWP present on the films over the opinion of certified B-reader, Dr. Smith, who opined the presence of CWP on the films.

Moreover, the Commission is further persuaded by the lack of respiratory issues documented in Petitioner's treatment records. Petitioner testified to noticing concerning symptoms halfway through his mining career; however, the treatment records do not corroborate the presence of such symptoms. Instead, Petitioner consistently denied shortness of breath to his medical providers and demonstrated normal lung examinations over the course of years. Despite claiming such alarming symptoms as coughing up a black substance for years, there is no evidence that Petitioner ever saw a doctor for these symptoms. The treatment records fail to establish a pattern of any chronic respiratory complaints whatsoever. Likewise, Petitioner's pulmonary function testing yielded normal results.

In consideration of the above, the Commission finds that Petitioner failed to prove that he suffered from causally related CWP, and by extension, failed to establish disablement from CWP or any other occupational disease pursuant to §1(e) and §1(f) of the Illinois Workers' Occupational Diseases Act. The Commission reverses the Decision of the Arbitrator accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated September 11, 2024 is hereby reversed.

IT IS FURTHER ORDERED that all benefits under the Act are hereby denied.

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

December 16, 2025

O: 11/5/25
FJS/met
046

/s/ Frank J. Soto
Frank J. Soto

/s/ Carolyn M. Doherty
Carolyn M. Doherty

/s/ Raychel A. Wesley
Raychel A. Wesley

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	22WC025216
Case Name	Jared West v. Patton
Consolidated Cases	
Proceeding Type	Request for Hearing
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	13
Decision Issued By	Adam Hinrichs, Arbitrator

Petitioner Attorney	Kirk Caponi
Respondent Attorney	Julie Webb, Kenneth Werts

s/Adam Hinrichs, Arbitrator SEPTEMBER 11 2024
Signature

INTEREST RATE WEEK OF SEPTEMBER 10 2024 4.53%

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**

JARED WEST
 Employee/Petitioner

Case # **22** WC **025216**

v.

Consolidated cases: _____

PATTON MINING, 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 Adam Hinrichs**, Arbitrator of the Commission, in the city of **Springfield** on **July 30, 2024**. 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 OD Act.**

FINDINGS

On **09/19/19**, 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 **\$64,857.52**; the average weekly wage was **\$1,247.26**.

On the date of accident, Petitioner was **36** 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** 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 the Petitioner the sum of \$748.35/week for a further period of 15 weeks, as provided in Section 8(d)(2) of the Act, because the injuries sustained caused a 3% loss of use to Petitioner's person as a whole.

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 11 2024

FINDINGS OF FACT

Petitioner lives in Nokomis, Illinois. He was married and 41 years old on the date of hearing. Petitioner has two children ages 13 and 10. Petitioner graduated from Nokomis High School and received a business certificate from Lakeland College in 2002. Petitioner worked in the coal mines for eight and a half to nine years with all of those years being underground. Petitioner testified that in addition to coal dust, he was regularly exposed to and breathed silica dust, roof bolting glue fumes and diesel fumes. Petitioner's last day of employment in the coal mine for Respondent was September 19, 2019, at its Deer Run location in Hillsboro, Illinois. Petitioner was 36 years old when he left coal mining. His job classification was miner operator. Petitioner testified that he was exposed to coal dust that day. Petitioner testified that he left mining at that time for a better quality of life for his family. After leaving mining, Petitioner took a job with Montgomery County Highway Department as a highway maintainer. He testified that it was a 7a.m. to 3:30p.m. job, Monday through Friday. He continued to work as a highway maintainer as of the date of hearing.

Petitioner started working in the coal mines in 2005 for Freeman United at its Crown 2 Mine. He was hired as an outby laborer. Petitioner testified that outby was considered anything beyond the tail piece in a section. Outby work included rock dusting the belt line, the travel way, the intake and return. He also shoveled a lot on the belt line. Petitioner described rock dusting as taking a fine dust and spreading it on the floor of the mine and underneath the belts and also throwing it on the ribs and the roof. He testified rock dusting is done to prevent fires. As an outby laborer he also set props, replaced roof bolts and anything else that needed to be done for MSHA regulations. Petitioner worked outby for about two weeks before he was put on coal production and stayed in a section. Petitioner testified that for the rest of his career he stayed in the area of the mine where the coal was being taken from the walls of the mine. He worked as a ram car operator meaning he would take the coal from the continuous miner to the feeder which would dump the coal on the belt to take it out of the mine. After six months on the ram car, Petitioner worked as a roof bolter for six to eight months. He testified that a roof bolter goes into the area that has been mined and installs roof supports which are known as roof bolts. Petitioner testified that Freeman used both conventional roof bolts and resin bolts. With resin bolts he would drill the hole in the roof and then insert the glue pin followed by the roof bolt. Petitioner testified that when the glue pins would break, there would be a strong odor. Petitioner's next job was continuous miner operator. He would operate the continuous miner by remote control to cut the coal from the face of the mine. He testified that he was exposed to quite a bit of coal dust when he ran that machine. Crown 2 closed in August 2007.

Petitioner left mining for a short period of time and returned to one of his prior jobs at a fertilizer plant. He worked there from March 2008 until February 2011. Petitioner went to work for Moriah Mining in February 2011. He was hired there as a roof bolter. Petitioner testified that he worked at Moriah for about nine months and then transferred to Respondent which was a sister mine to Moriah and stayed there until he left mining. Petitioner testified that at Respondent he was a continuous miner operator for two years and then took a foreman position on midnights. He was a belt and power mover. Petitioner testified that in 2015 the mine caught fire and in January 2016 all the foremen left. Petitioner testified that in 2019 Respondent began running coal again and he went back to work as a continuous miner operator from January 2019 until September 19, 2019.

Petitioner testified that when he was at the Hillsboro mine, he did quite a bit of walking and his mining gear was pretty heavy. He testified that he would get shortness of breath. He also noticed all the black that he would cough up or blow out of his nose. He first noticed breathing problems about halfway through his mining career. He testified that when he first noticed his breathing problems until the time he left mining, they stayed about the same. Petitioner testified that since leaving coal mining up until the time of arbitration, he had no more blowing black out of his nose or coughing up black stuff, but there was some shortness of breath. Petitioner enjoys playing sports with his oldest daughter, but it does not take too much to get him winded when they are playing basketball. Petitioner testified that he does not have any issues with his breathing at his current job unless he is

raking patch. He testified that after five to ten minutes of raking patch, he gets winded and must stop and catch his breath before going right back at it.

Petitioner testified that Dr. Cunningham with Pana Medical Group is his primary physician. Petitioner testified that he is a former smoker. He testified that it has been 21 years since he had a cigarette. Petitioner testified that he smoked from ages 17 to 20. He testified that at that time he smoked one pack every four days. Petitioner testified that he left the mine so he would not have rotating shifts. He testified that in the coal mine they rotated shifts every two weeks.

Petitioner testified that with his current job with Montgomery County, part of his duty is to patch holes in the roadway or on the road surfaces. They use a cold pack which is dropped onto the road and then has to be raked smooth. He described that work as heavy manual labor.

Petitioner testified that he was always honest with the health care individuals he came in contact with in terms of what symptoms and problems he was having or not having. Petitioner testified that as a truck driver, he has to undergo periodic IDOT exams. Petitioner testified that he has a two-year certificate.

Petitioner testified that from time to time while he was employed at the mine, he had an opportunity to undergo NIOSH chest x-ray screening for black lung. Petitioner testified that he could not recall if he went into the mobile unit that NIOSH brought to the mine for a chest x-ray.

Petitioner testified that he had COVID in January 2022. Petitioner testified that he swims in their swimming pool and rides bikes. He testified that he used to ride bikes from his house to the highway which is approximately 5/8 of a mile one way. He testified that he has not ridden his bike in over a year. He testified that his girls keep them pretty active in sports so he is not home very much. Petitioner testified that he hunts deer from a ground blind. Petitioner testified that this summer he put a roof on his house.

Dr. Suhail Istanbuly: Exam and Testimony

Dr. Suhail Istanbuly is board certified in internal medicine, pulmonary medicine, critical care medicine and sleep medicine. Dr. Istanbuly's main location is at the Hines VA in the Chicagoland area. He has a satellite clinic in Southern Illinois. He testified that he worked as a pulmonologist in all those locations. (PX1, p. 5). Dr. Istanbuly worked in Southern Illinois from April 2003 until April 2019. During that time, he worked at the black lung clinic in Southern Illinois. (PX1, p. 6). Dr. Istanbuly testified that when he was in Southern Illinois, between inpatient and outpatient, he was taking care of coal miners on a daily basis and they were roughly 10 to 20 percent of his practice. Dr. Istanbuly testified that in his practice he performed pulmonary function tests and interpreted same. He testified that he also had chest x-rays taken and interpreted those himself. Dr. Istanbuly is not a B-reader. (PX1, pp. 7-8).

Dr. Istanbuly examined Petitioner on December 13, 2022. Dr. Istanbuly saw Petitioner one time at his attorney's request for a workup in his state black lung claim. He testified that in the past for a number of years he performed five to seven such examinations per month. These examinations were always at the request of a claimant's attorney. (PX1, pp. 9, 26). Dr. Istanbuly still comes to Southern Illinois each month to see the clinical cases for pulmonary, black lung and sleep medicine and occasionally, not on a monthly basis, he still performs a few evaluations for black lung claims. (PX1, p. 27).

Dr. Istanbuly testified that Petitioner worked as a coal miner for eight to ten years, all of that time being underground. His last month of employment was September 2019. In the last year of his coal mining employment, Petitioner was a mine machine operator. Dr. Istanbuly testified that Petitioner left the coal mines mainly to look for a better lifestyle and opportunities rather than due to health problems. (PX1, p. 10). Dr. Istanbuly testified that Petitioner is a nonsmoker and has never smoked before. Petitioner denied being

diagnosed with asthma or chronic obstructive pulmonary disease in the past. He has not been on any inhaled or nebulized bronchodilators. Petitioner denied chronic daily cough although he mentioned that he did cough occasionally, and the cough was mostly dry. Petitioner noted that strenuous activity like brisk walking might aggravate his cough. (PX1, pp. 10-11). Dr. Istambouly recorded that Petitioner had occasional episodes of nocturnal dyspnea. In the past three months he had woken twice gasping for air. Petitioner reported exertional dyspnea. He would get short of breath by walking half a mile. He had had no significant worsening of his physical capacity in the past year. Petitioner reported no significant wheezing although he had some chest tightness following the pulmonary function test performed at Dr. Istambouly's examination. Petitioner reported he had gained 20 pounds since he left the coal mine. (Petitioner's Exhibit No. 1, pp. 11-12). Dr. Istambouly testified that Petitioner's spirometry performed on that date was within normal range. He testified that Petitioner's chest x-ray taken on August 5, 2022, revealed bilateral interstitial changes involving the mid and lower lung zones consistent with simple coal worker's pneumoconiosis, profusion 1/0 per the B-reader, Dr. Henry Smith. (PX1, p. 12). Dr. Istambouly testified that on examination Petitioner's lungs had good air entry bilaterally. There were no wheezes or rales. (PX1, p. 13).

Dr. Istambouly testified that Petitioner had simple coal workers' pneumoconiosis (early stage) related to long term coal dust inhalation. He testified that it was highly likely that long term coal dust inhalation was a significant contributor to Petitioner's current respiratory symptoms including intermittent cough, nocturnal dyspnea and exertional dyspnea. Dr. Istambouly testified that it was advisable for Petitioner to avoid any further coal dust inhalation to prevent the progression of his pulmonary disease. (PX1, p. 14).

Dr. Istambouly noted in his patient history that Petitioner worked six days a week for 10 hours a day when working in the coal mine. He testified that it would be a fair statement to assume that Petitioner's exposure as a coal miner rather than being equivalent to 8 to 10 years would be more equivalent to 12 to 15 years of exposure. He testified that one could also say he had 8 to 10 years of heavy exposure. (PX1, p. 15). Dr. Istambouly testified that a person could have coal worker's pneumoconiosis despite having an x-ray that does not show it. (PX1, pp. 17-18). Dr. Istambouly testified that for making a diagnosis of coal workers' pneumoconiosis, one needs medical history, occupational history and physical exam in addition to supportive diagnostic testing like pulmonary function tests and chest x-ray. He testified that the diagnosis is not made based on a simple aspect but rather combining all these aspects together to come up with a clinical diagnosis. (PX1, p. 18).

Dr. Istambouly testified that in the history he obtained from Petitioner he was not taking any breathing medication at the time of his examination and had never taken breathing medication in the past. Petitioner had no past history of respiratory disease. (PX1, p. 27). Dr. Istambouly testified that the consensus is that on average a minimum of 15 years' experience is required to develop coal workers' pneumoconiosis although it varies based on the level of exposure and the susceptibility of the host. Dr. Istambouly testified that Petitioner denied chronic daily cough and that when he coughed it was mostly dry. The only trigger for his cough was exercise. It was not triggered by smoke, dust or fumes. (PX1, p. 28). Dr. Istambouly testified that there are causes for exertional dyspnea other than respiratory disease. He testified that heart disease and deconditioning would be two such causes. Dr. Istambouly did not know what Petitioner had done since leaving the mine to stay physically fit. Petitioner did not relate to Dr. Istambouly leaving the mine at the time he did due to an inability to perform the duties of his job or as a consequence of a diagnosis of respiratory disease. (PX1, pp. 28-29). Dr. Istambouly testified that he reviewed no treatment records of Petitioner other than what was provided on the day of evaluation which included results from the spirometry performed on him prior to Dr. Istambouly's examination and the narrative report and B-reading of Dr. Henry K. Smith. (PX1, pp. 29-30).

Dr. Istambouly testified that Petitioner's forced vital capacity of 91.7 percent of predicted was normal. He testified that there was no indication of restriction in Petitioner. Petitioner's forced expiratory volume in one second was 88 percent of predicted which was normal. Dr. Istambouly testified that there was no evidence of obstruction based upon Petitioner's FEV1/FVC ratio of 77.29%. (PX1, pp. 30-31). Dr. Istambouly testified that

according to the *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition*, Petitioner has class 0 impairment based upon his pulmonary function testing. (PX1, pp. 31-32).

Dr. Istambouly testified that when he met with Petitioner, he was presented with a chest x-ray dated August 5, 2022, along with Dr. Smith's interpretation of same. Dr. Istambouly has not seen any other chest imaging or interpretations of chest imaging beyond the one x-ray and Dr. Smith's interpretation. Dr. Istambouly testified that he is not an A- or B-reader of films. (PX1, p. 32). Dr. Istambouly testified that he does not provide profusion ratings on the films he interprets for black lung. When he interprets a film for black lung, he determines whether the film is positive or negative for same, and if it is positive, he classifies what he sees as early or mild, moderate or severe. He characterized what he saw on Petitioner's chest x-ray as early or mild pneumoconiosis. Dr. Istambouly testified that he could not say whether the chest x-ray he reviewed had a profusion of 1/0 or 0/1. (PX1, p. 33). Dr. Istambouly testified that he did not do a side-by-side interpretation of Petitioner's film with the standard ILO films. Dr. Istambouly testified that his sole diagnosis for Petitioner was simple pneumoconiosis. Dr. Istambouly testified that one must be a susceptible host to develop pneumoconiosis. He testified that not all coal miners develop the disease. (PX1, p. 34).

Dr. Henry K. Smith: Report

Dr. Henry K. Smith interpreted Petitioner's chest x-ray of August 5, 2022. He interpreted same as positive for pneumoconiosis of profusion 1/0 with p/p opacities in the bilateral mid and lower lung zones. Dr. Smith is a board-certified radiologist and NIOSH B-reader. (PX2).

Dr. Cristopher Meyer: Testimony

Dr. Cristopher Meyer reviewed chest x-ray of Petitioner dated August 5, 2022, from Harrisburg Medical Center. Dr. Meyer testified that the film was quality 1. Dr. Meyer testified that there were no small or large opacities on the chest x-ray. Dr. Meyer's impression was that the lungs were clear and there were no radiographic findings of coal workers' pneumoconiosis. (RX1, pp. 42-43).

Dr. Meyer has been board certified in radiology since 1992. (RX1, p. 8). Dr. Meyer became a B-reader in 1999. (RX1, pp. 21-23). Dr. Meyer testified that one of the most important parts of the B-reading training and examination is making the distinction between a film with profusion of 0/1 which is a normal examination from 1/0 which is an almost normal but slightly abnormal examination. Dr. Meyer testified that making the distinction between a 1/0 versus a 0/1 is a critical component of the B-reader examination and is a point of emphasis in the B-reading course as well. (RX1, p. 36).

Dr. Meyer testified that the B-reader looks at the lungs to decide whether there are small nodular opacities and based on the size and appearance of the small opacities they are given a letter score. (RX1, p. 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. Diseases that cause pulmonary fibrosis, like asbestosis, are described by small linear opacities. (RX1, pp. 29-30). The distribution of the opacities is also described because different pneumoconiosis is seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper lung zone predominant process. Idiopathic pulmonary fibrosis or asbestosis is a basilar or linear process. The last component of the interpretation is the extent of the lung involvement or so-called profusion. (RX1, pp. 24-25). Dr. Meyer testified that profusion is basically trying to describe the density of the small opacities in the lung. (RX1, pp. 31-32).

Dr. Meyer testified that when he wants to determine the existence of lung disease, the gold standard is pathologic review of the tissue itself rather than radiology. (RX1, p. 48). Dr. Meyer testified that when he performs a B-reading, he just wants to look at the film and answer the simple question: Is there anything on

there that is consistent with the abnormalities of coal workers' pneumoconiosis. He testified that his assumption when he is asked to do a B-reading is that the worker has an appropriate exposure history to warrant having a chest x-ray. (RX1, pp. 48-49). Dr. Meyer testified that one of the issues with interpreting a chest x-ray for pneumoconiosis is making sure the individual who is interpreting the study has ample experience reading them to be able to sort out what the background variation is for normal. Dr. Meyer testified that part of trying to figure out whether or not there is an abnormality in the lung is recognizing the large spectrum of normal which is why someone like Dr. Meyer spends his entire career as a chest radiologist devoted to looking at chest radiographs day in and day out to establish that spectrum of normal. (RX1, pp. 50-51). Dr. Meyer testified that when he was reading films two days a week, he read between 150 to 200 chest x-rays in a week and depending upon the business of the service, he read 50 to 70 chest CT scans. (RX1, pp. 16-17).

Dr. Meyer testified that there are studies that show that at autopsy 50 percent or more of long-term coal miners are found to have abnormalities of coal workers' pneumoconiosis which might not have been apparent radiographically during their life. Dr. Meyer testified that if he reads an x-ray to be positive and the worker had a sufficient history to cause coal workers' pneumoconiosis that would warrant a finding of coal workers' pneumoconiosis. He testified that if he finds a chest x-ray negative that would not necessarily rule out that the miner may have pneumoconiosis pathologically. (RX1, pp. 89-90). Dr. Meyer testified that it would be fair to say that all long-term coal miners are going to come out of the mine with some dust deposit trapped in their lungs, however, the majority of those will not have changes in their lungs that qualify for coal workers' pneumoconiosis. (RX1, p. 54). Dr. Meyer testified that it is not possible to have coal workers' pneumoconiosis without having a tissue reaction to the coal dust. In category one pneumoconiosis there will be some change in the function of the lung at the very site of the tissue reaction which probably could not be measured. (RX1, pp. 56-57). Dr. Meyer testified that very rarely would opacities of coal worker's pneumoconiosis be found in the mid and lower lung zones and not the upper zones. (RX1, pp. 78-79). Dr. Meyer testified that simple pneumoconiosis typically will not progress once exposure ceases. (Respondent's Exhibit No. 1, p. 91).

Dr. David Rosenberg: Testimony

Dr. David Rosenberg conducted a review of medical records and a chest x-ray regarding Petitioner at the request of Respondent's counsel. Dr. Rosenberg testified that the issue to be addressed was whether Petitioner developed any respiratory-related disorder consequent to his employment. (RX3, pp. 10-11). Dr. Rosenberg has been board certified in internal medicine since 1977. After graduating from medical school, Dr. Rosenberg did a pulmonary fellowship at the National Institute of Health in Bethesda, Maryland. Dr. Rosenberg received his board certification in pulmonary disease in 1980. (RX3, pp. 4-5). Dr. Rosenberg testified that he received his board certification in occupational medicine in 1995. (RX3, p. 5). Dr. Rosenberg has been a B-reader since July 2000. Dr. Rosenberg has patients in his clinical practice who have black lung. (RX3, p. 10).

Dr. Rosenberg reviewed a chest x-ray of Petitioner dated August 5, 2022. Dr. Rosenberg testified that the film was quality 1 and 0/0 profusion without evidence of pneumoconiosis. (RX3, p. 22). Dr. Rosenberg testified that for a proper reading of a chest x-ray for pneumoconiosis, the reader first assesses the quality of the film. He testified that he next classifies the clinical abnormalities, if any. If they are present, he determines whether they are primary or secondary micronodular or linear changes. The reader next notes which of the six lung zones are involved. The reader notes the profusion rating and whether there are any large opacities. Dr. Rosenberg testified that the reader then classifies any pleural abnormalities and then notes on section 4 of the B-reading form whether there are any other abnormalities. (RX3, pp. 22-23). Dr. Rosenberg testified that the interpretation of the target film is done side-by-side with the standard ILO films. Dr. Rosenberg testified that he conducted this side-by-side review when reading Petitioner's film. (RX3, p. 23). Dr. Rosenberg testified that if one has never seen the standard ILO films, it would be impossible to be able to determine whether what one is seeing on the chest x-ray is either a category 0/1 or a category 1/0 profusion. Dr. Rosenberg testified that a profusion of 1/0 would be positive for pneumoconiosis and a negative film would be profusion of 0/1 or lower. Dr.

Rosenberg testified that making that distinction is a fine one and is a point of emphasis in the B-reading syllabus, course, and exam. (RX3, p. 24). Dr. Rosenberg testified that the use of profusion ratings avoids imprecise descriptive terms of what is seen on the film such as mild or early pneumoconiosis. He testified that what is early or mild for one person may not be the same as what it is to another. He testified that all A- and B-readers would know what a profusion of 1/0 means. (RX3, pp. 24-25).

Dr. Rosenberg testified that it is unlikely for simple pneumoconiosis to progress once the exposure ceases. Dr. Rosenberg agrees with the American Thoracic Society that an older worker with a mild pneumoconiosis may be at low risk for working in the mine at currently permissible dust levels until he reaches retirement age. (RX3, p. 25). Dr. Rosenberg is familiar with the *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition*, Chapter 5, The Pulmonary System. He testified that chest imaging under the *Guides* is not a factor, let alone a key factor, in the assessment of pulmonary impairment. (RX3, p. 16). Dr. Rosenberg testified that in terms of testing to know whether a pulmonary impairment exists regardless of whether there are symptoms or not requires three components – spirometry, lung volumes and diffusion capacity as well as some measurement of oxygenation if possible. (RX3, pp. 15-16). Dr. Rosenberg testified that an individual needs to be a susceptible host to develop coal workers' pneumoconiosis. He testified that not all coal miners develop pneumoconiosis and that a majority do not develop same. (RX3, p. 17). He testified that NIOSH has compiled statistics on the prevalence of coal workers' pneumoconiosis in the mining community. He testified that those statistics are based on the chest x-ray screening that NIOSH performed under the Coal Workers' X-Ray Surveillance Program. That program allows a coal miner every five years, should he choose, to undergo a chest x-ray for black lung. He testified that according to NIOSH the prevalence of coal workers' pneumoconiosis in the United States is a little over 3%. (RX3, pp. 17-18). He testified that the intensity or the duration of exposure for the individual is not important if the individual is not a susceptible host. He testified that for those individuals their films will have a negative profusion. (RX3, p. 18). Dr. Rosenberg testified that the Vallyathan article that was published in 1996 found there was a concordance of around 70% between chest x-ray evidence and pathologic evidence of pneumoconiosis. Dr. Rosenberg testified that given a concordance rate of 70%, it is more likely than not that if one has pathologic evidence of disease, he will also have radiographic evidence of pneumoconiosis. (RX3, pp. 18-19).

Dr. Rosenberg testified that the treatment records he reviewed did not contain a diagnosis of chronic bronchitis. He testified that the history provided by Petitioner to Dr. Istambouly of cough and sputum did not satisfy the diagnosis of chronic bronchitis. Dr. Rosenberg testified that the medical records he reviewed did not contain a diagnosis of chronic respiratory disease. (RX3, pp. 16-17).

Dr. Rosenberg further testified that the results for the pulmonary function testing performed on Petitioner were normal. He testified that the StatCare results could have been better with better effort, but they were still normal. He testified that the variability of the values outlined for the FEV1 was 170 milliliters which is greater than what one would like. He testified that one would like it generally 100 milliliters or less. Dr. Rosenberg testified that the standard for validity in spirometry is its reproducibility. In this testing Petitioner did not have variability within ATS guidelines for the FEV1. Dr. Rosenberg attributed that variability to lack of coaching the patient in the performance of the test. (RX3, pp. 19-20). Dr. Rosenberg testified that spirometry is an effort dependent test. Dr. Rosenberg testified that Petitioner's spirometry at StatCare was still normal regardless of whether Knudson or NHANES III prediction equations were used. Dr. Rosenberg agreed with Dr. Istambouly's testimony that if Table 5-4 of the *AMA Guides* were applied to the results from Petitioner's testing, he would fall in class 0 impairment. (RX3, p. 20). Dr. Rosenberg testified that when he has a patient in his clinical practice such as Petitioner, with the results he had in his pulmonary function testing, and the complaints he voiced, Dr. Rosenberg would look to causes other than respiratory disease to explain those complaints. Dr. Rosenberg testified that physiologically there was no explanation for any shortness of breath that would be from a pulmonary perspective because Petitioner's ventilation was normal as represented by the diffusion capacity. (RX3, pp. 20-21).

Dr. Rosenberg testified that Petitioner's diffusion capacity was normal. Dr. Rosenberg testified that subradiographic pneumoconiosis does not have any clinical significance. He testified that the normal diffusion capacity supports the fact that the lung parenchyma where the gas exchanges take place is not damaged. Dr. Rosenberg testified that based upon his forensic review of medical and imaging, Petitioner was capable of heavy manual labor from a respiratory standpoint. (RX3, pp. 21-22). Dr. Rosenberg testified that Petitioner had no impairment; he did not have an obstruction or restriction. Dr. Rosenberg testified that Petitioner did not have chronic bronchitis as supported by the lack of coughing and sputum production on a regular basis for three months out of the year for two consecutive years. Dr. Rosenberg testified that Petitioner was not disabled from performing his previous coal mine job. Dr. Rosenberg concluded that Petitioner did not have any condition related to past coal mine dust exposure. (RX3, pp. 26-27).

Dr. Rosenberg testified that a tissue reaction due to trapped coal dust is required either in the airways or in the parenchyma to have coal workers' pneumoconiosis. He testified that the tissue reaction can be called scarring or fibrosis. (RX3, p. 49). Dr. Rosenberg testified that the scar tissue of coal workers' pneumoconiosis cannot perform the function of normal healthy lung tissue. He testified that most patients with simple disease have preserved lung function. (RX3, p. 50). Dr. Rosenberg testified that for determining coal workers' pneumoconiosis between radiographic study and pathologic study, pathology is the gold standard. He testified that a person could have coal workers' pneumoconiosis pathologically with a negative chest x-ray. (RX3, pp. 75-76). Dr. Rosenberg testified that if one is going to have "p" opacities, they are more likely going to be in the upper lung zones. He testified that coal workers' pneumoconiosis would start in the upper lung zones not in the lower lung zones. (RX3, pp. 84-85).

Dr. Rosenberg testified that Petitioner's two spirometry tests were performed four months apart. He testified that there was a proportional decline in both his forced vital capacity and forced expiratory volume in one second between the results from Dr. Istanbuly's testing and the StatCare testing. Dr. Rosenberg testified that same was indicative of less effort. (RX3, pp. 87-88). Dr. Rosenberg testified that it was not possible for a decline in spirometry over four months to be related to coal dust exposure that had been over four years prior. Dr. Rosenberg testified that Petitioner's total lung capacity of 107 percent of predicted ruled out a restriction. Dr. Rosenberg testified that lung volume testing is the gold standard to determine whether a restriction exists. (RX3, p. 88).

Medical Records

Medical Records of Community Medical Clinic were admitted into evidence. Petitioner was seen on March 7, 2013, for DOT exam. He denied any complaints. Review of systems respiratory was negative for dyspnea. He had normal breath sounds with no adventitious sounds. (RX4, pp. 61-62). Petitioner was seen on December 5, 2018, for a physical. He reported he quit smoking in 2003. He was taking no medications. Physical examination of the chest revealed normal effort and breath sounds with no adventitious sounds. (RX4, pp. 59-60). Petitioner was seen on January 21, 2019, with complaints of cold symptoms that had been occurring for three weeks. Symptoms included fatigue, nasal congestion, stuffy nose, cough and bilateral ear pain. He was noted to be a truck driver. Examination of the chest revealed normal breath sounds with no adventitious sounds. Assessment was bacterial sinusitis. (RX4, pp. 56-57). Petitioner was seen on March 18, 2019, for DOT physical. He was taking no medications. His DOT paperwork was completed and he was cleared for two years. (RX4, p. 55).

Petitioner was seen on January 18, 2021, for a wellness exam. He related he was generally in good health. His only complaint was he noticed a slight worsening of his short-term memory over the last year. Examination of the chest revealed the lungs were clear to auscultation. Assessment was annual physical exam for individual who overall was generally very healthy. (RX4, pp. 53-54). Petitioner was seen on January 25, 2021, for DOT physical. He was given a two-year certificate. (RX4, p. 47). Petitioner was seen on April 12, 2021, regarding

anxiety. His review of systems respiratory was negative for shortness of breath. Examination of the chest revealed the lungs clear to auscultation. (RX4, pp. 44-45). Petitioner was seen on May 12, 2021, for follow-up on his anxiety. His condition had improved. Review of systems respiratory was negative for shortness of breath. Examination of the chest revealed the lungs clear to auscultation. (RX4, p. 42). Petitioner was seen on June 19, 2021, for a rash which he believed was caused by exposure to poison ivy. Review of systems respiratory was negative for shortness of breath or cough. Examination of the chest revealed the lungs clear to auscultation. (RX4, pp. 37-38). Petitioner was seen on August 2, 2021, for follow-up regarding medication. His review of systems respiratory was negative for shortness of breath. On examination of the chest his lungs were clear to auscultation. (RX4, p. 34).

Petitioner was seen on January 8, 2022, with cough and sore throat with nasal drainage for two days. Review of systems respiratory was negative for shortness of breath but positive for cough. Examination of the chest revealed the lungs clear to auscultation. COVID-19 test was positive. (RX5, pp. 19-20). Petitioner was seen on February 28, 2022, to discuss snoring issues. Review of systems respiratory was negative for shortness of breath. Examination of the chest revealed the lungs clear to auscultation. (RX4, pp. 16-17). He was seen for follow-up regarding his snoring issues on September 12, 2022. Review of systems was negative for shortness of breath. Examination of the chest revealed the lungs clear to auscultation. (RX4, pp. 13-14). Petitioner was seen on January 24, 2023, for a DOT physical. His only medication was Lexapro. He was given a two-year certificate. (RX4, pp. 10-11). Petitioner was seen on January 10, 2024, with right elbow pain which had moved into his shoulder and into the front of his chest. Review of systems respiratory was negative for shortness of breath or cough. Examination of the chest revealed normal breath sounds with no adventitious sounds. (RX4, pp. 4-6).

CONCLUSIONS OF LAW

Issue (C): Did an occupational disease occur that arose out of and in the course of Petitioner's employment with Respondent? & Issue (F): Is Petitioner's current condition of ill-being causally related to his occupational exposure?

Petitioner worked as a coal miner for 8.5 to 9 years, with all of them being underground. During his mining career, in addition to coal dust, Petitioner was regularly exposed to silica dust, roof bolting glue fumes, and diesel fumes. Petitioner was a light smoker for a few years over two decades ago. He was last exposed to the environment of a coal mine on September 19, 2019, at the age of 36, when he left Respondent for a new job with the Montgomery County Highway Department. Petitioner's testimony was un rebutted, consistent, and credible. Moreover, Petitioner has offered testimony of respiratory issues, along with expert opinions, relying on the same objective tests, and relating his current complaints to CWP.

In this case, there is a disagreement between the experts concerning whether CWP is apparent on the x-ray, with Petitioner's experts finding evidence, and Respondent's finding none. As to the readings of the chest x-ray, the testimony establishes conclusively that a miner can suffer from CWP despite having a completely normal chest x-ray. The testimony establishes that the gold standard for diagnosing CWP is pathology. Dr. Meyer and Dr. Rosenberg each testified that this Petitioner could have CWP notwithstanding their negative readings of the x-ray. The testimony also establishes that equally-qualified radiologist or B-readers could reasonably disagree on whether a coal miner's x-ray is positive or negative.

Respondent's retained expert, Dr. Rosenberg, did not conduct a physical examination or take a patient history. He did review treatment records. Dr. Rosenberg testified that Petitioner's treatment records did not outline the existence of a chronic respiratory disorder. Dr. Rosenberg also reviewed the chest x-ray of August 5, 2022, and found 0/0 profusion without evidence of pneumoconiosis. Dr. Rosenberg testified that an individual can have

coal workers' pneumoconiosis pathologically with a negative chest x-ray. Dr. Rosenberg testified that it is unlikely for coal workers' pneumoconiosis to progress once the exposure ceases.

Respondent's retained expert, Dr. Meyer, reviewed the chest x-ray of Petitioner dated August 5, 2022. Dr. Meyer's interpretation of the film was that the lungs were clear, and testified that there were no radiographic findings of CWP. Dr. Meyer also testified that simple pneumoconiosis typically will not progress once exposure ceases.

Petitioner's retained expert, Dr. Henry K. Smith, a board-certified radiologist and NIOSH B-reader, interpreted Petitioner's chest x-ray of August 5, 2022, as positive for simple CWP with "interstitial fibrosis of classification p/p, mid and lower zones involved bilaterally of profusion 1/0."

Petitioner's retained expert, Dr. Istambouly, took a patient history, performed a physical examination and reviewed x-rays. Dr. Istambouly testified that Petitioner's long term coal dust inhalation was a significant contributor to Petitioner's current respiratory symptoms including intermittent cough, nocturnal dyspnea and exertional dyspnea. Dr. Istambouly's diagnosed simple CWP related to coal dust inhalation.

The record reveals that Petitioner could have CWP notwithstanding the negative readings of Respondent's experts relating to the radiographic evidence. Petitioner's expert, Dr. Smith found evidence of simple CWP on x-ray. Dr. Istambouly credibly testified simple CWP was the likely cause of Petitioner's symptoms. Therefore, the Arbitrator finds that Petitioner has met his burden and proven by a preponderance of the evidence that his simple CWP arose out of and in the course of his employment, and that his current condition of simple CWP is related to his occupational exposure as a coal miner.

Issue (L): What is the Nature and Extent of the Injury?

With regard to the issue of nature and extent, the Arbitrator notes that 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 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, the Arbitrator finds as follows:

- (i) Impairment rating: Petitioner has a zero-impairment rating pursuant to the AMA 6th Edition guides. The Arbitrator has considered this and lends it moderate weight.
- (ii) Occupation of Injured Employee: Petitioner was a coal miner, a heavy labor position. He now works full-time and full duty as a highway maintainer, also a heavy labor position. The Arbitrator has considered this factor and lends it significant weight.
- (iii) Age: Petitioner was 36 years old when his employment with Respondent ended, he is currently 41 years old. The Arbitrator has considered and lends this factor some weight.
- (iv) Petitioner's future earning capacity: No evidence was submitted into the record showing a diminution in Petitioner's earning capacity. The Arbitrator has considered and lends some weight to this factor.
- (v) Evidence of disability corroborated by the treating medical records: Petitioner testified that he suffers occasional dry cough aggravated by strenuous exercise. Petitioner's recent spirometry

testing is within normal range. Dr. Smith found that Petitioner did suffer from simple CWP at the minimum level of profusion at 1/0 bilaterally, which is consistent with Petitioner's treatment records indicating little to no pulmonary dysfunction. The Arbitrator has considered this factor and lends it significant weight.

Considering the above factors, and the record taken as whole, the Arbitrator finds that Petitioner has sustained a 3% loss of use to his person as a whole.

Issue (O): Sections 1(d)-1(f) of the Occupational Diseases Act

The Illinois Occupational Diseases Act reads, in the relevant parts, as follows:

“[1](d) In this 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. 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. An 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...The employer liable for the compensation in this Act provided shall be the employer in whose employment the employee was last exposed to the hazard of the occupational disease claimed upon regardless of the length of time of such last exposure...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...
 (e) "Disablement" means an impairment or partial impairment, temporary or permanent, in the function of the body or any of the members of the body...
 (f) No 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.”

Incorporating the findings herein above, the issues relating to Sections 1(d) and 1(e) have been addressed. In regard to Section 1(f), the evidence supports a finding that Petitioner's partial disablement occurred within two years of his last date of exposure. Given this, the Arbitrator finds that Petitioner has satisfied the requirements of Sections 1(d) – 1(f) of the Occupational Diseases Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	13WC023103
Case Name	Hurbie Carney v. State of Illinois - Department of Human Services
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	25IWCC0492
Number of Pages of Decision	25
Decision Issued By	Raychel Wesley, Commissioner

Petitioner Attorney	Richard Bogusz Jr
Respondent Attorney	Danielle Curtiss

DATE FILED: 12/16/2025

/s/ Raychel Wesley, Commissioner

Signature

to the claim. While lacking, we do not find it fatal to Petitioner's claim. See *Edward Hines Precision Components v. Industrial Commission*, 356 Ill. App. 3d 186, 194 (2nd Dist. 1987) ("There is no requirement that a certain percentage of time be spent on a task in order for the [claimant's work] duties to meet a legal definition of 'repetitive.'") Rather, the Commission finds Petitioner's testimony that her 30-plus-year career as a caseworker involved "mainly typing" and "mostly typing" (T. 12, 22) is credible, and we note we have routinely held such job duties, i.e., typing, computer keyboarding, and data entry, are competent causes of repetitive trauma injuries and compensable. See *Joyce Miller v. State of Illinois, Dept. of Human Services*, 18 IWCC 0167; *Yvonne Hankins v. State of Illinois, Dept. of Human Development*, 19 IWCC 0405; *Beverly Hawley v. State of Illinois, Dept. of Transportation*, 20 IWCC 0559; *Ernestine Chris Jackson v. Illinois State University*, 24 IWCC 0053. Moreover, as set forth below, the Commission finds the medical evidence establishes a causal connection between Petitioner's typing and her bilateral carpal tunnel syndrome.

An employee who alleges injury based on repetitive trauma must meet the same standard of proof as any other claimant under the Act: "There must be a showing that the injury is work related and not the result of a normal degenerative aging process." *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill. 2d 524, 530 (1987). Here, Petitioner's treating orthopedic surgeon, Dr. Jay Brooker, concluded her carpal tunnel syndrome was causally related to her work activities. On June 7, 2013, Dr. Brooker documented, "This is clearly work related as it is occurring with heavily repetitive activities at work and no other significant cause." PX1. Later, at the November 14, 2014 re-evaluation, Dr. Brooker reiterated his causal connection opinion: "Again, these are work related injuries. I am not really clear on how her work is expecting that she should be on disability for this. This has been a work related injury all along and continues to be that." PX1. While Respondent argues there is no evidence Dr. Brooker knew the particulars of Petitioner's job duties, the Commission disagrees; we observe the doctor's records clearly evidence Dr. Brooker discussed Petitioner's job duties with her and he based his opinions on that information. The Commission finds Dr. Brooker's expert opinions regarding the repetitive nature of typing and its causal relationship to carpal tunnel syndrome to be persuasive. As to the contrary causation opinion provided by Dr. Vender, we are unpersuaded by the doctor's belief that Petitioner's development of carpal tunnel syndrome is attributable solely to her age, gender, and body habitus. The Commission finds the preponderance of the credible evidence, including Petitioner's un rebutted testimony and Dr. Brooker's medical records and expert opinions, establishes Petitioner sustained repetitive trauma injuries related to her work activities.

II. Manifestation Date

The next issue the Commission must address is the propriety of the April 18, 2013 manifestation date. The manifestation date "means the date on which both the fact of the injury and the causal relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person." *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill. 2d 524, 531 (1987). It is well-settled the date of manifestation of a repetitive trauma injury is subject to a "flexible standard" that "ensures a fair result for both the faithful employee and the employer's insurance carrier." *Three "D" Discount Store v. Industrial Commission*, 198 Ill. App. 3d 43, 49 (4th Dist. 1989). The test of when an injury manifests itself is an objective one, determined from the facts and circumstances of each case. *Id* at 47. In deciding the manifestation date of a repetitive-trauma injury, courts consider various factors, including the dates on which (1) the claimant first sought medical attention for the condition, (2) the claimant was first informed by a physician that the condition is work-related, (3) the claimant was first

unable to work as a result of the condition, (4) the symptoms became more acute at work, and (5) the claimant first noticed the symptoms of the condition. *Durand v Industrial Commission*, 224 Ill. 2d 53, 68-70 (2006) (citing *Peoria County Belwood Nursing Home*, 115 Ill. 2d at 531; *Three "D" Discount Store*, 198 Ill. App. 3d at 47-48; and *Oscar Mayer & Co. v. Industrial Commission*, 176 Ill. App. 3d 607, 611-12 (4th Dist. 1988)).

The April 18, 2013 manifestation date is based on Petitioner's completion of a Notice of Injury form on that date. On that same document, however, Petitioner identified her Date of Injury as January 1, 2008. While Respondent argues this proves Petitioner's condition manifested on January 1, 2008, the Commission disagrees. Our review of Petitioner's testimony reflects January 1, 2008 was when she first noticed symptoms and possibly sought treatment, though her recollection was unclear. The Commission finds Petitioner's inability to remember specifics from 2008 does not raise a negative inference; to the contrary, we believe her lack of recall is to be expected given the unexplained 17-year gap between those events and when the matter went to trial. We further find her symptom onset is not equivalent to there being a "plainly apparent" connection between her condition and her work activities at that time. Nonetheless, while the date of manifestation is subject to a "flexible standard," the Commission finds April 18, 2013 does not meet any of the criteria identified in *Durand*. Instead, the Commission finds June 7, 2013 is the date Petitioner's condition manifested itself. The Commission observes June 7, 2013 is the date Dr. Brooker "informed" Petitioner the condition was "clearly work related." PX1. As such, and based on the record in its entirety, the Commission modifies the Arbitrator's Decision and finds that Petitioner's condition of bilateral carpal tunnel syndrome manifested on June 7, 2013.

The Commission observes our amendment of the manifestation date necessarily implicates the disputed issues of whether Petitioner's claim was filed within the statute of limitations as well as whether Petitioner provided timely notice to Respondent. The record reflects Petitioner's Application for Adjustment of Claim was filed on July 17, 2013 (RX7), which is 41 days after the June 7, 2013 manifestation date. The Commission finds this satisfies both the three-year application filing period in §6(d) as well as the 45-day notice period in §6(c).

III. Temporary Disability

The Arbitrator awarded Temporary Total Disability ("TTD") benefits from April 18, 2013 through February 10, 2015. The Commission views the evidence differently. Initially, given our determination that Petitioner's condition manifested on June 7, 2013, the Commission finds Petitioner's entitlement to TTD benefits did not commence until that date. The Commission further observes the evidence establishes Dr. Brooker released Petitioner to "return to work on February 9" (PX1); as such, Petitioner's entitlement to TTD benefits terminated on February 8, 2015. Finally, the Commission notes the Order incorrectly utilized the PPD benefit rate instead of the TTD benefit rate. Therefore, the Commission modifies the Decision to find Petitioner is entitled TTD benefits in the sum of \$830.00 per week for 87 3/7 weeks, representing June 7, 2013 through February 8, 2015.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 14, 2025, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of \$830.00 per week for a period of 87 3/7 weeks, representing June 7, 2013 through February 8, 2015, 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 \$712.55 per week for a period of 26.6 weeks, as provided in §8(e)9 of the Act, for the reason that the injuries sustained caused the 14% loss of use of the right hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of \$712.55 per week for a period of 26.6 weeks, as provided in §8(e)9 of the Act, for the reason that the injuries sustained caused the 14% loss of use of the left hand.

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.

Pursuant to §19(f)(1), this decision is not subject to judicial review.

December 16, 2025

RAW/mck

/s/ *Raychel A. Wesley*

O: 11/19/25

/s/ *Carolyn M. Doherty*

43

/s/ *Frank J. Soto*

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	13WC023103
Case Name	Hurbie Carney v. State of Illinois - Department of Human Services
Consolidated Cases	
Proceeding Type	Request for Hearing
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	20
Decision Issued By	Daniel Swanson, Arbitrator

Petitioner Attorney	Richard Bogusz Jr
Respondent Attorney	Danielle Curtiss

DATE FILED: 3/14/2025

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



March 14, 2025

/s/ Daniel Swanson, Arbitrator
Signature

/s/ Michele Kowalski
Michele Kowalski, Secretary
Illinois Workers' Compensation Commission

INTEREST RATE WEEK OF MARCH 11 2025 4.08%

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**

Hurbie Carney

Employee/Petitioner

v.

Illinois Department of Human Services

Employer/Respondent

Case # **13 WC 023103**

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 **Daniel Swanson**, Arbitrator of the Commission, in the city of **Chicago** on **February 11, 2025**. 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 Petitioner file the Application for Adjustment of Claim within the period permitted pursuant to statute?

FINDINGS

On **April 18, 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 **\$64,740.00**; the average weekly wage was **\$1,245.00**

On the date of accident, Petitioner was **52** years of age, *married* with **1** dependent child.

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 **\$6,656.13** for other benefits, for a total credit of **\$6,656.13**

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

ORDER

The Arbitrator finds that Petitioner has sustained her burden of proving an accident occurred which arose out of and in the course of her employment.

The Arbitrator finds that Petitioner has sustained her burden of proving that her current condition is causally related to any work accident.

Respondent shall pay Petitioner temporary total disability benefits of \$712.55/week for 94 2/7 weeks for the period between April 18, 2013 and February 10, 2015, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of \$6,656.13 for medical benefits that have been paid. The parties have stipulated that there are no unpaid medical bills for which Respondent is liable.

Based on the factors enumerated in 8.1(b) of the Act and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 14% loss of use of the right hand and 14% loss of use of the left hand. Respondent shall pay Petitioner 53.2 weeks of permanency at the rate of \$712.55 per week.

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.

Daniel Swanson

MARCH 14 2025

Signature of Arbitrator

[illegible]

ILLINOIS WORKERS' COMPENSATION COMMISSION

Hurbie Carney,)
)
Petitioner,)
)
v.)
)
Department of Human Services,)
)
)
Respondent.)

Case No. 13WC023103

FINDINGS OF FACT

This matter proceeded to hearing on February 11, 2025 in Chicago, Illinois before Arbitrator Daniel Swanson on Petitioner’s Request for Hearing under the Illinois Workers’ Compensation Act “Act.” Issues in dispute include accident, notice, causation, average weekly wage, temporary total disability, statute of limitations, and nature and extent. Arbitrator’s Exhibit 1.

Job Duties

Petitioner testified that she began working as a caseworker at the Illinois Department of Human Services in 1980 and worked there 35 years. In this role, she used both hands to type on a computer.

Petitioner's unrebutted testimony was that her job consisted of 100% typing as a caseworker for the Illinois Department of Human Services. She testified that she typed 6 or 7 hours per day as a caseworker.

Notice of Injury

Petitioner completed a Notice of Injury form on April 18, 2013. (Rx 1). On this form, she reports that the date of injury or illness was January 1, 2008. She listed the duty she was performing at the time of injury as “intake processing and interview, typing on the computer.” (Rx. 1). Under “how the injury occurred,” she wrote, “carpal tunnel syndrome, typing on the computer keyboard

for the last 32 years of working..” She indicated that she notified her supervisor M. Pelmer but failed to state a date and time of the notice.

Mildred Pelmer completed a Supervisor Report on June 6, 2013. (Rx 2). Mildred Pelmer recorded that Petitioner notified her orally on April 15, 2013 that her physician had diagnosed her with carpal tunnel syndrome. . The Arbitrator notes that the Request for Hearing form states that Petitioner notified her supervisor on April 20, 2013. (Exhibit 1).

Application of Adjustment of Claim

Petitioner filed an Application of Adjustment of Claim on July 17, 2013, listing a date of accident April 18, 2013 (Rx 7). Petitioner listed her affected body parts as bilateral hands.

Average Weekly Wage

On Arbitrator’s Exhibit 1, Petitioner listed an average weekly wage of \$2730, which Respondent disputed and alleged an average weekly wage of \$1,245. There was no testimony elicited concerning wages at trial. Petitioner did not meet her burden of proving an average weekly wage of \$2730.

Respondent submitted a wage statement into evidence reflecting that Petitioner worked 37.5 hours per week, or 75 hours in a two-week period. (Rx 3). Her gross earnings were listed as \$2,697.50, or \$70,740.00 yearly. The wage statement was completed on May 7, 2018. However, the wage statement did not specify the time period represented. (RX 3).

Significantly, there was no testimony regarding wages and no evidence was admitted to corroborate the competing average weekly wage claims of \$2730 versus \$1245 listed by the parties on the Request for Hearing. (Arbitrator’s Exhibit 1).

Prior Medical Condition

The Petitioner testified that she started experiencing pain in her hands on January 1, 2008. Subsequently, she underwent an EMG in 2011 at Neurological Associates which revealed a bilateral median neuropathy. She was diagnosed with bilateral mild carpal tunnel syndrome.

From 2008 until 2013, Petitioner continued to work as she testified consisting of 100% typing. It is also unrefuted that the Petitioner lost no time from work before reporting the condition to her supervisor on April 20, 2013

Accident

On January 1, 2008, Petitioner noticed tingling and tightness in her hands. Petitioner denied sustaining any acute accident. On this same date, she began treating with Dr. Brooker, who diagnosed her with bilateral carpal tunnel syndrome. She treated for bilateral carpal tunnel syndrome until 2020. She did not lose any time from work until April 20, 2013 when her bilateral carpal tunnel syndrome condition progressed in severity to the point that she could no longer perform her job duties.

Petitioner testified she was off work from April 20, 2013 and returned to work “light duty” in February 2015 with no restrictions. When asked whether she returned to light duty work, or if her job was sedentary, she responded that the job was heavy duty for her.

Furthermore, Petitioner testified that she completed an Injury/Accident Notice Form on April 18, 2013 (RX1) and delivered oral notice to her supervisor, Mildred Pelmer, on April 20, 2013.

The Petitioner testified that she spent the majority or 6 or 7 hours of each working day typing on a computer. This took place for approximately 32 years. This testimony was not refuted.

The medical records from Dr. Brooker, her treating physician, Midland Orthopedic, Physical Therapy and Sports as well as Neurological Associates established that the Petitioner is and was suffering from carpal tunnel syndrome.

The testimony that the repetitive nature of her employment and job duties contributed to the condition of ill-being. There was no testimony presented to refute the Petitioner’s statements.

The Arbitrator is the finder of fact, and it is within his province to find the Petitioner credible and judge whether a causal connection exists. National Freight Industries v. Workers Compensation Commission 993 N.E.2d, 473. In the instant case, the Arbitrator concludes that the accident or date of manifestation for the repetitive trauma injury occurred on April 18, 2013.

Notice of Injury

Petitioner completed a Notice of Injury form on April 18, 2013. (Rx 1). On this form, she reports that the date of injury or illness was January 1, 2008. She listed the duty she was performing at the time of injury as “intake processing and interview, typing on the computer.” Under “how the injury occurred,” she wrote, “carpal tunnel syndrome, typing on the computer keyboard for the last 32 years of working.” Petitioner indicated that she also notified her supervisor, Mildred Pelmer. On cross examination, Petitioner admitted that she first noticed the carpal tunnel symptoms in her hands on January 1, 2008.

Mildred Pelmer completed a Supervisor Report on June 6, 2013. (Rx 2). Mildred Pelmer stated that Petitioner notified her orally on April 15, 2013 that her physician had diagnosed her with carpal tunnel syndrome. The Arbitrator notes that the Request for Hearing form states that Petitioner notified her supervisor on April 20, 2013. (Arbitrator’s Exhibit 1).

Application of Adjustment of Claim

Petitioner filed an Application of Adjustment of Claim on July 17, 2013, listing a date of accident April 18, 2013 (Rx 7). Petitioner listed her affected body parts as bilateral hands.

Summary of Medical Records

Petitioner testified that she began treating with Dr. Brooker for both hands on January 1, 2008. The Arbitrator notes that Petitioner’s medical exhibits do not include any records prior to October 30, 2009.

Petitioner saw Dr. Sreerama at Advocate on October 30, 2009 for right shoulder pain, left shoulder pain, and right leg pain. (Rx 6, p. 27). She reported that the right shoulder pain had been radiating to her right wrist for three months and was increasing in severity. She denied any trauma or injury. She was diagnosed with bilateral shoulder tendonitis and low back pain. She was referred to physical therapy. (Rx 6).

There are no further medical records in evidence until September 7, 2011, when Petitioner saw Dr. Sreerama with complaints of bilateral numbness and parenthesis in her hands exacerbated with activity at night. (Px 3). Petitioner underwent an EMG which revealed electrophysiologic evidence for bilateral median neuropathy at the level for the wrist involving motor and sensory fibers with demyelinating features which could be seen in mild carpal tunnel syndrome bilaterally. There was greater involvement on the right than the left side. (Px 3).

After approximately two years, Petitioner saw Dr. Brooker at Midland Orthopedic on March 11, 2013 for an evaluation of her bilateral hands. (Px 1, p. 17). Dr. Brooker noted that she had been having intermittent numbness and tingling, especially at nighttime, for many years. *Id.* He noted that she “occasionally gets some tingling with her data entry at work.” An examination revealed positive Tinel’s, Phalen’s, and carpal compression test. Dr. Brooker noted that an EMG done a couple of years ago that revealed compression at the median nerve consistent with carpal tunnel syndrome. Petitioner was diagnosed with bilateral carpal tunnel syndrome. Dr. Brooker stated that he was providing wrist braces because they control the symptoms better “especially since her symptoms are only at nighttime.” (Px 1).

Petitioner followed up with Dr. Brooker on June 7, 2013, at which time bilateral injections were recommended. (Px 1, p. 16). Dr. Brooker noted that “this is clearly work related as it is occurring with heavily repetitive activities at work, and no other significant cause.” *Id.*

Between June 25, 2013 and February 4, 2015, Petitioner underwent pre-operative and post-operative physical therapy at Physical Therapy and Sports for her bilateral hands. (Px 2). Petitioner completed a patient questionnaire on May 8, 2014 for physical therapy, which indicated a “date of onset/surgery” as January 2008, and “yes” is circled indicating that this is an on-the-job injury. (Px 2, p. 64).

Petitioner followed up with Dr. Brooker on January 17, 2014. (Px 1, p. 13). He noted that bracing, injections and activity modification and rest from work had not caused the symptoms to “settle down.” The left hand was more bothersome than the right. He recommended left carpal tunnel release. Also, Dr. Booker recommended that Petitioner be off work until the surgery. *Id.*

Petitioner underwent a left carpal tunnel release surgery with Dr. Brooker on April 22, 2014. (Px 1, p. 14). Her post-operative diagnosis was left carpal tunnel syndrome.

Petitioner followed up with Dr. Brooker on May 2, 2014. (Px 1, p. 12). He noted that the tingling was better than it was in the left hand, but he noted as she had previously had continuous

tingling, it will not completely go away. Dr. Brooker authorized physical therapy to restore mobility and strength in the left hand.

Petitioner next followed up with Dr. Brooker for her left hand on May 21, 2014. (Px 1, p. 11). He noted that she was coming along as he expected. He opined that she still needed a good deal of therapy before they could address the right hand. Petitioner was instructed to remain off work. *Id.* Dr. Brooker noted that he would reassess her in about a month, and that she would be off work for at least six to eight weeks. (Px 1 p. 11).

Petitioner saw Dr. Brooker on June 18, 2014. (Px 1, p. 10). Dr. Brooker noted that Petitioner's progress was coming along, and she should continue physical therapy.

Petitioner underwent a right carpal tunnel release surgery with Dr. Brooker on August 19, 2014. (Px 1, p. 15). Her post-operative diagnosis was right carpal tunnel syndrome.

On September 3, 2014, Petitioner followed up with Dr. Brooker on her right carpal tunnel release. (Px 1, p. 9). Her sutures were removed, and physical therapy was ordered.

On September 26, 2014, Dr. Brooker noted that her left hand was doing well. (Px 1, p. 8).. He further noted that the right hand had a good degree of sensitivity which was normal for this time frame after surgery. Petitioner was ordered to continue physical therapy three times per week and remain off work. (Px 1).

On October 24, 2014, Petitioner followed up on her bilateral hands with Dr. Brooker. (Px 1, p. 7). Her main complaint was intermittent tingling on half of the fourth digit and the fifth digit on her right hand. Dr. Brooker showed her how to avoid tingling by avoiding resting on the elbow. Petitioner displayed positive Tinel's in that area and had some sensitivity in that area.. Dr. Brooker noted that she was going to have to modify her positioning in order to help sensitivity. Further surgery was not recommended. Petitioner was instructed to follow up in three weeks. She was ordered to remain off work. (Px 1).

Petitioner followed up with Dr. Brooker on November 14, 2014. (Px 1, p. 6). Petitioner's right hand was recovering nicely. She was instructed to continue physical therapy. Dr. Brooker noted that Petitioner did not have the same carpal tunnel symptoms she had prior to surgery, and that the surgery should prevent her from getting worse. Dr. Brooker opined that the bilateral carpal tunnel conditions are work-related injuries and have been work-related all along. (Px 1 p. 16)

Petitioner followed up with Dr. Brooker on December 15, 2014 and January 12, 2015. (Px 1, p. 5; p. 4). On January 12, 2015 he noted that Petitioner needed to continue to work on strengthening in physical therapy.

Petitioner saw Dr. Brooker on February 4, 2015. (Px 1, p. 2). Dr. Brooker noted that Petitioner was coming along very well, and he opined that as long as she kept up with her exercises, she would not be prone to flare ups in the future. Petitioner was authorized to return to work full duty on February 9, 2015 with no restrictions. She was instructed to follow up as needed.

Petitioner saw Dr. Sreerama at Advocate Medical Group on December 3, 2015 for a physical. (Px 4, p. 8). Dr. Sreerama noted that Petitioner had been back to work and that her work “involved a lot of typing” causing tingling and numbness.

Petitioner followed up for her diabetes with Dr. Sreerama on June 17, 2016. (Px 4, p. 8). Petitioner complained of low back pain, carpal tunnel syndrome and pain in left hand. Petitioner noted that she was not able to follow a diet and recently had been busy with graduation and was out of town.

On November 3, 2016, Petitioner saw Dr. Dr. Myoung Kim at Advocate Medical Group. (Px 4, p. 6). Petitioner complained of bilateral carpal tunnel and requested an orthopedic referral.

On May 17, 2017, Petitioner underwent an EMG on her bilateral hands which revealed axonal peripheral polyneuropathy involving both upper extremities and was consistent with bilateral median nerve compression neuropathy at the wrist (CTS) without EMG evidence of axonal involvement. (Px 4, p. 5).

The last medical record entered into evidence is dated July 29, 2020. (Px 4, p. 27). On this date, Petitioner followed up with Dr. Sreerama for her diabetes with complications. Dr. Sreerama noted that Petitioner suffered from a fatty liver, used a CPAP machine, and was undergoing orthopedic treatment for her left knee. No complaints regarding Petitioner’s carpal tunnel were noted.

Respondent’s Section 12 Examiner, Dr. Michael Vender

Petitioner underwent an Independent Medical Examination (“IME”) on September 9, 2013 with Dr. Vender at Hand to Shoulder Associates. (Rx 4). Dr. Vender diagnosed Petitioner with bilateral carpal tunnel syndrome. Dr. Vender noted Petitioner’s risk factors of age, gender, and a significantly increased BMI. Further, Dr. Vender opined that bilateral carpal tunnel releases were warranted.

Furthermore, after analyzing a job description, Dr. Vender opined that Petitioner’s work activities were not forceful, sedentary and office based and there was no need for work restrictions. Moreover, Dr. Vender opined that the work activities were not contributory to the development of carpal tunnel syndrome. (Rx 4).

Petitioner’s Current Condition

Petitioner voluntarily retired on December 31, 2015. She has been retired for ten years. Petitioner testified that she still experiences tingling and numbness and has issues with her hands going limp, difficulty opening jars, and carrying bags. Petitioner denies typing in her daily life.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). 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 demeanor of the witness and any external inconsistencies with his/her testimony. Where a claimant’s testimony is inconsistent with his/her 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).

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 witness testimony. O'Dette v. Industrial Commission, 79 Ill.2d 249, 253 (1980); Hosteny v. Workers' Compensation Commission, 397 Ill. App. 3d 665, 674 (2009). 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 ILWC 004187 (2010).

In the case at hand, the Arbitrator observed Petitioner during the hearing and finds her be a credible witness. Petitioner was forthright and direct in her testimony, which was unrebutted. The Arbitrator compared Petitioner's testimony with the totality of the evidence submitted and did not find any material contradictions that would deem the witness unreliable.

Issue C, whether the accident arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds as follows:

Petitioner's testimony was unrebutted that in her capacity as a caseworker she types 100% of the time for 32 years. She testified that she experienced mild bilateral pain in her hands in January 1, 2008 and sought treatment. An EMG in 2011 revealed bilateral carpal tunnel syndrome. However, Petitioner's testimony was crystal clear that she continued to work full duty until she reported her condition which necessitated bilateral carpal tunnel releases of the right hand on April 22, 2014 and the right hand on August 19, 2014.

Further Petitioner testified that she returned to work after recovering from her bilateral carpal tunnel releases on February 10, 2015 and worked the same job. She retired on December 31, 2015.

Therefore, the Arbitrator concludes based upon the totality of the reliable medical evidence and unrebutted testimony, that the repetitive trauma-induced carpal tunnel condition of ill-being in both hands arose out of and in the course of Petitioner's employment with Respondent.

Issue D, the date of the accident, the Arbitrator finds as follows:

The date of injury in a repetitive trauma claim is the date in which the injury manifests itself, meaning the date on which both the injury and its causal link to the employee's work became plainly apparent to a reasonable person. Durand v. Industrial Comm'n (RLI Insurance Co.), 224 Ill. 2d 53, 65, 862 N.E.2d 918, 924 (2006). Courts have typically set the manifestation date on either the date on which the employee requires medical treatment or the date on which the employee can no longer perform work activities. Durand, 862 N.E.2d at 929.

The Arbitrator notes that the Petitioner's work history of 32 years of data entry and the Petitioner's un rebutted testimony that she typed 100% of her day for 6 to 7 hours. All of this combined with the treating medical records supports a finding that a causal connection exists between the Petitioner's condition of ill-being, her employment and the repetitive trauma accident of April 18, 2013. The Petitioner first started noticing and sought treatment for her mild carpal tunnel symptoms on January 1, 2008. However, the bilateral carpal tunnel condition did not reach the point where it was so severe that she could no longer perform her job duties until April 18, 2013.

One of Respondent's theories of defense is that the bilateral carpal tunnel syndrome manifested on January 1, 2008 and therefore the Application for Adjustment of Claim was filed beyond the Statute of Limitations. However, the Illinois Supreme Court in Durand v. The Industrial Commission, No. 101109, Illinois Supreme Court (October 19, 2006) found "flexibility" in determining accident dates in a repetitive trauma accident. That court looked toward the date the Petitioner required medical treatment or the date on which the employee could no longer perform work activities. Both of which were consistent with the April 18, 2013 filing in the instant case. The Supreme Court in Durand declined "to penalize an employee who diligently worked through progressive pain until it affected her ability to work and required medical treatment". The Petitioner missed no days from work from January 1, 2008 until she could no longer work on April 18, 2013 because of her debilitating bilateral carpal tunnel syndrome.

Based upon the totality of facts and circumstances surrounding this case, and especially in light of the un rebutted testimony regarding job duties and the treating medical records, the Arbitrator finds that the date of the accident is April 18, 2013, when the condition manifested or

progressed to the point that the Petitioner could no longer perform her job as a caseworker entering data 6 or 7 hours per day, as she had done for 32 years prior thereto..

Issue E, whether timely notice of the accident was given to Respondent, the Arbitrator finds as follows:

Pursuant to Section 6(c) of the Act, a claimant is required to give notice to his or her employer within 45 days of a work-related accident. 820 ILCS 305/6(c)

The Arbitrator finds that timely notice of the accident was given to Respondent on April 18, 2013 when she completed an Injury/Accident Notice Form. (RX 1) Petitioner also delivered oral notice of her bilateral carpal tunnel condition to her supervisor, Mrs. Pelmer., on April 20, 2013.

Issue F, whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds as follows:

An employee who alleges an injury based on a repetitive trauma theory must still meet the same standard of proof as other claimants alleging an accidental injury. There must be a showing that the injury is work related and not the result of a normal degenerative aging process. Peoria County Belwood Nursing Home v. Industrial Com., 115 Ill. 2d 524, 530, 505 (1987). The claimant need only prove that some act or phase of employment was a causative factor of the resulting injury. Three "D" Discount Store v. Industrial Com., 198 Ill. App. 3d 43, 49, 556 N.E.2d 261, 265 (4th Dist. 1989). Although 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 of laypersons, expert testimony is necessary to show that claimant's work activities caused the condition complained of. Nunn v. Industrial Com., 157 Ill. App. 3d 470, 477-78 (4th Dist. 1987).

The Arbitrator carefully considered the opinion of Dr. Vender before determining that the treating medical records and inferential connections established a nexus between repetitive typing and the bilateral carpal tunnel condition of ill-being. The Arbitrator finds that Dr. Vender's medical causation or non-causation opinion is not persuasive or reliable in the instant case based upon the totality of the reliable testimony and treating medical records. Dr. Brooker

recorded in his medical history notes from the onset that Petitioner “occasionally gets some tingling with her data entry at work.” (Px 1).

Petitioner underwent an Independent Medical Examination (“IME”) on September 9, 2013 with Dr. Vender at Hand to Shoulder Associates. (Rx 4). Dr. Vender diagnosed Petitioner with bilateral carpal tunnel syndrome. Dr. Vender reviewed a written job description for her job title of Human Services Caseworker. Dr. Vender opined that these types of activities are office-based and sedentary, and that they would not be contributory to the development of bilateral carpal tunnel syndrome. Moreover, Dr. Vender noted Petitioner’s risk factors of age, gender, and a significantly increased BMI. Dr. Vender opined that there was no need for work restrictions. Dr. Vender opined that bilateral carpal tunnel releases were warranted. He noted that, as Petitioner’s work activities were not forceful, and were sedentary and office-based, it would be reasonable for Petitioner to be performing her work activities while awaiting further medical care. Dr. Vender further opined that there was no need for work restrictions. (Rx 4). Again, the Arbitrator does not find Dr. Vender’s opinion persuasive or reliable given the un rebutted testimony of Petitioner that she typed 6 or 7 hours per day, 100% of her work-day, for 32 years.

Based upon the totality of the circumstances, the Arbitrator finds that the Petitioner’s job duties were contributory to the Petitioner’s condition of bilateral carpal tunnel syndrome, which first presented in a mild form on January 1, 2008 but progressively became more severe and debilitating on August 18, 2013. In other words, the Arbitrator finds that Petitioner’s current condition of ill-being is causally related to the repetitive trauma injury which manifested on April 18, 2013.

Issue G, Petitioner’s earnings, the Arbitrator finds as follows:

The only evidence admitted at trial regarding earnings was the wage statement submitted by Respondent reflecting \$2697 over two weeks, which was completed on May 7, 2018. The wage statement does not reflect the time period in which these wages were earned. (RX2).

There was no testimony, whatsoever, regarding the wages earned by Petitioner in the year prior to her accident/manifestation date of April 18, 2013. The Arbitrator notes that Petitioner alleged the average weekly wage on April 18, 2013 to be \$2730 which was disputed by Respondent, who alleged the average weekly wage to be \$1,245. However, no evidence was admitted by either side to corroborate what they listed on Arbitrator's Exhibit 1. There was a failure of proving any wages were earned specifically in the year prior to the April 18, 2013 accident/date of manifestation pursuant to Section 10 of the Act. However, Respondent indicated that the average weekly wage during the relevant time period was \$1245 and common sense dictates that Petitioner was earning wages.

The Arbitrator finds that Petitioner's AWW is \$1245 pursuant to Respondent's claim on Request for Hearing Form. (Arbitrator's Exhibit 1),

Issue K, whether Petitioner is entitled to temporary total disability benefits, the Arbitrator finds as follows:

A claimant is temporarily totally disabled from the time an injury incapacitates him from work until such time as he is as far recovered or restored as the permanent character of his injury will permit. Westin Hotel v. Indus. Comm'n, 372 Ill.App.3d 527, 542 (1st Dist. 2007).

In determining whether a claimant remains entitled to receiving TTD benefits, the primary consideration is whether the claimant's condition has stabilized and whether she is capable of a return to the workforce. Interstate Scaffolding, Inc. v. Illinois Workers' Comp. Comm'n, 236 Ill.2d 132, 148 (2010). Once an injured employee's physical condition stabilizes, she is no longer eligible for TTD benefits. Archer Daniels Midland Co. v. Indus. Comm'n, 138 Ill.2d 107, 118 (1990).

Petitioner first lost time from work as a result of her work-related carpal tunnel syndrome on April 20, 2013. After treatment, surgical repairs and recovery, the Petitioner returned to work on February 10, 2015

Based on the above, the Arbitrator finds Respondent liable for 94 2/7 weeks of TTD benefits, from April 20, 2013 through February 10, 2015 at a weekly rate of \$830, which corresponds to

\$78,257.14 to be paid directly to Petitioner. The parties stipulate that Respondent has not paid any TTD benefits.

Issue L, the nature and extent of the injury, the Arbitrator finds as follows:

Petitioner's claim for permanent partial disability benefits is evaluated and has been carefully considered by the Arbitrator in accordance with Section 8.1b of the Act.

(i) The reported level of impairment. The Arbitrator notes that no AMA impairment report was offered into evidence. Accordingly, the Arbitrator gives no weight to this factor.

(ii) The occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as caseworker for the Illinois Department of Human Services at the time of the accident and that she is not able to return to work in his prior capacity as a result of said injury. The Arbitrator notes that Petitioner's un rebutted testimony was that she typed 100% of the time for 6 or 7 hours per day for 32 years. As a result, the Arbitrator therefore gives *greater* weight to this factor.

(iii) The age of the employee at the time of the accident. The Arbitrator notes that Petitioner was 52 years old at the time of the accident. The Arbitrator notes that at the time of the hearing, no evidence was presented as to how the Petitioner's age affected her disability. However, the Arbitrator notes that that the Petitioner is an older individual who was working in a job consisting of repetitive typing. Despite the fact that Petitioner has been retired for 10 years and no longer types, her age makes her disability greater as the Petitioner testified that her condition persists to this day. As a result, the Arbitrator therefore gives slightly greater weight to this factor.

(iv) **Petitioner's future earnings capacity.** The Arbitrator notes that at the time of the hearing, the Petitioner had been retired for 10 years. The Arbitrator carefully considered this factor and the fact that Petitioner retired after a 35-year career with Respondent and that there was no evidence that Petitioner's future earning capacity was affected by her injuries, in light of a voluntary retirement after a long career. The Petitioner testified that she no longer types as a retiree. As a result, the Arbitrator therefore gives no weight to this factor.

(v) **Evidence of disability corroborated by the treating medical records.** The Arbitrator notes that the treating medical records that she suffered bilateral carpal tunnel syndrome as a result of repetitive typing at work over 32 years until the date of manifestation on April 18, 2013. Thereafter the Petitioner underwent a left carpal tunnel release on April 22, 2014 and a right carpal tunnel release on August 19, 2014. She returned to work full duty on February 10, 2015 and retired on December 31, 2015. As a result, 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 14% loss of use of the right hand and 14% loss of use of the left hand, pursuant to §8(e) of the Act which corresponds to 53.2 weeks of permanent partial disability benefits at maximum permanency weekly rate of \$712.55.

Issue N, Is Respondent due any credit, the Arbitrator finds as follows:

The Arbitrator finds pursuant to stipulation by the parties and consistent with Respondent's Exhibit 3 that Respondent made \$6,656.13 in medical payments for reasonable related medical expenses. Respondent would be entitled to that credit for \$6,656.13 for medical expense payments, if it ever becomes an issue. (Rx 3).

Issue O, Did Petitioner file the Application of Adjustment of Claim within the period permitted pursuant to statute?

The Arbitrator finds that Petitioner sustained her burden in proving that she named the State of Illinois within the three-year period pursuant to the statute of limitations under the Act.

Section 6(d) of the Act states:

In any case. . . unless the application for compensation is filed with the Commission within 3 years after the date of the accident, where no compensation has been paid, or within 2 years after the date of the last payment of compensation, where any has been paid, whichever shall be later, the right to file such application shall be barred. 820 ILCS 305/6(d).

In this case, the Arbitrator found the manifestation date or the accident to be April 18, 2013. Petitioner filed the Application of Adjustment of Claim on July 17, 2013. (Rx 7). Payment ledgers reflect that Respondent paid medical bills as late as January 26, 2015 with a date of service of June 25, 2013.

The Arbitrator finds that Petitioner sustained its burden in proving that she named IDHS within the statute of limitations under the Act.



Arbitrator Daniel Swanson

MARCH 14 2025

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	24WC033990
Case Name	Erica Caulton v. Chicago Transit Authority
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	25IWCC0493
Number of Pages of Decision	11
Decision Issued By	Raychel Wesley, Commissioner

Petitioner Attorney	Jordan Browen
Respondent Attorney	James Jackson, James Jackson

DATE FILED: 12/16/2025

/s/ Raychel Wesley, Commissioner

Signature

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)
☐ Modify	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ERICA CAULTON,

Petitioner,

vs.

NO: 24 WC 33990

CHICAGO TRANSIT AUTHORITY,

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 issue of Petitioner's entitlement to prospective medical care, and being advised of the facts and law, corrects the Decision as set forth below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission 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 (1980).

Correction

The Commission observes differing language is utilized in the Arbitrator's Order and the Decision with respect to Petitioner's request for prospective medical care. In affirming the Arbitrator's denial of prospective medical care and to resolve any inconsistencies in the Arbitrator's Decision, the Commission strikes the prospective medical care paragraph in the Order and in the Decision and inserts the following:

While Petitioner's current conditions of ill-being remain causally related to her December 11, 2024 accident, and she has yet to reach maximum medical improvement, Petitioner's request for prospective medical treatment pursuant to Section 8(a) of the Act is denied based on the fact that Petitioner's medical records in evidence do not reflect any specifically prescribed or pending medical treatment recommendations.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 29, 2025, as amended above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of \$1,068.34 per week for a period of 11 weeks, representing December 13, 2024 through February 27, 2025, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b), 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 medical expenses as follows: \$3,097.00 to City of Chicago EMS, \$8,212.00 to Advocate Trinity Hospital, \$10,311.01 to Injury Centers of IL, \$600.00 to Chicago Pain & Orthopedic Institute, \$1,000.00 to Munster Medical Imaging, Inc., and \$4,163.70 to Promedix, as provided in §8(a), subject to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that, while Petitioner's current conditions of ill-being remain causally related to her December 11, 2024 accident, and she has yet to reach maximum medical improvement, Petitioner's request for prospective medical treatment pursuant to Section 8(a) of the Act is denied based on the fact that Petitioner's medical records in evidence do not reflect any specifically prescribed or pending medical treatment recommendations.

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.

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 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 \$39,200.00. 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.

December 16, 2025

RAW/mck

O: 11/19/25

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/s/ Raychel A. Wesley

/s/ Carolyn M. Doherty

/s/ Frank J. Soto

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	24WC033990
Case Name	Erica Caulton v. Chicago Transit Authority
Consolidated Cases	
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	8
Decision Issued By	Elaine Llerena, Arbitrator

Petitioner Attorney	Jordan Browen
Respondent Attorney	James Jackson

DATE FILED: 4/29/2025

/s/Elaine Llerena, Arbitrator
Signature

INTEREST RATE WEEK OF APRIL 22 2025 4.05%

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)/8(a)

Erica Caulton

Employee/Petitioner

v.

Chicago Transit Authority

Employer/Respondent

Case # **24 WC 033990**

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 **Elaine Llerena**, Arbitrator of the Commission, in the city of **Chicago**, on **February 27, 2025**. 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, **December 11, 2024**, 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 **\$34,347.76**; the average weekly wage was **\$1,602.51**.

On the date of accident, Petitioner was **41** years of age, *single* with **0** dependent children.

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 \$1,068.34 per week for 11 weeks, commencing December 13, 2024, through February 27, 2025, as provided in Section 8(b) of the Act.

Respondent shall pay outstanding reasonable and necessary medical services as follows: \$3,097.00 to City of Chicago EMS, \$8,212.00 to Advocate Trinity Hospital, \$10,311.01 to Injury Centers of IL, \$600 to Chicago Pain & Orthopedic Institute, \$1,000.00 to Munster Medical Imaging, Inc., and \$4,163.70 to Promedix, as provided in Sections 8(a) and 8.2 of the Act.

Petitioner's claim for prospective medical care is denied for the reasons set forth below.

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 29 2025

FINDINGS OF FACT

This matter proceeded to hearing on February 27, 2025, in Chicago, Illinois before Arbitrator Elaine Llerena. The issues in dispute were accident, causal connection, medical expenses, temporary total disability benefits, and prospective medical care. Arbitrator's Exhibit 1 (AX1).

Job Duties

In December 2024, Petitioner was a bus operator for Respondent. (T. 6) Petitioner's job consisted of picking up and dropping off passengers, collecting fares, making sure the bus environment was safe, and driving safely. (T. 6-7)

Prior Medical Condition

On May 8, 2024, Petitioner was in a motor vehicle accident (MVA) where she sustained injuries to her right shoulder, back, lower back and both knees. (T. 18-19) Petitioner last treated for her injuries from the MVA on November 7, 2024, and was released to return to work, regular duty. (T. 19, RX2) Petitioner returned to work on or about December 2, 2024, or December 3, 2024. (T. 19-20)

The November 7, 2024, treatment visit was with Dr. John Dinh of Associated Medical Centers of Illinois. (RX2) Petitioner complained of low back, right shoulder, right knee, and left knee pain, and headaches. The visit note indicates that Petitioner underwent a right knee MRI on August 19, 2024, that revealed a suspected longitudinal tear of the far periphery of the midbody (sic) of the medial meniscus, partial thickness horizontal tear in the posterior root insertion of the medial meniscus, horizontal tear in the posterior horn of the lateral meniscus, diffuse extensor enthesopathy and prior apophyseal injury with extensor tendonitis, mild to moderate patellofemoral osteoarthritic changes, chondromalacia in the medial and lateral tibiofemoral compartment, and possible parameniscal cyst, ganglion cyst, synovitis and/or ganglion cyst. Also noted was that Petitioner underwent a left knee intra-articular steroid injection on September 19, 2024. Right knee examination showed full range of motion and no pain. Dr. Dinh noted that Petitioner wanted to defer orthopedic consultation regarding her knees due to improved symptoms. Dr. Dinh released Petitioner to return to work, full duty, starting November 8, 2024.

Accident

On December 11, 2024, Petitioner made her relief (ended her shift and another driver took over Petitioner's route) at Respondent's terminal at the area where drivers switch off. (T. 7-8) Petitioner noted some oil debris outside on the pavement and that it was cold and had rained. (T. 8, 10) Petitioner exited the bus and, as she was walking, she dropped her keys. (T. 7) As Petitioner bent over to pick up the keys, she slipped on a substance, causing her to roll over her ankle and fall on her stomach, injuring her right ankle, right knee, and right forearm. (T. 7-8) Petitioner did not know what substance she slipped on. (T. 10) Petitioner tried getting up, but her foot slipped again, and she fell back down. *Id.* Petitioner felt a lot of pain in her ankle. *Id.* As she was laying on the floor, the driver she had just switched with came to check on her and called control. (T. 10-11) After about 30 minutes, an ambulance arrived, and Petitioner was helped onto a gurney by coworkers and an EMT. (T. 11) The ambulance took Petitioner to the hospital. (T. 10-11) The report from Chicago Fire Department states that Petitioner reported that she tipped over and fell on concrete and complained of swelling in her ankle. (PX2) Under Cause of Injury, it states: "Fall on same level from slipping, tripping, and stumbling without subsequent striking against object."

On December 12, 2024, Respondent completed an interview record detailing the work accident. (PX1) The record was completed by Petitioner and a manager. (T. 16-17) The Employee Comments section states: “I was making a relief and I was stepping [sic] down onto the pavement and [sic] I dropped my keys. I bent over to pick up my keys and my foot slipped on a slippery substance on the pavement, causing me to fall forward onto my stomach. I tried to get up and remained on the cold pavement until the emt arrived.” (T. 16)

Respondent’s Exhibit 1 is video footage of Petitioner’s work accident on December 11, 2024. (RX1-Grid #9) The video shows Petitioner walking on pavement, reaching down to pick up her keys, her leg moving from under her and then Petitioner rolling and falling on the ground. Petitioner viewed the video at the hearing and agreed it was a fair and accurate depiction of the December 11, 2024, work accident. (T. 24)

Summary of Medical Records

Petitioner was taken by ambulance to Advocate Trinity Hospital’s Emergency Department on December 11, 2024. (PX2 & PX3) Petitioner complained of right arm, knee and ankle pain following a fall walking down bus stairs. (PX3) Another note from this visit indicates that Petitioner complained of right arm, knee and ankle pain following a fall. Dr. Albazzaz Samara obtained x-rays of Petitioner’s upper and lower extremities, all of which revealed no abnormalities. Petitioner also underwent a right ankle CT scan, the results of which showed no definitive acute fracture or dislocation. Dr. Samara provided Petitioner with an Ace wrap for her right ankle and a walker. Petitioner was to follow up with her primary care physician.

On December 13, 2024, Petitioner saw Vera Nisavic PA at Chicago Pain and Orthopedic Institute. (PX5) Petitioner reported that on December 11, 2024, she was doing a relief at work and as she was walking to another bus, she twisted her right foot. Petitioner complained of ongoing pain in the right forearm, right knee, and right ankle since the work accident. Nisavic noted significant swelling in Petitioner’s right ankle and that Petitioner was using a walker. Nisavic diagnosed Petitioner as having right forearm pain, right forearm contusion on the lateral side, right knee pain, right knee contusion, right ankle pain, and right ankle sprain. Nisavic provided Petitioner a walker cast boot, ordered physical therapy and took Petitioner off work.

On December 18, 2024, Petitioner saw Dr. Thomas John Ambrose DC at Injury Centers of Illinois. (PX4) Petitioner described the December 11, 2024, work accident, explaining that she was making relief and walking to another bus when she dropped her keys and as she went to pick them up, she rolled her right ankle and fell onto her right side. Petitioner complained of ongoing right ankle pain and that any weightbearing increases her pain. Petitioner also complained of mild pain in the right forearm and right leg. Dr. Ambrose ordered chiropractic treatment 3 times a week for 6 weeks, and restricted Petitioner from any pain causing activities, running, and prolonged standing. Throughout her treatment with Dr. Ambrose, Petitioner reported feeling slightly better after each visit.

On January 23, 2025, Petitioner followed up with Dr. Steven Sclamberg at Chicago Pain and Orthopedic Institute. (PX5) Petitioner complained of right knee, right ankle and right top of foot pain. Dr. Sclamberg ordered x-rays of the right knee, ankle, and foot. The x-rays of the right foot and ankle, taken on January 30, 2025, revealed degenerative osteoarthritis and a plantar calcaneal spur. X-rays of the right knee, also taken on January 30, 2025, revealed degenerative osteoarthritis in the patellofemoral and tibiofemoral joint and narrowing of the medial compartment of the right knee joint space. (PX6)

Petitioner’s Current Condition

Petitioner testified that her right arm is better than it was following the work accident, but it is still painful. (T. 17-18) Petitioner's right knee and right ankle are still sore. (T. 18) According to Petitioner, her right ankle is the worst of all because of the pain, and her right knee is second. *Id.*

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 (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:

The Arbitrator notes that, under the Illinois Workers' Compensation Act (Act), to obtain compensation, an employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 Ill. Comp. Stat. Ann. 305/1. A claimant must prove both elements were present to establish that her injury is compensable. *University of Illinois v. Industrial Comm'n*, 365 Ill. Ann. 3d 906, 910 (1st Dist. 2006). The "arising out of" component to obtain compensation under the Act 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. *Metro. Water Reclamation Dist. of Greater Chi. v. Ill. Workers' Comp. Comm'n*, 407 Ill. App. 3d 1010, 1014 (2011). Injuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing her duties, and while a claimant is at work, are generally deemed to have been received in the course of the employment. *Id.* at 1013-14.

In the case at bar, Petitioner testified that she slipped on a substance while making her relief at work and fell, injuring her right ankle, right knee, and right forearm. In the Accident Record taken by Respondent, Petitioner reported slipping on a substance and falling while making her relief at work. The video of the accident shows Petitioner walking on pavement, reaching down to pick up her keys, her leg sliding/slipping from under her and then Petitioner rolling and falling on the ground. Petitioner's testimony of how the accident occurred is corroborated by the Accident Record and video of the accident.

The Arbitrator notes that Petitioner was performing her job as a bus operator on Respondent premises when the accident occurred. Additionally, Petitioner noted there was some oil debris outside on the pavement at Respondent's premises and that it was cold and had rained on the day of the accident. Further, the Arbitrator finds that encountering substances and/or debris on the pavement of Respondent's terminal location while working is certainly a risk associated with Petitioner's employment with Respondent.

Based on the above, the Arbitrator finds that Petitioner sustained accidental injuries arising out of and in the course of her employment with Respondent on December 11, 2024.

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 notes that 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. The Arbitrator further notes that in the case at bar, Petitioner had returned to work on December 2, 2024, or December 3, 2024, following a motor vehicle accident on May 8, 2024. On August 19, 2024, Petitioner underwent a right knee MRI that revealed a suspected longitudinal tear of the far periphery of the midbody [sic] of the medial meniscus, partial thickness horizontal tear in the posterior root insertion of the medial meniscus, horizontal tear in the posterior horn of the lateral meniscus, diffuse extensor enthesopathy and prior apophyseal injury with extensor tendonitis, mild to moderate patellofemoral osteoarthritic changes, chondromalacia in the medial and lateral tibiofemoral compartment, and possible parameniscal cyst, ganglion cyst, synovitis and/or ganglion cyst. On November 7, 2024, Petitioner underwent a right knee examination by Dr. Dinh, who noted Petitioner had full range of motion and no pain. Dr. Dinh also noted that Petitioner wanted to defer orthopedic consultation regarding her knees due to improved symptoms, and he released Petitioner to return to work, full duty, as of November 8, 2024. When the December 11, 2024, work accident occurred, Petitioner was working full duty with no knee problems or pain. The record indicates that Petitioner's condition from the motor vehicle accident had resolved. However, following the work accident, Petitioner has continued to have right knee and ankle pain and continues to undergo treatment for her injuries sustained on December 11, 2024.

Based on the above, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the December 11, 2024, work accident.

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 Arbitrator notes her findings above that Petitioner sustained accidental injuries arising out of and in the course of her employment with Respondent on December 11, 2024, and that Petitioner's current condition of ill-being is causally related to the December 11, 2024, work accident. The Arbitrator further notes Petitioner has undergone treatment and continues to undergo treatment for injuries incurred during the December 11, 2024, work accident due to her ongoing pain and problems. Further, there are unpaid medical bills for the treatment Petitioner underwent for treatment of her injuries incurred on December 11, 2024.

Based on the above, the Arbitrator finds Respondent shall pay for outstanding reasonable and necessary medical services, as provided in Sections 8(a) and 8.2 of the Act, for the following: \$3,097.00 to City of Chicago EMS, \$8,212.00 to Advocate Trinity Hospital, \$10,311.01 to Injury Centers of IL, \$600 to Chicago Pain & Orthopedic Institute, \$1,000.00 to Munster Medical Imaging, Inc., and \$4,163.70 to Promedix.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator notes her findings above that Petitioner sustained accidental injuries arising out of and in the course of her employment with Respondent on December 11, 2024, and that Petitioner's current condition of ill-being is causally related to the December 11, 2024, work accident. However, the Arbitrator further notes that a recommendation for a specific treatment or procedure has not been made by Petitioner's treating physicians. Therefore, the Arbitrator makes no award for prospective medical care in this case.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator notes her findings above that Petitioner sustained accidental injuries arising out of and in the course of her employment with Respondent on December 11, 2024, and that Petitioner's current condition of ill-being is causally related to the December 11, 2024, work accident. The Arbitrator further notes that Vera Nisavic PA took Petitioner off work on December 13, 2024. The medical records do not indicate that Petitioner has been released to return to work in any capacity. Additionally, Petitioner's condition of ill-being resulting from the December 11, 2024, work accident continues, as does Petitioner's treatment for her injuries from the December 11, 2024, work accident.

Based on the above, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits from December 13, 2024, through February 27, 2025.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	22WC029677
Case Name	Linda Nalls v. P4 Security Solutions, LLC
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	25IWCC0494
Number of Pages of Decision	12
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Adam Rosner
Respondent Attorney	Matthew Ignoffo

DATE FILED: 12/17/2025

/s/Marc Parker, Commissioner
Signature

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

Linda Nalls,

Petitioner,

VS.

No. 22 WC 29677

P4 Security Solutions, LLC,

Respondent.

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 accident, causal connection, medical expenses, temporary total disability, permanent partial disability, and the denial of Respondent's motion for a continuance of trial, and being advised of the facts and law, affirms and adopts with changes, the Decision of the Arbitrator which is attached hereto and made a part hereof.

The Commission corrects two clerical errors in the Arbitration Decision. First, because Dr. Chunduri released Petitioner to full duty work on February 11, 2023, Petitioner's temporary total disability benefits are due from November 3, 2022 through February 10, 2023, not through February 11, 2023. That period totals 14-2/7 weeks.

Second, we correct the second sentence on page 6 of the Arbitration Decision addendum under ISSUE (F), to read, “The Arbitrator further notes the only prior lumbar spine pain Petitioner had was in *2012*.” (The Arbitration Decision incorrectly reported the year of Petitioner’s prior lumbar spine pain to have been *2021*.)

The Commission also changes the weight placed on §8.1b (b) factor (iii), the age of the employee at the time of the injury, to “moderate.” At the time of her accident, Petitioner was 56

22 WC 029677

Page 2

years old, and she still had a number of years left in the workforce to endure the effects of her injuries.

Finally, the Commission finds it was not an abuse of the Arbitrator's discretion to deny Respondent's oral motion to continue trial, made on the morning of trial.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits of \$484.77 per week for 14-2/7 weeks, commencing November 3, 2022 through February 10, 2023, as provided in Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that all else in the Decision of the Arbitrator filed April 29, 2025 is hereby affirmed and adopted, with the changes noted above.

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, 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 \$39,900.00. 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.

December 17, 2025

MP/mcp
o-11/20/25
068

/s/ Marc Parker

Marc Parker

/s/ Maria E. Portela

Maria E. Portela

/s/ Christopher A. Harris

Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION
DECISION SIGNATURE PAGE

Case Number	22WC029677
Case Name	Linda Nalls v. P4 Security Solutions, LLC
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	9
Decision Issued By	Elaine Llerena, Arbitrator

Petitioner Attorney	Adam Rosner
Respondent Attorney	Bryan Strand, Matthew Ignoffo

DATE FILED: 4/29/2025

/s/ Elaine Llerena, Arbitrator
Signature

THE INTEREST RATE FOR THE WEEK OF APRIL 29, 2025 4.07%

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**

Linda Nalls
 Employee/Petitioner

Case # **22 WC 029677**

v.

P4 Security Solutions
 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 **Elaine Llerena**, Arbitrator of the Commission, in the city of **Chicago**, on **February 28, 2025**. 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 23, 2022**, 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 **\$37,812.32**; the average weekly wage was **\$727.16**.

On the date of accident, Petitioner was **56** years of age, *single* with **0** dependent children.

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 \$484.77 per week for 14-2/7 weeks, commencing November 3, 2022, through February 11, 2023, as provided in Section 8(b) of the Act.

Respondent shall pay outstanding reasonable and necessary medical services of \$1,171.66 to ProCare DME, \$6,216.93 to Midwest Specialty Pharmacy, \$2,235.14 to Illinois Orthopedic Network, \$181.10 to Union Health Service, and \$6,752.34 to Bone & Joint Clinic, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of \$436.30 per week for 37.50 weeks, because the injuries sustained caused the 7.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of \$436.30 per week for 4.30 weeks, because the injuries sustained caused the 2% loss of use of the right leg, as provided in Section 8(e)(12) 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

April 29, 2025

FINDINGS OF FACT

This matter proceeded to hearing on February 28, 2025, in Chicago, Illinois before Arbitrator Elaine Llerena. The issues in dispute were accident, causal connection, medical expenses, temporary total disability benefits, and permanency. Arbitrator's Exhibit 1 (AX1).

Job Duties

As of October 23, 2022, Petitioner had worked for Respondent for 2 years but worked at the assigned site for 22 years. (T. 8) Petitioner was a security guard for Respondent. (T. 9) Her job consisted of customer service, patrolling, relieving for breaks, rounds, and lunches. *Id.* Petitioner worked as a security guard at the assigned site for the 22 years she was there. (T. 9-10)

Prior Medical Condition

Before October 23, 2022, Petitioner did not have any pain or problems with her neck, head, right knee, right shoulder, or low back. (T. 41) Petitioner was working full duty without any issues. (T. 41-42)

The October 24, 2022, visit note from Union Health Service indicates that Petitioner had a history of lumbar pain on October 30, 2012. (PX1)

Accident

On October 23, 2022, Petitioner was working the 7:00 a.m. to 3:00 p.m. shift, but was asked by her supervisor to stay until 7:00 p.m. (T. 10) During that call, Petitioner's supervisor, Tina Igaraviez, explained that Justin Pleasant was complaining that there was no one at the desk/front desk/security console. (T. 11-12) Ms. Igaraviez asked Petitioner to go and relieve Mr. Pleasant, who needed to go to the bathroom. (T. 11-13) Petitioner went to relieve Mr. Pleasant and had Ms. Igaraviez on the line as she did so. *Id.* Petitioner called Mr. Pleasant to tell him she was there to relieve him, but Mr. Pleasant indicated he had already gone to the bathroom and hung up on Petitioner, which Ms. Igaraviez heard. *Id.* At the end of her shift, Mr. Pleasant was walking within hearing distance of Petitioner and stated: "I'm going to beat this bitch ass." (T. 14) Petitioner spoke with Ms. Igaraviez and asked if she heard what Mr. Pleasant said. *Id.* Ms. Igaraviez indicated that she heard what Mr. Pleasant said and that they were "going to take care of everything." *Id.* As Petitioner was signing out, Mr. Pleasant again called her "fat bitch, nasty bitch, you dirty bitch." *Id.* A co-worker of Petitioner, Andrew Hoysen, heard Mr. Pleasant and indicated that he would be noting what Mr. Pleasant said. (T. 14-15) Mr. Pleasant also took pictures of Petitioner, which she reported to Ms. Igaraviez. (T. 15) Ms. Igaraviez again indicated that they would take care of it. *Id.* Petitioner finished signing out, went out the door and headed for her vehicle. (T. 16)

Respondent provided video footage of the incident as Respondent's Exhibit 1B. The video showed Petitioner at her vehicle and Mr. Pleasant approaching Petitioner's vehicle. (T. 19, RX1B) According to Petitioner, Mr. Pleasant was saying he was going to beat Petitioner's ass as he approached the vehicle. (T. 19) Once he got close to Petitioner, Mr. Pleasant asked Petitioner why she was getting people fired. (T. 20, RX1B) Petitioner then called Ms. Igaraviez as Mr. Pleasant continued to insult Petitioner. (T. 20-21) Petitioner did not speak with or respond to Mr. Pleasant. (T. 44) Petitioner was nervous and scared. (T. 21) It was only Petitioner and Mr. Pleasant in the dark parking lot. (T. 21, RX1B) Mr. Pleasant walked away from Petitioner and as he did so, Petitioner reported to Ms. Igaraviez that Mr. Pleasant had thrown water in her face. (T. 22, RX1B) The video footage shows Petitioner holding up the phone as she is speaking to Ms. Igaraviez. (T. 22) Mr. Pleasant had left the parking lot, but then walked back towards Petitioner and as he returned to Petitioner, who was still

in the parking lot, Mr. Pleasant resumed calling Petitioner names. (T. 23-24, RX1B) Mr. Pleasant then got in Petitioner's face. (T. 24, RX1B) According to Petitioner, Mr. Pleasant was about 6'2" and over 200 pounds, and she is 5'7". (T. 24-25) Mr. Pleasant then stated that he did not care that Ms. Igaraviez was on the phone and hit Petitioner's right jaw. (T. 26-27, RX1B) He then hit Petitioner on the top of her head and the left side of Petitioner's face, causing Petitioner to fall to the ground. (T. 27-28, RX1B) When she fell, Petitioner's back, shoulder and leg struck the concrete ground. (T. 29-30) Petitioner sustained injuries to her back, neck, right shoulder, right leg, eye, and jaw and was in pain after the incident. (T. 35-36) Petitioner's head did not strike the ground. (T. 51) After striking Petitioner, Mr. Pleasant left the parking lot. (T. 29, RX1B) Petitioner then got up, got in her vehicle and drove off. (T. 30)

Petitioner called the police, but they did not show up. (T. 31) Petitioner then drove home and then went to the police station near her home, where she filed a police report. (T. 31, PX6) Petitioner also provided a statement of the incident at Respondent's request. (T. 33-34) Petitioner was terminated from Respondent's employ as a result of the incident. (T. 34) The day after the incident, Petitioner sought treatment at Union Health Service. (T. 34-35)

Summary of Medical Records

On October 24, 2022, Petitioner had a telehealth visit, due to COVID-19 pandemic restrictions, with Cythia Quinn NP at Union Health Service. (PX1) Petitioner reported that she was hit by a co-worker the night before and complained of swelling and right arm, leg and neck pain. Quinn referred Petitioner for an in-person visit, which Petitioner underwent that same day with Dr. Helenaída Ortega. Petitioner reported that she was punched in the face multiple times by a co-worker which caused her to fall to the ground. Petitioner complained of headaches and dizziness on and off. Dr. Ortega diagnosed Petitioner as having headache, dizziness and a head injury and referred Petitioner to the Emergency Department at Christ Hospital. At Christ Hospital, which Petitioner went to that same day, she was seen by Taylor Neubeck RN, who noted that Petitioner reported being struck in the back of the head and bilateral face with a fist, and complained of pain in the right lower extremity from her hip to her knee and her right upper extremity from her shoulder to her elbow. Petitioner was diagnosed as having a concussion, was prescribed over the counter pain medication and advised to ice the areas of pain. Petitioner followed up at Union Health Service on October 27, 2022, with Dr. Doris McCulley. Petitioner complained of continued scalp pain and Dr. McCulley noted Petitioner had a bruise on the right side of her face.

On November 3, 2022, Petitioner saw Dr. Krishna Chunduri at Illinois Orthopedic Network, LLC. (PX2) Petitioner reported the October 23, 2023, assault at work and complained of right-sided facial pain, headaches, dizziness, neck pain with radiation into her shoulders, right shoulder pain, low back pain, and right knee pain. Petitioner further reported that her pain was aggravated by overhead movements, moving from a seated position to a standing position, standing, walking, and bending the right knee. Dr. Chunduri diagnosed Petitioner as having right facial contusion, headaches, cervicalgia, right shoulder pain, low back pain, and right knee pain. Dr. Chunduri ordered physical therapy, prescribed pain medication, and took Petitioner off work. Dr. Chunduri also referred Petitioner to a psychologist, noting that Petitioner was visibly upset and in tears during the appointment.

Petitioner began chiropractic treatment at Bone & Joint Clinic, starting November 7, 2022. (PX3) Per the chiropractic records, Petitioner was referred by Dr. Eugene Lipov.

Petitioner followed up via telephone with Dr. Chunduri on December 5, 2022. (PX2) Petitioner reported improvement in her symptoms, but still complained of intermittent low back pain exacerbated by prolonged standing, right anterior shoulder pain exacerbated with direct pressure and internal rotation, and right anterior knee pain exacerbated using stairs. Petitioner complained of midline cervical pain that she reported was almost

completely resolved and significantly improved. Petitioner also reported that her headaches had almost completely resolved. Dr. Chunduri continued physical therapy and kept Petitioner off work. Petitioner's last chiropractic visit was on December 28, 2022, where she indicated that her symptoms were unchanged. (PX3) On January 13, 2023, Petitioner returned to Dr. Chunduri and reported she was 90% better pain-wise. (PX2) Dr. Chunduri released Petitioner to return to work starting February 11, 2023.

On January 17, 2023, Petitioner underwent a Section 12 examination (IME) by Dr. Thomas Gleason at Respondent's request. (RX2-EDX2) Dr. Gleason examined Petitioner and reviewed her medical records and the video footage of the October 23, 2022, assault. Petitioner reported that on October 23, 2022, she was attacked at work and was hit two times in the face and her head, then pushed to the ground, falling on her hands and knees. Petitioner further reported that the next day she started having pain in her neck, right shoulder, low back and right knee. Dr. Gleason noted Petitioner's complaints as follows: 1. Neck pain improved and improving; 2. Right shoulder pain improved and plateaued; 3. Low back pain improved and plateaued; and 4. Right knee pain improved and plateaued. Petitioner underwent x-rays of the cervical spine, right shoulder, lumbar spine, and knees. X-rays of the cervical spine and right shoulder showed no evidence of fracture, dislocation, osseous, or joint pathology. X-rays of the lumbar spine revealed severe degenerative disc disease at L4-L5, moderate at L5-S1, with disc space narrowing and spur formation. X-rays of the knees revealed moderate degenerative joint disease of the right knee with marginal spurring medial tibial plateau and patellofemoral joint and joint space narrowing of the patellofemoral joint. Dr. Gleason diagnosed Petitioner as having impingement of the right shoulder, improved and stable, with diminished range of motion of the right shoulder relative to the left and degenerative joint disease of the right knee with diminished range of motion relative to the left. Dr. Gleason found no positive objective findings on physical examination with respect to Petitioner's spine or otherwise. Dr. Gleason opined that, based on Petitioner's subjective complaints, physical exam and the video footage of the October 23, 2022, incident, Petitioner's current conditions were not causally related to the October 23, 2022, incident. Dr. Gleason explained that Petitioner's conditions, and any further treatment for those conditions, were the result of degenerative or personal conditions. Dr. Gleason found that Petitioner's treatment had been excessive and unnecessary, and that Petitioner did not require any additional treatment. Dr. Gleason further opined that Petitioner did not require any work restrictions.

On January 31, 2023, Petitioner saw Dr. Tessa Qualkinbush at Sinai Medical Group. (PX5) Petitioner reported the October 23, 2022, assault and wanted to see a therapist to work through the trauma she endured. Dr. Qualkinbush referred Petitioner to clinical psychology. Petitioner returned on April 13, 2023, for unrelated issues and then followed up on lab tests done the next day.

On October 15, 2024, Dr. Gleason's evidence deposition was taken. (RX2) Dr. Gleason's testimony was consistent with the findings and opinions in his IME report.

Petitioner's Current Condition

Petitioner's right shoulder still pops sometimes. (T. 39) Petitioner continues to have headaches once a week. *Id.* Petitioner still has difficulty with walking and standing for prolonged periods of time. (T. 40) As Petitioner does her rounds, her right leg stiffens. *Id.* Sitting for a long period of time also causes her right leg to stiffen. (T. 40-41) Petitioner is still upset about the incident and watching the video during the hearing hurt due to losing a job at a place she had been at for 22 years. (T. 42)

Petitioner now works for Paul Simon Job Corps as a mobile advisor. (T. 8) The job consists of checking students in, patrolling and doing grounds. *Id.* Petitioner agreed it was like security work. *Id.*

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 (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:

The Arbitrator notes that when a fight at work arises out of a purely personal dispute, resulting injuries do not arise out of the employment. *Franklin v. Industrial Commission*, 211 Ill.2d 272, 280 (2004). However, when a fight at work arises out of disputes concerning the employer's work, it is a risk that is incidental to the employment. *Id.* at 280-281. The resulting injuries are compensable unless the injured employee was the aggressor. *Id.* Additionally, only one participant in a fight may be deemed an aggressor. *Id.* at 283. As the Court in *Franklin* explained, while it is difficult to identify the aggressor at times, "[a] typical fight involving two employees has only one aggressor. When one employee escalates the dispute, he changes the circumstances and typically makes it reasonable for the other employee to respond in kind. This is not to condone answering violence with violence. It is to acknowledge that a claimant's conduct must be judged in light of the circumstances, and the circumstances include the conduct of others." *Id.* at 284.

The Arbitrator notes that in the case at bar, Petitioner at no time struck or attempted to strike Mr. Pleasant. It was Mr. Pleasant that approached Petitioner, twice. It was Mr. Pleasant to throw water at Petitioner and it was Mr. Pleasant that pushed and struck Petitioner. Respondent argues that Petitioner somehow incited Mr. Pleasant by not entering her vehicle immediately after Mr. Pleasant approached her and somehow causing Mr. Pleasant to return a second time to assault her. The Arbitrator notes that the video of the assault has no sound. Petitioner testified that Mr. Pleasant was hurling curse words and threats at her and that she kept her cell phone on so that Ms. Igaraviez, who was on the line, could hear what was going on. Petitioner's testimony is unrebutted. Based on the totality of the evidence provided, the Arbitrator finds that Mr. Pleasant was the aggressor in this altercation, and not Petitioner. The Arbitrator further finds that, based on the unrebutted testimony, the dispute arose out of issues between Petitioner and Mr. Pleasant regarding employer's work, i.e. Petitioner covering for Mr. Pleasant at his workstation.

Based on the above, the Arbitrator finds that Petitioner sustained accidental injuries arising out of and in the course of her employment with Respondent on October 23, 2022.

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 notes her finding above that Petitioner sustained accidental injuries arising out of and in the course of her employment with Respondent on October 23, 2022. The Arbitrator further notes the only prior lumbar spine pain Petitioner had was in 2021. Further, Petitioner was not experiencing any pain or problems regarding her neck, head, right knee, right shoulder, or low back prior to the October 23, 2022, work incident. The video of the incident shows Mr. Pleasant striking Petitioner and Petitioner falling to ground, with her back, shoulder and leg hitting the concrete. Following this incident, Petitioner continues to suffer from issues with her right shoulder, right leg, and back, as well as headaches. Additionally, Dr. Chunduri and Dr. Qualkinbush have referred Petitioner to a psychologist, noting ongoing trauma following the October 23, 2022, assault. The Arbitrator notes that Dr. Gleason opined that Petitioner's conditions of ill-being were not causally related to the incident and that her treatment had been excessive and unnecessary. However, Dr. Gleason also noted that Petitioner had neck pain, right shoulder pain, low back pain and right knee pain, which had improved, but still painful. He also diagnosed Petitioner as having impingement of the right shoulder with diminished range of motion and degenerative joint disease in the right knee with diminished range of motion. Considering

Petitioner's lack of any problems prior to the incident, her ongoing conditions of ill-being following the incident and Dr. Gleason's acknowledgement of ongoing neck, right shoulder, low back and right knee pain and diminished range of motion in the right shoulder and right knee, the Arbitrator finds Dr. Gleason's opinion that Petitioner's conditions are not causally related to the incident and that Petitioner's treatment has been excessive and unnecessary unpersuasive.

Based on the above, the Arbitrator finds that Petitioner's ongoing conditions of ill-being are causally connected to the October 23, 2022, incident.

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 Arbitrator notes her findings above that Petitioner sustained accidental injuries arising out of and in the course of her employment with Respondent on October 23, 2022, and that her conditions of ill-being are causally related to the October 23, 2022, incident. The Arbitrator further notes Petitioner underwent treatment for her conditions of ill-being incurred on October 23, 2022, at Union Health Service, Christ Hospital, Illinois Orthopedic Network, Bone & Joint Clinic, ProCare DME, and Sinai Medical Group. As noted above, Dr. Gleason found Petitioner's treatment to be unnecessary and excessive. For the reasons stated above, the Arbitrator finds Dr. Gleason's opinions unpersuasive.

Based on the above, the Arbitrator finds that Respondent shall pay outstanding reasonable and necessary medical services as follows: \$1,171.66 to ProCare DME, \$6,216.93 to Midwest Specialty Pharmacy, \$2,235.14 to Illinois Orthopedic Network, \$181.10 to Union Health Service, and \$6,752.34 to Bone & Joint Clinic, as provided in Sections 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:

The Arbitrator notes her findings above that Petitioner sustained accidental injuries arising out of and in the course of her employment with Respondent on October 23, 2022, and that her conditions of ill-being are causally related to the October 23, 2022, incident. The Arbitrator further notes that Dr. Chunduri took Petitioner off work on November 3, 2022, and released her to return to work starting February 11, 2023.

Based on the above, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits from November 3, 2022, through February 11, 2023.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

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.

With regard to subsection (i) of Section 8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator gives this factor no weight.

With regard to subsection (ii) of Section 8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a security guard at the time of the accident and that she was able to return to work in her prior capacity for another employer as a result of said injury. The Arbitrator gives this factor substantial weight.

With regard to subsection (iii) of Section 8.1b(b), the Arbitrator notes that Petitioner was 56 years old at the time of the accident. The Arbitrator gives this factor its appropriate weight.

With regard to subsection (iv) of Section 8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that no evidence was presented regarding the effect of the incident on Petitioner's future earning capacity. The Arbitrator gives this factor no weight.

With regard to subsection (v) of Section 8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Dr. Chunduri diagnosed Petitioner as having right facial contusion, headaches, cervicgia, right shoulder pain, low back pain, and right knee pain. After conservative treatment, Dr. Chunduri noted that Petitioner reported improvement in her symptoms, but still complained of intermittent low back pain exacerbated by prolonged standing, right anterior shoulder pain exacerbated with direct pressure and internal rotation, and right anterior knee pain exacerbated using stairs. On January 13, 2023, Dr. Chunduri noted Petitioner was 90% better pain-wise and released Petitioner to return to work without restrictions. The Arbitrator gives this factor significant weight.

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 the person as a whole pursuant to Section 8(d)2 of the Act and 2% loss of use of the right knee pursuant to Section 8(e)(12) of the right leg.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	24WC014193
Case Name	Alex Lorisca v. Carl Buddig & Company
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	25IWCC0495
Number of Pages of Decision	33
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Steven Tenzer
Respondent Attorney	Nicole Wiza

DATE FILED: 12/17/2025

/s/ Kathryn Doerries, Commissioner
Signature

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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)
☐ Modify Choose direction	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ALEX LORISCA,

Petitioner,

vs.

NO: 24 WC 014193

CARL BUDDIG & COMPANY,

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, causation, temporary total disability, medical expenses, prospective medical, and penalties, and being advised of the facts and law, reverses the Decision of the Arbitrator, and denies Petitioner's claim for compensation, for the reasons stated below.

The Arbitrator found that Petitioner proved a compensable accident arising out of and in the course of his employment on May 21, 2024, with resulting injuries to the cervical spine and lumbar spine. The Arbitrator further found Petitioner's current condition of ill-being was causally related to the accident. The Arbitrator awarded medical expenses, temporary total disability benefits, prospective medical, and penalties under §19(l), §19(k) and §16 of the Act. The Commission views the evidence differently and finds Petitioner failed to prove by the preponderance of the evidence that he sustained a compensable accident.

I. FINDINGS OF FACTS

Petitioner filed an Application for Adjustment of Claim alleging he injured his cervical spine, lumbar spine, and right shoulder when he was "hit with a rack of meat" while working on

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May 21, 2024. Petitioner testified he worked the third shift from 8:00 p.m. to 4:30 a.m., with a 30-minute rest break at 10:00 p.m. and a one-hour rest break at 1:00 a.m. Sometime between 2:00 a.m. and 2:25 a.m., after he returned from his one-hour rest break, Petitioner was cutting logs of meat in the “basket room” when a coworker operating a standing forklift pushed the rack holding the meat he was cutting. Petitioner testified he was bending down working on the rack, cutting the meat, when the forklift came into contact with the rack. (T. 54-56) Petitioner testified he stumbled and heard a “click” in his back. (T. 56) Petitioner testified his lower back and neck began to hurt. Petitioner testified he reported the accident to his supervisor, Mike, about three to four minutes after the incident. (T. 59) Petitioner testified his supervisor brought him to his office at which time an ambulance was called. Petitioner testified he described the accident to the paramedics who then transported him to Ingalls Hospital. Petitioner testified he provided the same accident description at the hospital.

On cross-examination, Petitioner was questioned further as to the mechanism of injury. Petitioner testified he was hit by the rack of meat. (T. 78) Additionally, Petitioner explained the rack was in front of him, and he was cutting the meat, bending over, when suddenly he felt “something (indicating)” which caused him to “stumble and stumble and stumble” and feel a click in his back. (T. 79)

Mike Lowry testified for Respondent. Mr. Lowry was a crew leader working the same shift when Petitioner reported an injury sometime between 2:25 a.m. and 2:30 a.m. (T. 134-135, 142) Mr. Lowry testified Petitioner was assigned the job of cutting logs of meat which involved making incisions into logs with a peeling knife. (T. 136) The logs of meat were situated on a metal rack. Mr. Lowry was making his rounds and learned of the accident from Petitioner when he entered the room. Mr. Lowry testified he brought Petitioner to his office. Mr. Lowry testified he called his manager, Tony, who instructed Mr. Lowry to get Antoine to translate since Petitioner is Haitian. Mr. Lowry prepared an Employee Incident Report on which he wrote down what happened as translated by Antoine. The incident report noted the time of accident as 2:00 a.m. and the location of accident as the basket room. (RX3) The incident report indicated Petitioner was bending over cutting meat logs when he was hit by a rack. (RX3) The incident report further indicated that “Phillip” was pushing the rack with a power walker (standing forklift). The report included notations that the report was “written by” Mike Lowry and “witnessed” by Antoine. (RX3) Mr. Lowry testified he called for an ambulance. (T. 145-146) The reported injuries involved the neck and back. (T. 146) Mr. Lowry testified he did not question the validity of the accident at that time. (T. 147)

Petitioner admitted into evidence the records of the South Holland Fire Department. (PX1) Per the ambulance report, dispatch was notified at 2:59 a.m. and the paramedics arrived at Respondent’s location at 3:04 a.m. Petitioner reported that “either a forklift or crate hit him when facing away crouching.” The mechanism of injury was listed as “blunt.” (PX1) Petitioner complained of back pain and denied any other symptoms. The paramedics arrived at the hospital at 3:17 a.m.

In the emergency room at Ingalls Hospital, Petitioner reported he had been working at a factory cutting meat when a forklift hit the conveyor which caused him to be “jarred backward.” (PX2 at 33) Petitioner complained of neck and upper back pain. X-rays of the cervical and thoracic spines were negative for acute findings. The diagnosis was listed as “neck pain.” (PX2 at 36)

Ms. Pamela Powers, who worked in Respondent’s Human Resources Department, testified for Respondent. Ms. Powers testified she received an email from Mike Lowry regarding the accident which occurred around 2:00 a.m. (T. 98-99) Ms. Powers testified she was involved in the investigation of Petitioner’s claimed accident. (T. 97) Ms. Powers testified there are about 200 or more security cameras at the facility. (T. 97) She accessed video from a camera in the basket room and reviewed the video looking for the reported accident. Ms. Powers viewed video recording the activity in the basket room from 1:55 a.m. to around 2:30 a.m. (T. 99-100) Ms. Powers testified she observed the incident described by Petitioner during the timeframe between 1:59 a.m. and 2:01 a.m. (T. 101-102) She then downloaded video for that time period. Ms. Powers also downloaded a second video showing Petitioner was still located on the factory floor in the basket room during the period of 2:18 a.m. to 2:20 a.m. (T. 103)

Ms. Powers testified Petitioner was seen in the first video working on a meat rack when Phillip Loveless accidentally “bumped” the rack while driving a power walker. (T. 102) Ms. Powers further testified that the rack “kinda moved off” and there was no contact between the rack and Petitioner. (T. 103-104) Ms. Powers testified that Petitioner noticed the rack move and looked up to see why the rack had moved and looked at Phillip. Ms. Powers testified she saved the first video because it lined up timewise with what was reported in the accident report. (T. 101) The remaining video recorded on the night in question no longer exists as the system erases all video after 30 days unless it has been saved. (T. 104) Ms. Powers compared the video with Petitioner’s description of the injury and concluded that Petitioner had falsified his report in violation of company policy. Ms. Powers testified Respondent then terminated Petitioner. (T. 117)

Mr. Lowry testified he viewed the video the next day which caused him to question Petitioner’s claimed accident. (T. 147) As the first video was played before the Arbitrator, Mr. Lowry identified Petitioner as the employee standing by the garbage can with the blue trash bag. (T. 149) The employees seen in the video were all dressed in white smocks with face coverings and yellow hardhats. Mr. Lowry testified he can identify all the workers in the video despite not seeing their faces because he gives the crew their assignments and knows who they are in the video based on their placement. (T. 152-153) Mr. Lowry further testified he assigned only two employees to the job of trimming that night – Petitioner was one and the second was Don Diego. (T. 149) Mr. Lowry testified he observed the incident in the video when Phillip pushed the rack with the forklift. Mr. Lowry testified the video showed the rack being pushed to the left without making contact with Petitioner. (T. 151) As the video continued, Mr. Lowry testified that Petitioner was seen moving the same rack after the claimed injury. (T. 150) Mr. Lowry testified the rack, which is a wheeled rack, contained between 1,800 and 2,200 pounds of meat and Petitioner did not appear to have any problem rolling the rack after the incident. (T. 150) On cross-examination, Mr. Lowry agreed the power walker being operated by Phillips made contact with the rack. (T.

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158-159) Mr. Lowry testified that immediately after the power walker contacted the rack, Petitioner stood straight up. On re-direct examination, Mr. Lowry testified he did not see any contact between the rack and Petitioner. Mr. Lowry further testified that the meat rack Petitioner was working on had been pushed “away from him.” (T. 161)

David Streeter also testified for Respondent. Mr. Streeter is the Director of Occupational Safety and Security. (T. 165) He learned of the claimed accident from Mike Lowry. (T. 169-170) Mr. Streeter testified he viewed video of the basket room for the period starting around 1:30 a.m. and continuing through 2:24 a.m., possibly to 3:00 a.m. (T. 171) Mr. Streeter testified the workers returned from their break around 1:45, at which time the workers can be seen getting dressed again and returning to their respective roles. (T. 171) Mr. Streeter testified he observed Petitioner working on the meat rack when a forklift driven by Phillip Loveless “grazed” the rack at around 2:00 a.m. (T. 173-175) Mr. Streeter confirmed that he did not see the rack make any contact with Petitioner’s person but rather the rack moved off to the left whereas Petitioner was standing on the right. (T. 175-176) Mr. Streeter conferred with Mike Lowry and then made the determination to deny the claim. (T. 178-179; 185)

Petitioner presented to Concentra for treatment on May 23, 2024. (PX3) Petitioner reported he was “cutting meats, with his head down, when a forklift crashed into the meat car.” (PX3 at 16) The documented history indicated “The meat cart then fell onto the back of the patient and including his neck.” (PX3 at 16) Petitioner was diagnosed with a cervical strain.

Respondent held a meeting with Petitioner on May 23, 2024. It is unknown whether this meeting took place before or after Petitioner’s treatment visit at Concentra. As a result of that meeting, Petitioner was terminated effective immediately. (PX12) Petitioner then retained legal representation and signed an Application for Adjustment of Claim on May 24, 2024. The filed Application was not included as an exhibit in the transcript of the trial proceedings; however, we take judicial notice of the Commission’s records in the CompFile system.

A termination letter memorializing the meeting was issued on May 28, 2024 and admitted into evidence by Petitioner. (PX12) The letter described the mechanism of injury as reported by Petitioner and indicated that an investigation showed no accident had occurred as described by Petitioner. (PX12)

Petitioner began treating with Dr. Salehi on May 29, 2024. Petitioner complained of neck pain and reported he was cutting meat and leaning forward when he was pushed by a forklift. (PX4 at 18) He denied upper extremity symptoms and denied back pain. Dr. Salehi noted diffuse pain to superficial touch throughout the spine and paraspinal muscles. (PX4 at 19) Dr. Salehi diagnosed cervicgia and ordered physical therapy. (PX4 at 19) Petitioner returned on June 19, 2024 complaining of neck pain and pain in the interscapular region. (PX4 at 21) An MRI of the cervical spine performed on June 26, 2024, demonstrated multilevel posterior disc/osteophyte complexes superimposed on hypertrophic uncinat processes resulting in mild to moderate bilateral foraminal stenosis with central canal stenosis at C6-C7. (PX9) There was no mention of any disc herniation

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by the radiologist. Petitioner also underwent an MRI of the thoracic spine. Petitioner returned to Dr. Salehi with the imaging on July 9, 2024. Dr. Salehi reviewed the MRI and noted a moderate disc herniation at C6-C7 with bilateral foraminal stenosis and a small centrally located herniated disc at C7-T1 with mild foraminal stenosis. (PX4 at 24)

Petitioner presented for an initial physical therapy evaluation at ATI Physical Therapy on July 18, 2024. The therapist described the nature of injury as “[p]atient was hit on his head, right shoulder and chest by the meat rack while he was stooped down at work.” (PX7 at 40) Petitioner returned to Dr. Salehi for follow-up on August 13, 2024, and reported he began noticing lower back pain with a popping sensation over the preceding weekend. (PX4 at 26) Dr. Salehi diagnosed cervical spine spondylosis with disc disorders and low back pain, and commented that Petitioner’s ongoing neck pain was “secondary to the described work injury.” (PX4 at 27) Dr. Salehi further opined that the neck pain stemmed from the herniated disc at C6-C7 and to a lesser extent the disc herniation at C7-T1, which were “causally related to the work injury.” Dr. Salehi recommended a medial branch block at C6-C7 and an MRI of the lumbar spine.

Dr. Deutsch examined Petitioner for a section 12 evaluation on July 26, 2024. During the IME, Petitioner’s wife was present along with an interpreter. (RX4 at 11-12) Dr. Deutsch testified there were no problems with communication. Dr. Deutsch testified Petitioner reported to him that “a forklift ran into the rack and that the rack pushed into him.” (RX4 at 11) Petitioner did not fall down. Dr. Deutsch reviewed medical records and the aforementioned video of the incident. (RX4 at 12) For the IME, the medical records available for review pre-dated the recent onset of low back pain as there were no documented back complaints in the records he reviewed. (RX4 at 15)

Dr. Deutsch testified he reviewed both the radiology report and the imaging from the MRI of the cervical spine and noted mild degenerative changes with no objective findings of injury. (RX4 at 17) Dr. Deutsch further testified the radiologist’s report gave no indication there was a herniation and Dr. Deutsch testified he agreed there was no herniation. (RX4 at 17) Dr. Deutsch further testified there was bulging but it was minimal and inconsistent for herniation. (RX4 at 17-18) Dr. Deutsch further testified there were no signs for trauma in the MRI imaging. (RX4 at 28) Dr. Deutsch disagreed with Dr. Salehi’s diagnosis for cervical disc herniation at C6-C7. Dr. Deutsch testified that Dr. Salehi’s records indicated Petitioner had denied radiating pain in the upper and lower extremities and Dr. Salehi documented a normal neurological exam. (RX4 at 15-16)

During Dr. Deutsch’s examination, Petitioner complained of neck pain rated as 6/10 and low back pain rated 8/10 but denied radiating arm pain or leg pain. (RX4 at 18) Dr. Deutsch reiterated there were no documented complaints of lower back pain in the treatment records he saw. (RX18-19) Dr. Deutsch noted Petitioner “was groaning a lot” and testified there was some degree of symptom magnification. (RX4 at 19-20) Dr. Deutsch testified Petitioner exhibited normal strength with motor testing and normal sensation. (RX4 at 21) Petitioner exhibited some pain to light palpation of the neck and decreased range of motion due to guarding but the neck exam was otherwise normal. Petitioner also had some pain to palpation of the lower back with

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guarding. Dr. Deutsch testified Petitioner demonstrated a normal gait and had no abnormal neurological findings. Dr. Deutsch testified that Petitioner exhibited four out of five positive Waddell findings consistent for symptom exaggeration. (RX4 at 21-23) Dr. Deutsch opined there were no objective findings of injury and the subjective complaints were not consistent with any objective findings. (RX4 at 23)

Regarding the security camera video, Dr. Deutsch testified he observed a forklift device hit the rack when someone was next to the rack and added, “honestly don't really see much of any kind of accident.” (RX4 at 32) Dr. Deutsch was further questioned regarding the alleged mechanism of injury:

Q. Was there any mechanism that you saw on this video which would support a cervical spine injury if the individual in question was Mr. Lorisca?

A. Based on the video there is really no injury that occurred. There is really no documentation of any injury on the video. (RX4 at 32-33)

Dr. Deutsch went on to testify how he formulated his opinions regarding diagnosis and causation. (RX4 at 33) In short, Dr. Deutsch opined if we go off the medical records alone, then Petitioner sustained a strain injury, but if we go off the video there was no injury. (RX4 at 33-34)

Dr. Deutsch later reviewed updated medical records and authored an addendum report dated October 31, 2024. (RX4 at 37) Specifically, Dr. Deutsch reviewed records from Dr. Salehi for treatment visits on August 13 and September 24, 2024, a pain management evaluation by Dr. Bayran, and the imaging and report regarding an MRI of the lumbar spine performed on August 30, 2024. Dr. Deutsch testified the lumbar MRI showed some mild degenerative changes with no objective findings of injury. (RX4 at 39) Dr. Deutsch disagreed with Dr. Salehi's finding of an annular tear. Dr. Deutsch further noted that the radiologist likewise made no mention of any annular tear. Furthermore, even assuming the presence of an annular tear, Dr. Deutsch testified that would be a degenerative finding and not a traumatic finding. (RX4 at 39) On cross-examination, Dr. Deutsch agreed he could not identify Petitioner in the video as Petitioner's face was not visible. (RX4 at 44-45)

The Commission viewed the two security camera videos. (RX1 and RX2) The videos present a fisheye 360° panoramic view of the room below, looking down from the ceiling. None of the workers' faces are visible. They are all dressed in white smocks with face coverings and yellow hardhats. In the first video, the employee identified as the Petitioner is seen bending forward and *facing* the rack. His waist, buttocks, back, and legs are away from the rack. Petitioner's arms are extended out in front of him at shoulder level with his hands appearing to be working with the logs of meat. The rack is a wheeled rectangular shelving unit with several shelves holding logs of meat, the ends of which are protruding out from the shelves towards Petitioner. A coworker operating a power walker is seen driving towards the rack. The coworker slows down the power walker and the forks bump the narrower side or end of the rectangular rack. The rack

then moves *sideways*. Petitioner is situated perpendicular to and facing the long side of the rack. The rack appears to move an inch or two and then roll back to its starting position. The rack makes a subtle movement from the left side of Petitioner to his right side. The rack never moved closer to Petitioner and never contacted Petitioner's head, neck, shoulders, torso, or legs. (See RX1 at time 1:59:33 a.m.) At trial, Petitioner testified the impact caused him to stumble; however, the video shows no stumbling or loss of balance or sudden movement by Petitioner. Instead, Petitioner is seen standing straight up and looking to his left to see who pushed the rack. He then resumes working and his hands return to the logs of meat on the rack. We note Petitioner did not exhibit any pain behavior after the meat rack was bumped.

In the second video, which captured the time period between 2:18:44 and 2:20:59, Petitioner is seen standing around with other workers. Petitioner then walks over to a metal bin containing wrapped meat and leans resting against the bin. After a short period of time, Petitioner is seen placing his left hand on the left side of his neck.

We further note that Petitioner watched the two videos before trial at his attorney's office, with Respondent's counsel present. It is unknown when that viewing took place. This was elicited during Petitioner's testimony. (T. 73-74) Petitioner testified he did not see himself in either of the two videos; however, Petitioner never offered any testimony suggesting incidents involving power walkers and meat racks were a frequent occurrence or even an occasional occurrence. It is difficult to fathom how the incident captured in the first video was not the same incident reported by Petitioner. Additionally, Mike Lowry credibly testified he assigned only two employees to the job of trimming that night and could identify all the workers based on their location since he was the crew leader who gave out the assignments. As such, though we generally agree with the Arbitrator that employers offering security camera videos into evidence should preserve and present more complete videos to avoid gaps in the timeline before and after the events in question, we find in this case the 17-minute gap between the end of the first video clip at 2:01 a.m. and the start of the second video clip at 2:18 a.m. is immaterial for resolution of this claim.

II. CONCLUSIONS OF LAW

The claimant has the burden of establishing, by a preponderance of the evidence, that his injury arose out of and in the course of his employment. *McAllister v. Illinois Workers' Compensation Comm'n*, 2020 IL 124848, P32. Whether a work-related accident occurred in the first instance, and whether it caused the employee's condition of ill-being, are questions of fact for the Commission to determine. *Pryor vs. Industrial Commission*, 201 Ill. App. 3d 1, 5, 588 N.E.2d 788 (1990). It is the function of the Commission to decide questions of fact, judge the credibility of witnesses, determine the weight that their testimony is to be given, draw reasonable inferences from the evidence, and resolve conflicts in the evidence. *Sisbro, Inc. vs. Industrial Comm'n*, 207 Ill. 2d 193, 206-207, 797 N.E.2d 665 (2003). The Commission exercises original jurisdiction and is not bound by the arbitrator's findings. See e.g., *Lemons vs. Industrial Comm'n.*, 155 Ill. App. 3d 125, 129, 507 N.E.2d 884 (1987)

The issue in this case is whether Petitioner's claimed accident actually happened. The Commission finds the alleged accident as described by Petitioner is contradicted by the video evidence and concludes Petitioner has failed to prove he sustained an accidental injury arising out of and in the course of his employment on May 21, 2024. Where a claimed accident cannot be corroborated by security camera surveillance video which casts doubt as to the occurrence of the accident, it is within the province of the Commission to place greater weight on the video evidence than the testimony of the claimant. See e.g., *Roach vs. Chicago Transit Authority*, 19 IWCC 190; 2019 Ill. Wrk. Comp. LEXIS 472 (alleged accident contradicted by CTA garage surveillance camera video), and *Munoz-Bautista vs. Buckey Diamond Logistics*, 18 IWCC 766; 2018 Ill. Wrk. Comp. LEXIS 1110, 18 IWCC 766 ("The video contradicts both Petitioner's testimony as to how the accident occurred and his initial report of the pallet falling and striking his right wrist. Neither event is shown on the video.") Respondent's three witnesses all viewed the video and testified they saw no physical contact between the meat rack and Petitioner. Respondent's section 12 physician, Dr. Deutsch, also viewed the video and testified he saw no accident. The treating physician, Dr. Salehi, gave a supporting causation opinion in his treatment records; however, he was never deposed and never viewed the video evidence. This Commission has viewed the video and agrees there was no physical contact between the meat rack and Petitioner. Furthermore, the Commission finds Petitioner not credible. The video fails to show Petitioner being hit by the meat rack, "jarred back", or stumbling after the meat rack was bumped by the power walker. The video contradicts Petitioner's testimony and histories provided to the medical providers thus rendering Petitioner not credible.

Petitioner attempts to challenge the reliability of the video because the three defense witnesses were unable to testify regarding the frames per second recorded by the camera system. This argument is wanting as the Commission did not detect skipping in the videos; the workers shown in the video appear to be moving fluidly and it appears the videos in question are continuous action video which captured everything without missing anything. Compare, *Rescino vs. Sysco Food Service, Inc.*, 12 IWCC 1391; 2012 Ill. Wrk. Comp. LEXIS 1408 (where the Commission noted the surveillance video did not greatly assist in the case as the video was stop motion photography rather than a continuous smooth video.)

We acknowledge that injuries caused by common bodily movements can, in appropriate settings where the evidence permits, be considered a compensable accident arising out of and in the course of employment. See *McAllister vs. Illinois Workers' Compensation Comm'n*, 2020 IL 124848 (sous-chef searching for misplaced pan of carrots inside walk-in cooler sustained a recurrent tear of a previously repaired medial meniscus while attempting to stand up from a kneeling position), citing with approval, *Steak 'n Shake vs. Illinois Workers' Comp. Comm'n*, 2016 IL App (3d) 150500WC (waitress injured her hand wiping down table), *Mytnik vs. Illinois Workers' Comp. Comm'n*, 2016 IL App (1st) 152116WC (assembly-line worker injured his back reaching down to grab a bolt that had fallen), and *Young vs. Illinois Workers' Comp. Comm'n*, 2014 IL App (4th) 130392WC (inspector injured his shoulder while bending and reaching into a box to retrieve a machine part). The Commission finds those circumstances are not present in this case.

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Petitioner's claimed accident is predicated on an alleged blunt force trauma between the meat rack and his body. There was no allegation made, and no theory put forth, that the injury resulted from a common bodily movement (i.e., standing up). There was no documented medical history attributing Petitioner's neck and back injuries to standing up after the meat rack was pushed, and there was no causation opinion supporting compensability for Petitioner's claimed neck and back injuries under a common bodily movement theory.

Therefore, after considering the totality of the evidence adduced at trial, the Commission finds that Petitioner failed to prove by a preponderance of the evidence that he sustained an accidental injury arising out of and in the course of his employment on May 21, 2024. All other issues are rendered moot. Accordingly, the Arbitrator's decision is hereby reversed and Petitioner's claim for compensation is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's award dated March 31, 2025, is vacated and Petitioner's claim for compensation is hereby denied.

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 bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." 820 ILCS 305/19(f)(2) (West 2013). Based upon the denial of compensation herein, no bond is set by the Commission. 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.

December 17, 2025

KAD/swj

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/s/ Kathryn A. Doerries

Kathryn A. Doerries

/s/ Amylee H. Simonovich

Amylee H. Simonovich

/s/ Stephen J. Mathis

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
DECISION SIGNATURE PAGE

Case Number	24WC014193
Case Name	Alex Lorisca v. Carl Buddig & Company
Consolidated Cases	
Proceeding Type	19(b) Petition Remand Arbitration
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	23
Decision Issued By	Crystal Caison, Arbitrator

Petitioner Attorney	Steven Tenzer
Respondent Attorney	Nicole Wiza

DATE FILED: 3/31/2025

/s/ Crystal Caison, Arbitrator

Signature

THE INTEREST RATE FOR THE WEEK OF MARCH 25, 2025 4.09%

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)

Alex Lorisca
 Employee/Petitioner

Case # **24** WC **14193**

v.

Consolidated cases: **n/a**

Carl Buddig
 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 **Crystal L. Caison**, Arbitrator of the Commission, in the city of **Chicago**, on **December 9, 2024**. 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 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 **May 21, 2024**, 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 **\$20,152.31**; the average weekly wage was **\$671.74**.

On the date of accident, Petitioner was **40** years of age, *married* with **2** dependent children.

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 **\$0.00** for TTD, **\$0.00** for TPD, **\$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 Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of his employment with Respondent on 05/21/24.

The Arbitrator finds that the Petitioner has met his burden of proving that his current condition of ill-being is causally related to the work accident of 05/21/24.

The Arbitrator orders the Respondent to pay reasonable and necessary medical services as set forth in Petitioner's Exhibit 13 for causally related treatment Petitioner underwent, as provided in Sections 8(a) and 8.2 of the Act and more specifically as follows: \$2,050.64 to South Holland Fire Department, \$4,925.00 to Ingalls Memorial Hospital, \$87.80 to SouthWest Laboratory Physicians, \$361.00 to Specialist in Medical Imaging, \$562.00 to Concentra, \$3,459.32 to Adco Billing Solutions, \$1,575.00 to Chicago Neurospine Surgery, \$1,435.00 to Flexus Medical, \$7,020.00 to Nella Diagnostics, \$8,543.98 to ATI Physical Therapy and \$870.00 to Pain Center of Illinois for a total of **\$30,889.74**.

Petitioner is entitled to prospective medical under Section 8(a) of the Act, and therefore, Respondent is responsible for authorizing and paying for same.

Respondent shall pay Petitioner temporary total disability benefits of **\$541.33/week** for **28 6/7** weeks (**\$15,621.24**), commencing May 22, 2024 through December 9, 2024, as provided in Section 8(b) of the Act.

The Arbitrator awards \$5,400 under Section 19(1) and \$ under Section 19(k) \$23,255.49 and \$9,302.20 in attorney's fees and costs under Section 16 against Respondent, to be paid directly to Petitioner and Petitioner's Counsel.

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.

Crystal L. Caison

Signature of Arbitrator

March 31, 2025

and neck were hurting him. T. 60-61. At Ingalls, where Petitioner was transported, he reported pain in the back and also much worse in the neck. T. 61.

Petitioner testified that he treated at Concentra and subsequently Dr. Salehi. T. 62-65. Petitioner testified that he underwent MRIs, was prescribed medications, and underwent therapy. T. 63-65. Petitioner testified that he saw a physician, Dr. Bayran at the Pain Center of Illinois starting in October, 2024 where medications and injections were ordered. T. 66-67. Petitioner testified he is afraid of undergoing an injection but wants to continue treating with Dr. Salehi. T. 67- 68.

Petitioner was shown PX 12 (Company Termination Letter dated 5/28/24) and testified that he was subsequently terminated by the Respondent. T. 73, PX12.

On cross examination, Petitioner testified that his injury occurred at or around “2:00 or 2:00 something.” T. 78. Petitioner testified that he was hit by a meat rack that was in front of him that made contact with him and this caused him to stumble and feel a “click” in his back. T. 78-79. Petitioner testified that he did report his injury a few minutes later to Mike, but that he was not asked about medical treatment, and did not sign or prepare any incident report. T. 80-82. Petitioner denied that his signature was affixed to either an incident report or medical records from Concentra. T. 81-82, RX3, PX3, p. 22.

Petitioner testified that he was not given light duty at Concentra. T. 84. Petitioner could not recall how he came under the care of Dr. Salehi. T. 85-86. Petitioner could not remember telling Dr. Salehi about a specific incident in August, 2024 when he felt a pop in his back over the weekend. T. 86-87. Petitioner testified that physical therapy was recommended for him in May, 2024 and confirmed that he did not start therapy until July, 2024. T. 86. Petitioner testified that he has not worked since May 21, 2024. T. 89-90.

Petitioner confirmed that he reviewed two approximately two-minute videos from the injury date with his attorney and the attorney for the Respondent present and that he was not on the videos that were shown to him. T. 73 – 74, 92.

Respondent’s Witness – Pamela Powers

Respondent presented Human Resources (HR) Generalist Pamela Powers to testify. T. 94. Ms. Powers, in her capacity as such for the Respondent, handles investigations into employee incidents and also for HR violations. T. 95. She was familiar with Mr. Lorisca because they both used to work during the second shift. T. 96-97. Ms. Powers was involved in investigating the

May 21, 2024 incident alleged by the Petitioner, including watching video of the incident. T. 96-99. The day after the claimed incident, she received an e-mail from Mike Lowry stating Petitioner's injury occurred at 2:00 AM. T.98-99. Therefore, she accessed and watched video from the basket room and watched video from 1:55 am – approximately 2:30 AM. T. 99-100. During that time, she preserved two sections of video ranging from approximately 1:59 AM – 2:01 AM and 2:18 AM – 2:20 AM. T.101, RX1, RX2. According to Ms. Powers, what she witnessed on the video between 1:59 and 2:01AM aligned with the description of the incident that had been reported by Petitioner to Mike Lowry. T. 101-102. She confirmed that it was, in fact, Petitioner on the video during that time working on a meat rack that is bumped by a power walker driven by another worker, Phillip Loveless. T. 102. She testified that she saw no actual injury on that video or during any of the video she watched from 1:55 p 2:30 am. T. 103-104. The second video that Ms. Powers retained showed the Petitioner standing and leaning on large metal containers holding meat logs, known as a “combo.” T. 116.

Ms. Powers testified that she did not alter, destroy or delete any of the video that she watched from the night of the incident. T. 101. The reason she only saved the two clips of video is that she believed the first to show the alleged incident in question and later footage showing Petitioner still on the floor 20 minutes after the alleged incident. T.101-103. During the period from approximately 2:01 to 2:18, which were not retained by Ms. Powers, she saw Petitioner moving around and continuing to work. T. 126. Complete footage from that time was not saved because the system erases any video footage after 30 days that has not been actively saved. T. 104. Ms. Powers confirmed that during the video she watched from 1:55 – 2:30 am, there was only one incident of a power walker coming in contact with a meat rack and no injury whatsoever that she witnessed. T. 109, 119.

Ms. Powers testified that after comparing the video to the Petitioner's statement of injury, it was concluded that Petitioner falsified his report in violation of company policy and Petitioner was terminated. T. 117.

Respondent's Witness – Mike Lowry:

Mike Lowry testified on behalf of the Respondent. On May 21, 2024, he was employed as third shift crew leader. T. 134. He confirmed that as crew leader he supervised the entire crew that worked the night shift, from 8:00 pm until 4:30 am, including Mr. Lorisca. T. 134 – 135. Lowry testified that evening, Mr. Lorisca was one of only two individuals assigned the task of

cutting logs of meat. T. 135-136. To perform this task, Lorisca would use a peeling knife to make an incision in meat logs located in a metal rack. T. 136. Mr. Lowry testified that breaks during this shift occurred from 10:30 – 11:00 pm and from 1:00 am to 1:45 am. T. 137.

Lowry testified that it is Buddig's policy to report any injury exactly when it occurs. T. 140-141. Mr. Lorisca reported an injury to him on May 21, 2024 somewhere between 2:25 – 2:30 am. T. 142. Subsequently, Mr. Lowry took him into the office and inquired about getting him medical attention. T. 143. He also had Mr. Lorisca prepare a report with the use of another individual named Antoine, a Haitian speaker, to translate. T. 144-145. Mr. Lowry confirmed that Respondent's Exhibit 3 detailed the incident as spoken by Mr. Lorisca with translation by Antoine and signed by Petitioner. T. 145. At the time, the incident was not questioned. T. 147.

However, once Mr. Lowry reviewed the video of the basket room floor the next day, he now questioned the incident. T. 150-151. Mr. Lowry confirmed that on May 21, 2024, the Petitioner was performing his meat cutting tasks out on the basket room floor and would not have been performing his work in either the coolers or smoke houses which are located outside the scope of the basket room video feed. T. 137-140. Again, he was one of only two individuals doing this task that night. He also confirmed that Mr. Loveless was only one of two individuals operating a power walker that shift. T. 137. Aware of his team and their assigned tasks, Mr. Lowry testified that the Petitioner was the individual in the video at 1:59/2:00 am working cutting meat when Mr. Loveless' power walker made contact with the meat rack. T. 149-151. Mr. Lowry testified he saw no injury sustained or contact with Mr. Lorisca's body. T. 149-151. Mr. Lowry substantiated this position by explaining that the meat logs in the rack lay out from the rack during the cutting process such that the rack would not make contact with the Petitioner as he described. T. 161-162. Also, Lowry pointed out that after the alleged incident, Petitioner continues to work, pushing the meat cart on the floor and did not immediately stop working or report the injury. T. 150. Rather, the Petitioner waited at least 20 minutes for Lowry to come on the floor before he claimed an injury had occurred. T. 151-153. This also caused Mr. Lowry to now question the validity of Petitioner's story. T. 151-152.

Respondent's Witness – Mr. David Streeter:

Mr. Streeter, Director of Occupational Safety and Security also testified for the Respondent. T. 165. Mr. Streeter oversees all safety programs and issues at Carl Buddig. T. 166-167. In this capacity, he is involved with work injury claims and investigations. T. 166-168.

He was made aware of the Petitioner's reported work injury after being notified of it by Mike Lowry on or around May 21, 2024. T. 169-170. Based on the reporting by Mr. Lowry, Mr. Streeter now began his investigation of the incident, which included watching video of the basket room during third shift, from 1:30 – 2:45 or 3:00 am. T. 170-171. Streeter confirmed that he saw Petitioner at around 2:00 am working on the meat rack cutting when a forklift driven by Phillip Loveless grazed the rack. T. 173 – 175. Streeter confirmed that he did not see the rack make any contact with Petitioner's person but rather the rack moves off to the left whereas Mr. Lorisca was standing on the right. T. 175-176. Throughout the rest of the video reviewed by Mr. Streeter, he did not see any other instances of an injury or near miss on the basket room floor. T. 176. After his review of the reports, discussion with Mr. Lowry, and review of the video, Mr. Streeter made the determination to deny the Petitioner's claim as there was no injury that occurred as he reported it to the employer. T. 178-179, 185

Medical

Septembem, 2023, Petitioner was seen at Concentra for pre-employment medical testing for Buddig. PX 3, p. 23 – 43.

November 29, 2023, Petitioner was evaluated at the Ingalls Emergency Department on complaining of abdominal pain and vomiting. A CT of the upper abdomen and pelvis was obtained and showed evidence of congenital slender spinal canal with mild stenosis in the lumbar region. For that visit, he suffered acute gastritis without hemorrhage, serum lipase elevation, and hypomagnesemia. PX 2, p. 82 – 157.

May 21, 2024, Petitioner was taken via ambulance to South Holland Fire Department. The ambulance arrived at Buddig at 3:04 AM. Petitioner reported to EMTs that either a forklift or crate hit him when facing away crouching. He reported back pain only. PX 1, p. 1-2.

The ambulance took Petitioner to the ER at U Chicago Ingalls Memorial Hospital where his chief complaint was back pain. PX 2, p. 38. Triage notes say he was backed into by a forklift. PX 2, p. 37. Patient states he was kneeling down while at work when the incident occurred. He denied any neck pain at 3:44 am when admitted. PX 2, p. 37. He was at work overnight at factory where he cuts meats and he was sitting at the conveyor belt cutting meat when a forklift hit the conveyor belt causing him to be jarred backward which resulted in neck and upper back pain. PX 2, p. 33. Labs were drawn on the patient and blood work shows things that require he

follow up with outside physicians. Cervical spine x-ray was normal. PX 2, p. 58. Thoracic spine x-ray was also normal. PX 2, p. 60. He was diagnosed with neck pain/cervicalgia and transaminitis. PX 2, p. 33. When he left the hospital, his pain level was 0/10. PX 2, p. 37. He was advised to follow up with a GI physician for un-related liver enzyme issues. PX 2, p. 28.

May 23, 2024, Petitioner presented to Concentra for treatment. PX 3, p. 15 – 22. He reported that while cutting meats with his head down, a forklift crashed into the meat cart causing the meat cart to fall onto his back, including his neck. PX 3, p. 16. He reported neck pain and issues moving his neck ever since. Id. His neurologic exam was normal and x-ray negative. Id. Petitioner was given a therapy referral, and prescribed ibuprofen and meloxicam. Id. This physician excused Petitioner from work through 5/29 with return to work on 5/30 with light duty work, no lift greater than 10 pounds, no continuous neck bending, stretch neck as needed. PX 3, p. 15. The diagnosis was cervical strain. PX 3, p. 16.

May 29, 2024, Petitioner next treated with Dr. Salehi at Chicago Neurospine Surgery. PX 4, p. 18. The Petitioner reported he was cutting meat and leaning forward when he was pushed by a forklift causing immediate pain in his right neck. PX 4, p. 18. He said he was scheduled to begin physical therapy the following day. Id. He presented with a towel wrapped around his neck for support and had significant complaints of pain in the neck. Id. Dr. Salehi noted no neurologic abnormalities and assessed him with cervicalgia and ordered therapy. PX 4, p. 19. He noted no back pain. PX 4, p. 18. He also excused Petitioner from work and prescribed Mobic, Fexmid, Lidocaine patches. PX 4, p. 19. A soft cervical collar ordered. Id. He was to follow up in three weeks to assess the need for MRI imaging. Id.

June 19, 2024, Petitioner returned to Dr. Salehi's office for follow up. PX 4, p. 21. He complained of continuous and significant pain in the neck and into the interscapular region. Id. He wears a hard collar with some relief. Id. He experienced no radiation into the arms and no weakness in extremities. Id. He had not yet started therapy. Id. He reported NO back pain. Id. Dr. Salehi diagnosed cervicalgia and pain in the thoracic spine. PX 4, p. 22. The Petitioner was directed to remain off work, obtain MRIs and wear cervical collar only as needed. Id. MRIs were ordered for cervical and thoracic spine. Id.

June 26, 2024, Petitioner underwent MRIs of the thoracic and cervical spine. PX 9, 10. The thoracic spine impression was disc bulges at T4-T5 and T9-T10 with indent of the ventral surface of the thecal sac. PX 10. The cervical MRI Impression was read as: 1) multilevel

posterior disc/osteophyte complexes superimposed on uncinate hypertrophy as detailed above causes mild bilateral C3-4, moderate bilateral C4-5, severe left /moderate right C5-6, moderate bilateral C6-7, and mild bilateral C7-T1 foraminal stenosis, 2) mild central canal stenosis at C6-7. PX 9.

July 9, 2024, Petitioner returned to Dr. Salehi's office for follow up and review of the MRIs. PX 4, p. 23. At that visit, the Petitioner reported constant pain in the neck – the interscapular region at a 7/10. Id. He denied radiation of pain down into the arms and any weakness in upper or lower extremities or paresthesias. Id. He denied any back pain. Id. He was wearing the collar and had not yet started therapy. Id. According to Dr. Salehi's review of the MRIs, the thoracic had no obvious pathology. PX 4, p. 24. Dr. Salehi reported a moderate central / left paracentral herniation at C6-7, moderate – significant bilateral foraminal stenosis at C6-7 and a small centrally herniated disc at C7-T11 with mild bilateral foraminal stenosis. Id. He diagnosed Petitioner with cervical spondylosis and "other cervical disc disorders." Id. According to Dr. Salehi, as a result of the work injury, Petitioner suffered herniated discs at C6-7 and C7-T1. Id. He ordered therapy for the cervical spine, discontinue the cervical collar and continue Meloxicam and Fexmid. Id. He was to remain off work. Id.

July 18, 2024, Petitioner began physical therapy at ATI for cervicalgia and thoracic sprain/strain, myofascial in nature. PX7, p. 40. The assessment utilized a baseline PDL for Petitioner as a meat cutter in the light physical demand level (11 to 20 lbs). Petitioner was to undergo treatment 3 times a week for 8 weeks. Id. The Petitioner attended therapy on July 19, 23, 25, and August 1st. PX 7, p. 27 - 39. He either cancelled or was a no show on July 30, August 2nd, 13th and 15th. PX 7, p. 53.

August 13, 2024, Petitioner returned to Dr. Salehi for a follow up on August 13, 2024. PX4, p. 26. At that time, he reported constant pain in the neck into the interscapular region at 7/10 and continued to deny any radiation into the arms or any weakness. Id. Now, **he also reported a lot of pain in the lower back with a popping sensation over the weekend. He reported numbness in two toes of both feet.** Id. Dr. Salehi examined the neck and spine and assessed Petitioner with: cervical spondylosis and low back pain. PX4, p. 27. He ordered medial branch block and rhizotomy at C6-7 and provided a pain management referral for same. Id. He ordered a lumbar MRI at that time. Id. Dr. Salehi provided work restrictions of desk work only, no lifting over 10 pounds and no overhead work. Id. **Emphasis added.**

August 25, 2024, Petitioner was sent for an IME by the Respondent by Dr. Harel Deutsch at Midwest Orthopedics at Rush. RX4, EX 2. Dr. Deutsch evaluated medical records, video of the alleged incident and examined the Petitioner. Id. Dr. Deutsch found the Petitioner's physical examination was normal and that there were no objective findings of any injury or any correlation between the Petitioner's subjective complaints and objective findings. Id. He noted specifically that the Petitioner displayed symptom magnification with 4/5 positive Waddells findings. Id. He specifically noted, "there is questionable relationship of neck pain complaints to the May 21, 2024 work injury given that no injury is documented on the video of the alleged incident." Id, para. 11.

August 30, 2024, the lumbar spine MRI was obtained. PX 11. The radiologist who reviewed it noted bilateral foraminal stenosis at L5-S1 and disc bulges at L3-4 and L4-L5 indenting the ventral surface of the thecal sac. Id.

September 13, 2024, Petitioner presented for evaluation by Dr. Bayran at the Pain Center of Illinois. PX 6, p. 1. The Petitioner described his injury as while cutting meat, he was bent down and someone in front of him hit a meat rack with a forklift which caused the rack to hit him on the head and right shoulder. Id. He reported neck pain radiating to his mid and low back as well as low back pain. Id. The Petitioner described now having numbness in the left foot. Id. After physical exam and review of the MRIs, Dr. Bayran diagnosed cervicalgia, pain in the thoracic spine, and low back pain. PX 6, p. 4. For the neck, he prescribed Meloxicam and Cyclobenzaprine; ordered therapy, TENS unit and recommended nerve blocks at C5, C6 and C7. Id. Bayran continued Petitioner off work. Id.

September 24, 2024, Petitioner returned to Dr. Salehi for review of the lumbar MRI. PX 4, p. 29. At that time, the Petitioner reported neck pain radiating into the shoulder blades and low back pain with no radiation into the legs. Id. However, he did describe numbness in the 3rd through 5th toes of both feet and some left calf cramping. Id. According to Dr. Salehi, the Petitioner's neck pain was related to a small herniated disc. PX 4, p. 30. The Petitioner was not interested in injections to address these issues. Id. As for the lumbar spine, Dr. Salehi opined Petitioner sustained an annular tear at L3-4. Id. Dr. Salehi did not provide an opinion relative to causation and Petitioner's lumbar MRI. Lumbar ESIs were recommended, but refused by

Petitioner. Id. Therefore, Dr. Salehi recommended 6 weeks of additional physical therapy and felt Petitioner could work at “desk work” level restrictions. Id.

October 4, 2024, the Petitioner returned to Dr. Bayram. PX 6, p. 6. At that visit, Dr. Bayram diagnosed causally related neck, mid and low back pain. PX 6, p. 8. He prescribed Meloxicam and Cyclobenzaprine, physical therapy and cervical medial branch block at C5-C7. Id. He kept the Petitioner off of work. PX 6, p. 12.

Since around the lumbar MRI, the Petitioner attended 15 physical therapy visits on: 8/16, 8/20, 8/22, 8/27, 8/30, 9/6, 9/12, 9/18, 9/20, 9/25, 9/27 (at which time he felt he could work at least light duty), 10/4, 10/10, 10/17, 10/25. PX 8, p.30 – 52. During that time, he also was a no show for 12 of his therapy visits on the following dates: 8/23, 8/29, 9/5, 9/10, 9/13, 9/17, 10/1, 10/9, 10/18, 10/23, 10/29 and 10/31. PX 8 p, 56-58. By October 31, the Petitioner was discharged from therapy by ATI due to a lack of attendance. PX 8, p. 56.

October 31, 2024, IME Dr. Deutsch prepared an updated report at Respondent’s request. RX4, Ex 3. In connection with that report, Dr. Deutsch evaluated updated medical records and reiterated that, at most, Petitioner sustained a cervical strain, which would require only one month of treatment, if Petitioner’s subjective complaints were legitimate. Id, para. 2.

IME DEPOSITION TESTIMONY:

Dr. Deutsch’s testimony was obtained via deposition on November 26, 2024. RX 4. He testified that at his examination of the Petitioner, on August 25, 2024, the thoracic spine MRI showed no injuries, the cervical spine showed only degeneration, and the lumbar spine complaints had not been diagnosed or really mentioned until his exam. RX4, p. 16-19. During his physical examination, Dr. Deutsch noted 4/5 positive Waddell’s findings, showing signs of symptom magnification. RX 4, p. 21-23. In addition to complete medical records, Dr. Deutsch reviewed the video which began at 1:59 am from May 21, 2024. RX4, p. 31 – 32. He testified to seeing a forklift hitting a rack, but “clearly in the video there is really no accident that is visible that would result in any injury.” RX4, p. 32-34.

Overall, Dr. Deutsch concluded that there were no objective findings to correlate to Petitioner’s cervical subjective complaints and that no acute injury was sustained. RX 4, p. 23. In support of this opinion, Dr. Deutsch explained that Petitioner had no findings on exam or in the medical records to support any disc herniations. RX 4, p. 24-28. Dr. Deutsch testified there was absolutely no injury to the thoracic spine. RX 4, p. 29. He disagreed with Dr. Salehi’s review

of the lumbar MRI, finding only evidence of lumbar degeneration and no acute injury. RX 4, p. 39-40. Dr. Deutch opined there was no injury or causation to any lumbar condition based on a lack of complaints, treatment and objective evidence. RX 4, p. 41-43. While Dr. Deutsch did assign *at most* a cervical sprain, he qualified this, explaining that it was based on the reports made by Petitioner of subjective pain to him and Concentra but not to any objective findings or other evidence of injury. RX 4, p. 30.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). 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 demeanor of the witness and any external inconsistencies with his/her testimony. Where a claimant's testimony is inconsistent with his/her 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).

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 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). 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 ILWC 004187 (2010).

The Arbitrator compared the Petitioner's testimony with the totality of the evidence submitted and did not find any material contradictions that would deem the witness unreliable. Overall, Petitioner's testimony forms a solid foundation for assessing the merits of his claims.

Issue C, whether the accident arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds as follows:

The phrase "in the course of employment" refers to the time, place, and circumstances of the injury. McAllister v. Illinois Workers' Compensation Comm'n, 2020 IL 124848, ¶ 34. A compensable injury occurs 'in the course of' employment when it is sustained while he performs reasonable activities in conjunction with his employment. Id.

"The 'arising out of' component is primarily concerned with causal connection. To satisfy this requirement it must be shown that the injury had 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." Id. at ¶ 36. To determine whether a claimant's injury arose out of his employment, the risks to which the claimant was exposed must be categorized. Id. The three categories of risks are "(1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks which have no particular employment or personal characteristics." Id. at ¶ 38. "A risk is distinctly associated with an employee's employment if, at the time of the occurrence, the employee was performing (1) acts he or she was instructed to perform by the employer, (2) acts that he or she had a common-law or statutory duty to perform, or (3) acts that the employee might reasonably be expected to perform incident to his or her assigned duties." Id. at ¶ 46.

Petitioner testified that on May 21, 2024 the injury occurred at 2:00 to 2:25, 2:20. T. 54. Petitioner testified that while cutting meat in the basket room, he was bent down and a forklift driving by a man named Phillip hit the rack he was working on. T. 54-56. Petitioner testified that he stumbled because he was going to fall and heard a "click" on his back. T. 56. Petitioner testified that this caused him to have pain in his back and neck. T. 57. Petitioner testified that three or four minutes after this incident, he reported the injury to his supervisor Mike. T. 59. Petitioner testified that Mike had him go to the office and later an ambulance was called. T. 58 – 59. The Petitioner testified he told the paramedics his entire back and neck were hurting him. T. 60-61. At Ingalls, where Petitioner was transported, he reported pain in the back and also much worse in the neck. T. 61.

Respondent submitted two separate videos of the alleged incident timestamped 1:59/2:00 & 2:18/2:20 AM. (Respondent's Exhibit 1 & 2) The Arbitrator notes that in the first video Petitioner was working on the meat rack that shifts as Phillip Loveless' power walker comes into

contact with it. After this contact, the Petitioner continues to work pushing the meat rack around the basket room floor.

Respondent called three witnesses, Pam Powers, Mike Lowry, and David Streeter. Pam Powers testified that she accessed and watched video from the basket room and watched video from 1:55 am – approximately 2:30 AM. T. 99-100. During that time, she preserved two sections of video ranging from approximately 1:59 AM – 2:01 AM and 2:18 AM – 2:20 AM. T.101, RX1, RX2.

Mike Lowry testified that it is Buddig’s policy to report any injury exactly when it occurs. T. 140-141. Petitioner reported an injury to Mr. Lowry on May 21, 2024 somewhere between 2:25 – 2:30 am. T. 142. Subsequently, Mr. Lowry took Petitioner into the office and inquired about getting him medical attention. T. 143. He also had Petitioner to prepare a report with the use of another individual named Antoine, a Hatian speaker, to translate. T. 144-145. Mr. Lowry confirmed that Respondent’s Exhibit 3 detailed the incident as spoken by Petitioner with translation by Antoine and signed by Petitioner. T. 145. At the time, the incident was not questioned. T. 147.

However, once Mr. Lowry reviewed the video of the basket room floor the next day, he now questioned the incident. T. 150-151. Mr. Lowry confirmed that on May 21, 2024, the Petitioner was performing his meat cutting tasks out on the basket room floor and would not have been performing his work in either the coolers or smoke houses which are located outside the scope of the basket room video feed. T. 137-140. Mr. Lowry testified that the Petitioner was the individual in the video at 1:59/2:00 am working cutting meat when Mr. Loveless’ power walker made contact with the meat rack. T. 149-151. Mr. Lowry testified he saw no injury sustained or contact with Mr. Lorisca’s body. T. 149-151.

Based on the reporting by Mr. Lowry, Mr. Streeter began his investigation of the incident, which included watching video of the basket room during third shift, from 1:30 – 2:45 or 3:00 am. T. 170-171. Streeter confirmed that he saw Petitioner at around 2:00 am working on the meat rack cutting when a forklift driven by Phillip Loveless “grazed” the rack. T. 173 – 175. Streeter confirmed that he did not see the rack make any contact with Petitioner’s person but rather the rack moves off to the left whereas Mr. Lorisca was standing on the right. T. 175-176. Throughout the rest of the video reviewed by Mr. Streeter, he did not see any other instances of an injury or near

miss on the basket room floor. T. 176. After his review of the reports, discussion with Mr. Lowry, and review of the video, Mr. Streeter made the determination to deny the Petitioner's claim as there was no injury that occurred as he reported it to the employer. T. 178-179, 185

All three Respondent witnesses testified that Petitioner is still on the basket room floor in video taken between 2:18 – 2:20 am. Yet, the Arbitrator notes that there are significant gaps in time namely between 2:00 and 2:18 , 2:20 to 2:30 AM and 2:30 AM to 3:04 AM. The Arbitrator finds these gaps problematic for the Respondent who had control over the video and the obligation to preserve the entire video captured on that day and time.

Notwithstanding, the second video timestamped 2:18 – 2:20 AM reflected a person (who was identified to be Petitioner by all three Respondent witnesses) leaning back stretching his back and also holding the back of his neck after Phillip Loveless' power walker came into contact with the meat rack that Petitioner was working on, albeit not immediately after the alleged incident, The ambulance arrived at Buddig at 3:04 AM.

Based upon the record as a whole, the Arbitrator finds that the Petitioner met his burden of proving by a preponderance of credible evidence that he did sustain an accident to his neck and back that arose out of and in the course of Petitioner's employment by Respondent on May 21, 2024.

Issue F, whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds as follows:

To obtain compensation under the Act, a claimant must prove that some act or phase of his employment was a causative factor in his ensuing injuries. A work-related injury need not be the sole or principal causative factor, as long as it was *a* causative factor in the resulting condition of ill-being. Even if the claimant had a preexisting degenerative condition which made him more vulnerable to injury, recovery for an accidental injury will not be denied as long as he can show that his employment was also a causative factor. Thus, a claimant may establish a causal connection in such cases if he can show that a work-related injury played a role in aggravating his preexisting condition. Sisbro, Inc. v. Industrial Comm'n, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003). "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 Com., 93 Ill. 2d 59, 63 442 N.E.2d 908 (1982).

Petitioner immediately sought medical attention after he was taken from his workplace by ambulance to Ingalls Hospital at 3:04 AM and complained of neck and back pain. He was diagnosed with a cervical strain. PX 3, p. 16. He followed up within two days at Concentra where the handwritten notes indicate he complained of neck and back pain. He was also diagnosed with a cervical strain after providing a consistent history of the workplace incident. Following up with Dr. Salehi, he had neck complaints as well and Dr. Salehi found a causal connection between his accident and the disc involvement in both his cervical spine and lumbar spine. Dr. Bayran also found causal connection after taking a history and examining the Petitioner.

Dr. Deutsch (IME Dr.) found a causal connection in determining that the Petitioner had a cervical strain and that at least some treatment was appropriate. Regarding back treatment, the Petitioner complained of back pain from the outset. However, there was not significant treatment to the back initially. As he continued to complain of back pain, Dr. Salehi then turned his attention to that as well. Dr. Deutsch opined that there were no back complaints initially despite them being well documented in the medical records from the outset.

Based on the above, as well as the credible evidence, the Arbitrator finds the medical records and opinions of Petitioner's treaters to be more persuasive than those of Dr. Deutsch. Further, the Arbitrator finds the Petitioner's current condition of ill-being, as it relates to his neck and back, is causally related to the injuries sustained on May 21, 2024.

Issue J, whether the medical services that were provided to Petitioner were reasonable and necessary and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

Section 8(a) of the Act states a Respondent is responsible ... "for all the necessary first aid, medical and surgical services, and all necessary medical, surgical and hospital services thereafter incurred, limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury..." A 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 (2nd Dist. 1990).

Having found the Petitioner's current condition of ill-being as it relates to his neck and back being causally related the injuries sustained on May 21, 2024, the Arbitrator finds the Petitioner's

treatment to be reasonable and necessary and finds that Respondent has not paid for said treatment. As such, the Arbitrator orders the Respondent to pay reasonable and necessary medical services as set forth in Petitioner's Exhibit 13 for causally related treatment Petitioner underwent, as provided in Sections 8(a) and 8.2 of the Act and more specifically as follows: \$2,050.64 to South Holland Fire Department, \$4,925.00 to Ingalls Memorial Hospital, \$87.80 to SouthWest Laboratory Physicians, \$361.00 to Specialist in Medical Imaging, \$562.00 to Concentra, \$3,459.32 to Adco Billing Solutions, \$1,575.00 to Chicago Neurospine Surgery, \$1,435.00 to Flexus Medical, \$7,020.00 to Nella Diagnostics, \$8,543.98 to ATI Physical Therapy and \$870.00 to Pain Center of Illinois for a total of \$30,889.74.

Issue K, whether Petitioner is entitled to any prospective medical care, the Arbitrator finds as follows:

Having found Petitioner's current condition of ill-being, as it relates to his neck and back, is causally related to the injuries sustained on May 21, 2024, the Arbitrator finds that Petitioner is entitled to prospective medical. The Arbitrator notes that Petitioner testified he is afraid of undergoing an injection but wants to continue treating with Dr. Salehi. T. 67- 68.

Respondent shall authorize and pay reasonable and necessary medical services associated with said treatment.

Issue L, whether Petitioner is entitled to temporary total disability benefits, the Arbitrator finds as follows:

A claimant is temporarily totally disabled from the time an injury incapacitates him from work until such time as he is as far recovered or restored as the permanent character of his injury will permit. Westin Hotel v. Indus. Comm'n, 372 Ill.App.3d 527, 542 (1st Dist. 2007).

In determining whether a claimant remains entitled to receiving TTD benefits, the primary consideration is whether the claimant's condition has stabilized and whether she is capable of a return to the workforce. Interstate Scaffolding, Inc. v. Illinois Workers' Comp. Comm'n, 236 Ill.2d 132, 148 (2010). Once an injured employee's physical condition stabilizes, she is no longer eligible for TTD benefits. Archer Daniels Midland Co. v. Indus. Comm'n, 138 Ill.2d 107, 118 (1990).

Based on the above, the Arbitrator finds Respondent liable of \$541.33/week for 28 & 6/7 weeks (\$15,621.24), of temporary total disability (TTD) benefits commencing May 22, 2024 through December 9, 2024, as provided in Section 8(b) of the Act.

Issue M, whether penalties or fees should be imposed upon Respondent, the Arbitrator finds as follows:

With regards to Section 19(1), the Act reads,

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(1)

Case law dictates that penalties authorized by Section 19(1) serve as a late fee and apply whenever the employer or its carrier simply fails or neglects to make payment or unreasonably delays payment "without good and just cause." McMahan v. Industrial Comm'n, 702 N.E.2d 545 at 553 (1998). If the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay, an award of Section 19(1) penalties is mandatory. *Id* (emphasis added).

The standard for determining whether an employer has good and just cause for a delay in payment is defined in terms of reasonableness. Board of Education of the City of Chicago v. Industrial Comm'n, 442 N.E.2d 861 at 865 (1982). The employer has the burden of justifying the delay. *Id*. The employer's justification for the delay is sufficient only if a reasonable person in the employer's position would have believed that the delay was justified. *Id*.

Although the Respondent presented and relies on its three witnesses, the two videos and Dr. Deutsch's IME, the Arbitrator finds that Respondent was unable to show an adequate justification for its delay, and an award of Section 19(1) penalties is mandatory. The Arbitrator fines Respondent \$30.00 a day starting June 13, 2024. As of the date of trial, December 9, 2024, 180 days had passed. \$30.00 per day multiplied by 180 days equals \$5,400. Therefore, the Arbitrator imposes penalties of \$ 5,400 under Section 19(1) against Respondent, to be paid directly to Petitioner.

Section 19(k) Penalties

The Act reads,

In cases 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. When determining whether this subsection (k) shall apply, the Commission shall consider whether an Arbitrator has determined that the claim is not compensable or whether the employer has made payments under Section 8(j).

820 ILCS 305/19(k).

While Section 19(1) penalties apply when Respondent delays payment "without good and just cause," Section 19(k) penalties require a lack of good faith. The Commission has the discretion to impose Section 19(k) penalties where there is not only a delay in payment, but the delay was in bad faith. McMahan, 702 N.E.2d at 552 citing Smith v. Industrial Comm'n, 525 N.E.2d 81 (1988). Good faith must be assessed objectively; thus, the question is whether an employer's denial of benefits was reasonable. *Id.* The employer bears the burden of demonstrating that its denial of benefits was reasonable. Residential Carpentry, Inc. v. Workers' Compensation Comm'n, 910 N.E.2d 109 at 117 (2009).

Through the testimony of its witnesses, the Respondent testified that it followed all company policies and protocol with regard to the investigation of the incident claimed by Petitioner. Upon completion of that investigation, all Respondent's witnesses concluded that Petitioner was not truthful about the occurrences of May 21, 2024 and that no work injury occurred.

However, all three Respondent witnesses testified that Petitioner is still on the basket room floor in 2nd video taken between 2:18 – 2:20 am. This video timestamped 2:18 – 2:20 AM reflected a person (who was identified to be Petitioner by all three Respondent witnesses) leaning back stretching his back and also holding the back of his neck after Phillip Loveless' power walker came into contact, albeit not immediate after, with the meat rack that Petitioner was working on.

Pam Powers testified that she accessed and watched video from the basket room and watched video from 1:55 AM – approximately 2:30 AM. T. 99-100. During that time, she preserved two sections of video ranging from approximately 1:59 AM – 2:01 AM and 2:18 AM – 2:20 AM. T.101, RX1, RX2.

Mike Lowry testified that it is Buddig’s policy to report any injury exactly when it occurs. T. 140-141. Petitioner reported an injury to Mr. Lowry on May 21, 2024 somewhere between 2:25 – 2:30 am. T. 142. Subsequently, Mr. Lowry took Petitioner into the office and inquired about getting him medical attention. T. 143. He also had Petitioner to prepare a report with the use of another individual named Antoine, a Hatian speaker, to translate. T. 144-145. Mr. Lowry confirmed that Respondent’s Exhibit 3 detailed the incident as spoken by Petitioner with translation by Antoine and signed by Petitioner. T. 145.

Based on the reporting by Mr. Lowry, Mr. Streeter began his investigation of the incident, which included watching video of the basket room during third shift, from 1:30 – 2:45 or 3:00 am. T. 170-171. Streeter confirmed that he saw Petitioner at around 2:00 am working on the meat rack cutting when a forklift driven by Phillip Loveless “grazed” the rack. T. 173 – 175. Streeter confirmed that he did not see the rack make any contact with Petitioner’s person but rather the rack moves off to the left whereas Mr. Lorisca was standing on the right. T. 175-176. Throughout the rest of the video reviewed by Mr. Streeter, he did not see any other instances of an injury or near miss on the basket room floor. T. 176. After his review of the reports, discussion with Mr. Lowry, and review of the video, Mr. Streeter made the determination to deny the Petitioner’s claim as there was no injury that occurred as he reported it to the employer. T. 178-179, 185

The Arbitrator notes that there are significant gaps in time namely between 2:00 and 2:18 , 2:20 to 2:30 AM and 2:30 AM to 3:04 AM. The Arbitrator finds these gaps problematic for the Respondent who had control over the video and the obligation to preserve the entire video captured on that day and time.

The ambulance arrived at Buddig at 3:04 AM taking Petitioner to the Emergency Department.

Because the Arbitrator finds Respondent's behavior was in bad faith, penalties under Section 19(k) are warranted. Per fee schedule, Respondent is liable for \$15,627.33 (28 & 6/7 weeks), and \$30,889.74 for medical bills. 50% of \$46,516.97, is \$23,255.49. As a result, the

Arbitrator fines Respondent \$23,255,49 in penalties under Section 19(k), to be paid to Petitioner directly.

Section 16 Fees

Section 16 reads,

Whenever the Commission shall find that the employer . . . 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

Both Sections 16 and 19(k) are similar in that they require an unreasonable or vexatious delay in payment. Vulcan Materials Co. v. Industrial Comm'n, 842 N.E.2d 204 (2005).

It is so ordered:

Crystal L. Caison

Arbitrator Crystal L. Caison

March 31, 2025

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	22WC016721
Case Name	Ruby Henderson v. TeeJet Technologies
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	25IWCC0496
Number of Pages of Decision	22
Decision Issued By	Frank Soto, Commissioner, Frank Soto, Commissioner

Petitioner Attorney	Francis Lynch
Respondent Attorney	Sarah Hocking

DATE FILED: 12/18/2025

/s/Frank Soto, Commissioner

Signature

DISSENT

/s/Frank Soto, Commissioner

Signature

22 WC 16721

Page 1

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)
☐ Modify	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RUBY HENDERSON,

Petitioner,

vs.

NO: 22 WC 16721

TEEJET TECHNOLOGIES,

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, medical expenses, temporary total disability benefits, and permanent partial 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 April 29, 2024 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.

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Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of \$20,000.00. 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.

December 18, 2025

FJS/dw

O-11/5/25

046

/s/ Carolyn M. Doherty

Carolyn M. Doherty

/s/ Raychel A. Wesley

Raychel A. Wesley

DISSENT

I respectfully dissent from the Decision of the majority and would have found that Petitioner failed to prove by a preponderance of credible evidence that she sustained a compensable accident arising out of her employment on June 16, 2022.

For an injury to “arise out of” one’s employment, its origin must be 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. Indus. Comm’n*, 129 Ill. 2d 52, 58 (1989). To determine whether an employee’s injury arose out of her employment, we must first categorize the risk to which she was exposed. *First Cash Financial Services v. Indus. Comm’n*, 367 Ill. App. 3d 102, 105 (1st Dist. 2006). There are three categories of risk to which an employee may be exposed: (1) risks distinctly associated with the employment; (2) risks personal to the employee, such as idiopathic falls; and (3) neutral risks that have no particular employment or personal characteristics. *Id.*

The first category, risks distinctly associated with the employment, are compensable under the Illinois Workers’ Compensation Act. *McAllister v. IWCC*, 2020 IL 124848 (2020). The second category, personal risks, are generally not compensable, unless workplace conditions significantly contribute to the injury or expose the employee to an added or increased risk of injury. *Id.* The third category, neutral risks, are compensable only where the employee is exposed to the risk to a greater degree than the general public. *Id.* Such an increased risk may be either qualitative, such as some aspect of the employment which contributes to the risk, or quantitative, such as when the employee is exposed to a common risk more frequently than the general public. *Id.*

In the case at bar, Petitioner’s testimony that sticky flooring had caused her to stumble and fall is directly contradicted by two witnesses as well as Petitioner’s initial statements made to the

medical staff while at the emergency room.¹ Both John Lake and Michael Clark testified that they rushed to Petitioner's aid immediately post-fall, and at the time they found her still laying on the floor, Petitioner told them that she had tripped over her own feet. Mr. Clark filled out his accident report within a half hour of the ambulance taking Petitioner to the hospital. Mr. Clark wrote in the accident report that Petitioner said she tripped over her own feet. Petitioner's explanation of the mechanism of injury she reported to Mr. Clark, as contained in his accident report, is the same mechanism of injury Petitioner reported to the medical staff at the emergency room. The consistency of Mr. Clark's statement when compared to the emergency room records supports the reliability of the content of Mr. Clark's statement, as the courts presume that when a person seeks treatment for an injury, he or she will not falsify statements to a physician from whom he or she expects to receive medical aid. *Shell Oil Co. v. Industrial Comm'n*, 2 Ill.2d 590, 602 (1954). Additionally, Mr. Lake's accident report also contains Petitioner's initial description of the mechanism of injury as contained in Mr. Clark's accident report and the emergency room records. Mr. Lake's accident report was completed several days after the incident, which implies that Mr. Lake and Mr. Clark authored their accident reports independently and further supports their reliability.

Petitioner's testimony was inconsistent with the statements she made to Mr. Clark, Mr. Lake, and the staff at the emergency room. Unlike the Petitioner, who testified to being in shock after the fall, Mr. Clark and Mr. Lake had ample opportunity to observe the condition of the floor while waiting with Petitioner for the ambulance to arrive. Both testified to observing the floor to determine whether a dangerous condition existed which could cause harm to other coworkers. Both witnesses presented with reliable first-hand knowledge of the condition of the floor at the time of the accident and observed no defect or sticky substance.

Since Petitioner's trial testimony regarding what caused her fall is fundamentally inconsistent with both witnesses' accounts and the emergency room record, I would have found that Petitioner's trial testimony lacked credibility regarding the mechanism of injury. Both Mr. Lake and Mr. Clark are unbiased witnesses with no financial stake in the present claim. Both witnesses presented with reliable first-hand knowledge of the condition of the floor at the time of the accident and observed no defect or sticky substance. Moreover, Petitioner exhibited flaws in the strength of her memory regarding the condition of the floor, because she could not recall the dates, or even provide a general timeframe, for the times that she told her supervisor the floors were sticky. When questioned on this point, Petitioner testified, "I don't have the date, I don't know what date it was. I know it was before I fell." (T.50). Petitioner testified it was some point prior to June 16, 2022, but she did not know the date. (T.50). However, Petitioner testified the

¹ The emergency room records from the accident date fail to attribute a sticky substance as the source of Petitioner's fall and instead state that Petitioner reported tripping over her "show," which appears to be a typographical error presumably intended to read "shoe."

floors were only sticky for three or four days after being cleaned and on the day she fell, the floors were only a “little sticky”.² (T.22).

The majority believes that LaDonna Miller, Petitioner’s supervisor, acknowledging a prior comment or comments by Petitioner regarding the floor being sticky after being professionally cleaned means the floors were also sticky at the time of Petitioner’s fall. This is inconsistent with the statements and testimony of the two independent witnesses who had first-hand knowledge of the condition of the floor. The fact that Petitioner could not recall when she made those statements, and LaDonna Miller’s inability to recall when the statement(s) were made, undermines Petitioner’s trial testimony that the floors were sticky at the time of her fall. Had that conversation occurred just prior to her fall, it would potentially support a temporal relationship between the condition of the floor and her fall. It is reasonable to assume based upon the inability of either Petitioner or her supervisor to recall when that conversation occurred, and Petitioner not testifying to hearing her shoes make any noise prior to the fall, that the floors were not professionally cleaned in the days prior to her fall. At best, Petitioner’s testimony only implies that the floors, if sticky, would only be sticky three or four days after being professionally cleaned and that the level of stickiness reduced each day and, therefore, had the condition existed, it was completely resolved prior to her fall. It is also important to note that LaDonna Miller testified any issue with the floor that may have existed was resolved prior to Petitioner’s fall.

Additionally, Petitioner failed to prove that her fall was caused by a substance on the floor that created a dangerous condition. Petitioner testified the floors were just “a little sticky”. (T.24). This is not a situation where a substance remained on the floor after being professionally cleaned that caused her to stick to the floor or her foot to come out of her shoe. She testified that she believed the floor was just “a little sticky”. If the floor was “a little sticky,” it means there was some minimal friction between her shoes and the surface of the floor. It is the absence of friction that causes one to slip. In order for the surface of a floor to be safe, some friction between the shoes and the surface of the floor is needed. In the case at bar, Petitioner failed to prove how the presence of some friction between her shoes and the surface of the floor which equates to “a little sticky” created a dangerous condition.

Based upon the credible testimony, Petitioner failed to establish the existence of a defect or dangerous condition which created an employment-related risk. Petitioner’s fall was either idiopathic and a personal risk or a neutral risk. Regardless of whether the fall was due to a personal risk or a neutral risk, Petitioner failed to prove the conditions necessary to make either risk compensable.

² Petitioner’s belief the floors were sticky after being professionally cleaned is nothing more than speculation because she believed the floors were sticky by the sound her shoes made walking on the floors but she did not testify to feeling or touching the floors.

22 WC 16721

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For these reasons, I dissent from the Decision of the majority and would have denied benefits due to Petitioner's failure to prove that she sustained a compensable fall arising out of and in the course of her employment with Respondent.

/s/ Frank J. Soto

Frank J. Soto

December 18, 2025

ILLINOIS WORKERS' COMPENSATION COMMISSION
DECISION SIGNATURE PAGE

Case Number	22WC016721
Case Name	Ruby Henderson v. TeeJet Technologies
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	16
Decision Issued By	Linda Cantrell, Arbitrator

Petitioner Attorney	Francis Lynch
Respondent Attorney	Frank Johnston

DATE FILED: 4/29/2024

/s/ Linda Cantrell, Arbitrator
Signature

THE INTEREST RATE FOR THE WEEK OF APRIL 23, 2024 5.16%

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**

Ruby Henderson

Employee/Petitioner

v.

TeeJet Technologies

Employer/Respondent

Case # **22** WC **016721**

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 **Linda J. Cantrell**, Arbitrator of the Commission, in the city of **Springfield**, on **February 26, 2024**. 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 **6/16/22**, 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 **\$27,726.37** in regular hours; the average weekly wage was **\$570.84**.

On the date of accident, Petitioner was **68** 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 **\$TBD and any and all paid** under Section 8(j) of the Act, pursuant to the stipulation of the parties.

ORDER

Respondent shall pay the medical bills outlined in Petitioner's Exhibit 3 pursuant to the medical fee schedule, as provided in Section 8(a) and Section 8.2 of the Act. Respondent shall pay directly to Petitioner out-of-pocket medical expenses in the amount of \$4,280.63. Pursuant to the stipulation of the parties, Respondent shall receive credit for any and all medical bills paid through its group medical plan under Section 8(j) of the Act. Respondent shall hold Petitioner harmless from any and all claims or liabilities made by the group medical plan to the extent of such 8(j) credit.

Respondent shall pay Petitioner temporary total disability benefits of **\$380.56/week** for **4-6/7** weeks, commencing **6/17/22** through **7/20/22**, under Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **\$342.50/week** for **53.25** weeks, because the injuries sustained caused permanent partial disability to the extent of **1%** loss of the person as a whole for injuries sustained to her left ribs and left cheek/face, as provided in Section 8(d)2 of the Act; **5%** loss of use of a right leg for a nondisplaced tibial plateau fracture, as provided in Section 8(e) of the Act; and **7.5%** loss of use of the person as a whole for mildly displaced left humeral neck and greater tuberosity fractures, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from **6/21/23** through **2/26/24**, 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.



Arbitrator Linda J. Cantrell

April 29, 2024

**ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION**

RUBY HENDERSON,)
)
Employee/Petitioner,)
)
v.) Case No.: 22-WC-016721
)
TEEJET TECHNOLOGIES,)
)
Employer/Respondent.)

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Springfield on February 26, 2024. On 6/28/22, Petitioner filed an Application for Adjustment of Claim alleging injuries to her left shoulder, left ribs, right knee, and left face/scar as a result of falling on a foreign substance on the floor on 6/16/22. (AX2) The parties stipulated that Respondent is entitled to a credit for any and all medical bills paid through its group medical plan, pursuant to Section 8(j) of the Act.

The issues in dispute are accident, average weekly wage, medical bills, temporary total disability benefits, and the nature and extent of Petitioner's injuries.

TESTIMONY

LaDonna Miller testified as an adverse witness for Petitioner. Ms. Miller is a supervisor on the production floor at Respondent's facility where they make and assemble electronic parts. Ms. Miller had an independent recollection of Petitioner's accident on 6/16/22. She testified that Petitioner was a good employee. Mr. Miller testified that Petitioner typically arrived to work and assembled her worktable a little earlier than her scheduled start time. She testified that after Petitioner worked for a couple of minutes she would get up and use the restroom. Ms. Miller agreed that Petitioner was allowed to use the restroom while she was working, and it was never a problem when she did.

Ms. Miller testified that the restroom was approximately 50 feet from Petitioner's workstation in the production room. She stated that Petitioner had to walk down a tiled hallway to access the restroom. Ms. Miller testified that she does not use the restroom that Petitioner attempted to use on 6/16/22 and she has no firsthand knowledge of the condition of the hallway. She testified that after Petitioner fell on 6/16/22 someone told her that the cleaning people had been there, and they thought there was something on the floor. Ms. Miller testified that she spoke

to an agent of the cleaning company after Petitioner fell who told her the problem had been resolved before Petitioner fell. She agreed there were occasions around the time Petitioner fell where the floor was sticky. Ms. Miller was not involved in having the floor cleaned or had any first hand knowledge of the condition of the floor. When asked if the problem with the floor appeared to have gone away after Petitioner fell, Ms. Miller replied, "Yes, I guess so. I don't go up there". Ms. Miller testified that Petitioner told her she was walking along and stumbled. On cross-examination, Ms. Miller testified that she did not have any specific recollection about the condition of floor where Petitioner fell on 6/16/22.

Petitioner testified that she has worked for Respondent for seven years. She testified that at the time of her accident she earned \$16.22 per hour and regularly worked 40 hours per week. She occasionally worked more than 40 hours per week but never less than 40 hours.

Petitioner testified that from her workstation in the production room she had to walk down a very short hall and turn left to walk down a 50-foot hallway to access the restroom. She stated the hallway floor is concrete covered with tiling. She testified that when she arrives at work she puts her personal items away, lays out the tools she needs on her worktable, and starts working. She testified that several days prior to 6/16/22 she noticed issues with the floor in the hallway and she spoke to LaDonna Miller about it. She stated that all of the employees talked about the condition of the hallway floor. Other than Ms. Miller, Petitioner did not speak to anyone in management about the floor.

Petitioner testified that the floors in the hallway and breakroom would get sticky after the cleaning company cleaned and polished them. She stated the floors would be sticky for 3 or 4 days after they were cleaned and became less sticky as they got dirty. Petitioner testified that she mentioned the condition of the floors to Ms. Miller prior to her fall.

Petitioner testified that she had to be very careful walking down the hallway because she could hear and feel the stickiness on the floor as she walked. She stated that on the day she fell there were no objects in the hallway such as a cleaning machine, vacuum, or cord.

Petitioner testified that on 6/16/22 she was walking down the hallway to go to the restroom. She testified that she was not required to ask permission to use the restroom and it was a privilege that she could exercise at her own free will. Petitioner testified that she walked halfway down the hallway and the floor was a little sticky. Her right foot stuck on a sticky spot and when she stepped forward with her left foot it hit the back of her right calf and knocked her off balance. Petitioner testified that had her right foot not stuck to the floor she would not have fallen. She fell to the ground on her left side and the air was knocked out of her. Petitioner stated she laid on the floor for a while and wondered when someone would come to her assistance. She estimated she laid on the floor for 10 to 15 minutes before a co-worker came looking for her. The co-worker left to get assistance and Mike Clark and John Lake came to the scene. Mr. Clark told Mr. Lake to call 911.

Petitioner testified that when Mr. Clark asked her what happened she was still in shock and trying to catch her breath. She stated that Mr. Lake also asked her what happened, and she

told him she tripped over her feet. Petitioner testified that what she reported to Mr. Lake was accurate, that her left foot hit the back of her right leg and she was thrown off balance.

Petitioner testified that the fire department arrived first, and they called an ambulance which took some time to arrive. Petitioner testified that she did not speak to anyone else at Respondent's facility about how the accident occurred prior to being transported to the emergency room. Petitioner testified that she provided the same history of injury to the emergency room personnel. Her arm was placed in a sling at the hospital, and she was discharged the same day. Petitioner was seen by Physician's Assistant Lauren Ray with the Springfield Clinic while in the hospital and she continued to treat with her after being discharged.

Petitioner testified that her son drove her back to the hospital for knee pain. She stated that her knee pain was minimal compared to the pain in her shoulder. She stated that her knee was skinned up from the fall and the ambulance personnel noted the marks on her knee. Petitioner treated with PA Ray for her knee injury. Petitioner broke ribs on her left side that she believed was caused by landing on top of her elbow. Petitioner testified that she sustained fractures in her arm, ribs, and knee. PA Ray placed her off work for six weeks and released her with light duty restrictions on 7/28/22. Respondent accommodated her light duty restrictions and provided her one-armed work. Petitioner received regular pay while working light duty.

Petitioner testified that she wore her arm brace for a period of time after returning to work and then stopped using it. She wore a knee brace for approximately three weeks and had pain when standing from a seated position. Petitioner wore a shoulder sling longer than the knee brace. She testified that prior to being released to light duty work her left arm was painful and she could not move it at all. Petitioner underwent physical therapy and was released to full duty in early winter of 2022. She testified that her symptoms gradually improved with physical therapy. She was released from treatment in the Spring of 2023.

Petitioner testified that she is 70 years old. She has an Associate's Degree in Secretarial Science but she did not work in that profession. She has never worked a secretarial position. Petitioner performed clerical work for Illinois Bell for 10 years, AT&T for over 14 years, and St. John's Hospital for over 17 years.

Petitioner testified that she still has pain in her left arm, and she cannot use her arm like she did prior to the accident. Petitioner testified that she has difficulty lifting and has lost strength in her arm. Her arm and shoulder get sore and fatigued while working. Her pain level is activity driven and she takes Ibuprofen occasionally. Petitioner cannot raise her left arm above a right angle since the accident. She cannot pull her car door closed with her left arm and has to reach across with her right arm. Petitioner is not able to reach behind her back. Her grandson has mowed her lawn for the past two years because she can no longer use a push mower. Petitioner testified that she can perform all of her job duties but it takes her longer. Petitioner was not examined by a physician at the request of Respondent.

On cross-examination, Petitioner testified that she had three conversations with Ms. Miller on different dates about the condition of the floor. Petitioner stated that the floor was

sticky on more than those three days. Prior to her accident, Petitioner commented to Ms. Miller that the floor was awfully sticky. The second time she spoke to Ms. Miller the floor was really bad, and Petitioner asked Ms. Miller if she wanted her to mop the floor. Petitioner stated that Ms. Miller told her she could mop if she wanted to, and Petitioner did mop the floor. Petitioner could not recall the dates those conversations occurred.

Petitioner testified that she did not always use the restroom after setting up her workstation at the start of her shift. On 6/16/22, Petitioner started working at 7:00 a.m. and spent 3 to 4 minutes setting up her workstation. She then walked to the restroom. She agreed that she told Mr. Lake and Mr. Clark that she tripped over her own feet. Petitioner clarified that she tripped over her feet because her foot stuck to the floor. She testified that she did not tell Mr. Lake or Mr. Clark that the floors were sticky before she went to the emergency room because she was in pain and trying to get herself together. She testified that she did tell the emergency room personnel that her foot stuck to the floor. She agreed that when she was released from treatment, she reported 0/10 pain and limited range of motion. Petitioner testified that she has health insurance through her employment with Respondent and it paid her medical bills.

John Lake testified on behalf of Respondent. Mr. Lake has been employed by Respondent for 30 years. He has worked as an engineering technician for 20 years and sets up the production tooling and equipment and keeps production running. Mr. Lake testified that he knew Petitioner from interacting with her on the production floor when she had a mechanical or production issue.

Mr. Lake testified that he arrived to work around 6:45 a.m. on 6/16/22. He typically goes directly to his office to review emails and prepare for the day. His office is located next to Mr. Clark's office. Mr. Lake testified that he was in his office when an employee named Jennifer came to Mr. Clark's office and told him that Petitioner fell and needed help. Jennifer asked Mr. Lake to assist as well. Mr. Lake and Mr. Clark walked 100 to 150 feet and found Petitioner laying on the floor. Petitioner told them she was hurting. Mr. Clark asked Petitioner what happened, and she said, "I think I tripped over my own feet". Mr. Lake stated Petitioner was wincing in pain, and she wanted him to help her up. Mr. Lake testified that they did not want to move her in case she broke something, and Mr. Clark called 911.

Mr. Lake agreed that he completed a witness report on 6/29/22. (RX1) He testified that the hallway looked normal to him, and nothing looked out of the ordinary when he assisted Petitioner. He did not notice any substances on the floor or that the floor was sticky. Mr. Lake identified photographs of the hallway where Petitioner fell. (RX4) He testified that the photos accurately depict the condition of the hallway on 6/16/22.

On cross-examination, Mr. Lake testified that he was asked to fill out a witness report by the HR department in Wheaton, Illinois. He testified that he did not know Petitioner filed a workers' compensation claim when he was asked to fill out the report. He agreed that he reported there were no obstructions or trip hazards with respect to Petitioner's accident. He testified that at the time he filled out his report he was not aware that Petitioner was claiming she fell due to the floor being sticky.

Mr. Lake was not aware that anyone spoke to Ms. Miller or the cleaning service about the floor being sticky. He testified that there are two men's restrooms and two women's restrooms at the facility. He testified that he uses whichever restroom is closest as he is all over the building throughout the day.

Michael Clark testified on behalf of Respondent. Mr. Clark has worked for Respondent for 29 years. He has worked as a production manager for 15 years. His job duties include scheduling orders and shipping dates and managing floor production. He has known Petitioner for 6 or 7 years as a production employee. He typically arrives at work around 6:50 a.m. and goes straight to his office. Mr. Clark testified that around 7:05 a.m. Jennifer Brayden came to his office and told him Petitioner fell. He immediately ran toward the accident location and Mr. Lake followed him. He stated his office was 75 to 100 feet from where Petitioner fell. He observed Petitioner laying on the floor and he asked her what happened. Petitioner told him she must have tripped or stumbled over her feet. He stated that Mr. Lake stayed with her while he went around the corner and called 911.

Mr. Clark filled out an accident reported approximately 30 minutes after emergency personnel took Petitioner to the hospital. (RX2) He testified that the form he filled out was a form regularly used to report accidents. He completed the report using his office computer and sent the report to HR in Wheaton. Mr. Clark testified that the photographs (RX4) accurately depict where he saw Petitioner laying on the floor and the condition of the floor. He testified that the hallway seemed fine to him, and he did not notice any sticky substance on the floor. Mr. Clark testified that they looked to make sure there was nothing there so nobody else would fall and they did not see anything. He testified that Petitioner never told him on 6/16/22 that the floor was sticky.

On cross-examination, Mr. Clark testified that he was not aware that Petitioner made reports to Ms. Miller about the condition of the floor. He never spoke to Ms. Miller about who may have told her about the floor. He was not aware that the floor was occasionally sticky before Petitioner fell. He testified that the floor could have been sticky and he was not aware of it. Mr. Clark had no explanation for why Mr. Lake filled out a different style form than the one he filled out. He was not sure if he ever saw the form that Mr. Lake completed. On re-direct examination, Mr. Clark testified that he knelt down on one knee while assisting Petitioner and he did not notice the floor was sticky.

MEDICAL HISTORY/ACCIDENT REPORTS

On 6/16/22, at 7:10 a.m., Mike Clark completed an Injury/Illness Log Sheet. (RX2) Mr. Clark reported that Petitioner told him she tripped over her feet while walking towards the bathroom. She complained of pain in her left shoulder and side. They told Petitioner to stay still until paramedics took her to the hospital. Petitioner was awake and aware during the whole incident. He would have Petitioner fill out an accident report when she returned to work.

Petitioner presented to the emergency room at Springfield Memorial Hospital via ambulance. (PX1) It was noted that Petitioner presented after a ground level mechanical fall where she tripped over her shoe causing her to fall onto her left side. Petitioner complained of

pain in her left shoulder, left lateral chest wall, and left ribs. X-rays revealed acute fractures of the surgical neck and greater tuberosity of the left humerus without any significant displacement or distension, and no obvious left rib fractures or deformities. (PX1, p. 13) Petitioner was provided pain medication and her arm was placed in a sling. She was discharged with instructions to follow up with her primary care physician and prescribed Hydrocodone.

On 6/20/22, Petitioner was examined by PA Lauren Ray in the orthopedics department of Memorial Health for left shoulder pain that radiated to her biceps and chest, left rib pain, and right knee pain. (PX2, p. 69, 78) It was noted that Petitioner fell onto concrete on 6/16/22. PA Ray noted Petitioner was wearing a left arm sling and not using her arm. Petitioner had left rib pain with deep inspiration and shortness of breath. Petitioner's right knee pain was tolerable, and she could put full weight on it. X-rays were performed that day that revealed no displaced rib fractures and mildly displaced left humeral surgical neck and greater tuberosity fractures. (PX2, p. 59) PA Ray recommended removal of the sling three times a day to perform elbow extensions. She prescribed Norco and placed Petitioner off work.

On 6/22/22, Petitioner presented to Memorial Health for follow up of chest x-ray results and pain in her left ribs and the left side of her face. It was noted her left cheek was still bruised and facial x-rays had not been completed. (PX5, p. 10) Petitioner reported the floor at work was sticky and she got tripped up and her foot stopped causing her to fall off balance. She tried to regain her balance but fell face first onto her left arm, chest, and head. Petitioner complained of pain in her left face, shoulder, ribs, and right knee. She had knee pain with getting up from a seated position and full weight bearing. A small abrasion on her right knee was noted.

On 6/28/22, Petitioner underwent x-rays of her facial bones for left facial pain and bruising after a fall "2010" days ago. (PX3, p. 5) No fractures were identified. Petitioner underwent x-rays of her right knee for pain after a fall 6 days ago. She had pain under the medial patella. Small joint effusion was noted with subtle lucency in the tibial plateau suggesting a nondisplaced fracture. Mild degenerative arthrosis and vascular calcifications were present. A CT scan was recommended. (PX3, p. 6)

On 6/29/22, John Lake prepared a Witness Report. (RX1) Mr. Lake reported that an employee came and said Petitioner had fallen. They found Petitioner laying face down in the hall moaning but coherent. They told her to lie still, and Mike Clark called 911. Mr. Lake reported that Petitioner stated she tripped over her own feet. Petitioner complained of shoulder and knee pain. In response to "What were the environmental conditions at the accident site?", Mr. Lake replied, "No visible obstructions or trip hazards that I saw".

On 7/6/22, Petitioner returned to the Springfield Clinic and reported she had been wearing her left arm sling and her pain was significantly improving. (PX2, p. 65) Petitioner reported she occasionally took Norco for pain. She stated that her ribs and pulmonary issues were also improving. Physical examination revealed Petitioner could perform gentle passive range of motion of the left shoulder with resolving ecchymosis. No edema was noted and sensation was intact. X-rays performed that day revealed increased healing and callous formation of the humerus fractures with unchanged alignment. (PX2, p. 58, 66) PA Ray ordered Petitioner to continue wearing the left arm sling and perform pendulum exercises and range of motion

exercises of the wrist and elbow. Petitioner was continued off work. A Sick Pay Benefit Application was completed that day by Dr. Matthew Gardner who noted Petitioner had a closed left proximal humerus fracture, multiple rib fractures, and a closed fracture of the right tibial plateau. (PX2, p. 83) He indicated that Petitioner would be off work for 8 to 12 weeks.

On 7/20/22, PA Ray noted Petitioner was limiting weightbearing with her left arm at less than 5 pounds. Petitioner was continuing to wear her sling and perform home exercises. She declined formal physical therapy. PA Ray allowed Petitioner to return to work with a 5-pound weight restriction of the left upper extremity. (PX2, p. 119)

On 8/17/22, PA Ray referred Petitioner to physical therapy. (PX2, p. 113) She noted Petitioner was weightbearing as tolerated with her left arm and had some stiffness in her shoulder. Petitioner reported some twinges in her shoulder but no pain. PA Ray noted Petitioner still had pain and tenderness in her left cheek and her primary care physician ordered facial bone x-rays to rule out fracture.

On 9/28/22, Petitioner reported 2/10 pain in the lateral aspect of her shoulder and twinges with range of motion. (PX2, p. 109) PA Ray noted Petitioner had completed two weeks of physical therapy. Her restrictions were modified to 10-pounds lifting.

On 10/26/22, Petitioner reported great improvement with physical therapy. (PX2, p. 105) She was not able to reach her back pocket or put her bra on due to limited range of motion. Her light duty work restrictions were continued.

On 12/7/22, Petitioner reported her symptoms varied between the anterior lateral aspect of her shoulder to the posterolateral aspect. She rated her pain 1/10 and was continuing physical therapy. PA Ray ordered Petitioner to work full duty 4 hours per day and work with a 10-pound restriction the remaining 4 hours.

On 1/18/23, PA Ray noted Petitioner's physical therapy had decreased in frequency. (PX2, p. 97) Petitioner had limitations mostly with internal rotation. She had extreme difficulty putting on her bra and reaching behind her. PA Ray released Petitioner to full duty work and ordered her to complete physical therapy.

On 4/19/23, Petitioner reported she recently completed physical therapy and she had not regained full range of motion. She was not able to reach her back pocket and had some stiffness and pain in the anterior aspect of her shoulder. Petitioner reported difficulty pulling her car door shut with her left arm and she used her right arm to do so. PA Ray ordered Petitioner to continue home exercises and to follow up in two months.

On 6/21/23, PA Ray noted Petitioner continued to have difficulty with certain tasks at work. She rated her pain 0/10. Petitioner was released at MMI and ordered to weight bear with her left arm as tolerated.

CONCLUSIONS OF LAW

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

Petitioner bears the burden of proving every element of her case by a preponderance of the evidence. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). To meet her burden of proving her injury was the result of a compensable accident, Petitioner must show by a preponderance of the evidence that she sustained a disabling injury which arose out of and in the course of her employment. *Sisbro*, 207 Ill. 2d at 203. The phrase “in the course of employment” refers to the time, place, and circumstances surrounding the injury. *Id.* It is undisputed that Petitioner’s injuries occurred in the course of her employment.

To satisfy the “arising out of” prong of the analysis, Petitioner must show that her injury “had its origin in some risk connected with, or incidental to, the employment.” *Id.* A risk is incidental to the employment “...when it belongs to or is connected with what the employee has to do in fulfilling his or her job duties.” *McAllister v. Ill. Workers’ Comp. Comm’n*, 2020 IL 124848, ¶36. Illinois courts recognize the following three categories of risks: “1) risks distinctly associated with the employment; 2) risks personal to the employee; and 3) neutral risks which have no particular employment or personal characteristics.” *Id.* at ¶38 (citations omitted).

Courts have consistently reasoned that a neutral risk analysis is unnecessary when the injury is the direct result of a hazardous condition on the employer's premises. Instead, courts have deemed injuries resulting from a hazardous condition or defect on the employer's premises to be “risks distinctly associated with the employment.” *See, Dukich*, 2017 IL App (2d) 160351WC at ¶40. Quintessential examples of risks distinctly associated with the employment include “tripping on a defect at the employer’s premises, falling on uneven or slippery ground at the work site, or performing some work-related task which contributes to the risk of falling.” *Id.* at ¶39 (citations omitted).

After considering the credible evidence, the Arbitrator finds that Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent on 6/16/22. The Arbitrator finds that Petitioner’s injury was due to the presence of a defect, or hazardous condition, on Respondent’s premises.

Petitioner credibly testified that the tile floors in the hallway and breakroom would get sticky after the cleaning company cleaned and polished them. She stated the floors would be sticky for 3 or 4 days after they were cleaned and became less sticky as they got dirty. Petitioner testified that she mentioned the condition of the floors to her supervisor LaDonna Miller a few times prior to her accident. On one occasion she told Ms. Miller the floor was “really bad”, and she asked Ms. Miller if she wanted her to mop. Petitioner testified that Ms. Miller told her she could mop if she wanted to, and Petitioner did mop the floor.

Ms. Miller denied having any conversations with Petitioner about the condition of the floors; however, she agreed there were occasions around the time Petitioner fell where the floor was sticky. She testified that after Petitioner fell on 6/16/22 someone told her that the cleaning

people had been there, and they thought there was something on the floor. Ms. Miller stated she spoke to an agent of the cleaning company after Petitioner fell who told her the problem had been resolved before Petitioner fell. Ms. Miller testified that she was not involved in having the floor cleaned and she had no firsthand knowledge of the condition of the floor. When asked if the problem with the floor appeared to have gone away after Petitioner fell, Ms. Miller replied, "Yes, I guess so. I don't go up there". Ms. Miller admitted that she does not use the restroom that Petitioner attempted to use on 6/16/22 and again stated she did not have any specific recollection about the condition of floor where Petitioner fell.

Petitioner credibly testified that the floor was sticky when she fell on 6/16/22. Her right foot stuck on a sticky spot and as she stepped forward with her left foot it hit the back of her right calf and knocked her off balance. Petitioner testified that she would not have fallen had her right foot not stuck to the floor. The Production Manager, Michael Clark, came to Petitioner's aid and observed Petitioner laying on the floor. He testified that Petitioner told him that she must have tripped or stumbled over her feet. He testified that Petitioner never told him on 6/16/22 that the floor was sticky. Petitioner testified that she was still in shock and trying to catch her breath when she spoke to Mr. Clark and Mr. Lake about her fall. She agreed that she did not tell them about the floor being sticky before she was taken to the hospital. The Engineering Technician, John Lake, confirmed that Petitioner was lying face down in the hallway when he came to her aid, and she was wincing in pain but coherent.

On 6/22/23, Petitioner presented to Memorial Health for follow up of the emergency room visit. Petitioner reported the floor at work was sticky and she got tripped up and her foot stopped causing her to fall off balance. She tried to regain her balance but fell onto her left side face first on her arm, chest, and head. On 6/28/22, Petitioner filed an Application for Adjustment of Claim alleging she sustained injuries as a result of falling on a foreign substance on the floor. On 6/29/22, John Lake prepared a Witness Report and reported Petitioner tripped over her own feet, and there were, "No visible obstructions or trip hazards that I saw". The Arbitrator does not find Mr. Lake's testimony credible that he was not aware Petitioner was claiming she fell due to the floor being sticky when he filled out his report, particularly given the language included in his report regarding hazards. Further, Mr. Lake was ordered to fill out the Witness Report by human resources the day after Petitioner filed the Application alleging a substance was on the floor.

Mr. Clark filled out an injury report within 30 minutes of Petitioner leaving the facility in an ambulance. His report did not include any information regarding the condition of the floor despite his testimony that he looked to make sure there was nothing on the floor so nobody else would fall. He testified that the floor could have been sticky before Petitioner's accident, and he was not aware of it.

Based on the evidence as a whole, the Arbitrator finds that Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent on 6/16/22.

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

Petitioner alleged that her earnings during the year preceding the injury were \$33,737.60, resulting in an average weekly wage of \$648.80. Respondent alleges an average weekly wage of \$570.84. Petitioner testified that at the time of her accident she earned \$16.22 per hour and regularly worked 40 hours per week.

Petitioner's wage records were admitted into evidence. (RX3) There was no testimony regarding the wage records. Petitioner was paid on a bi-weekly basis and earned \$27,726.37 in regular hours worked for pay periods 6/18/21 through 6/3/22, representing 26 payments. The parties do not dispute that Petitioner's overtime pay shall be excluded from the calculation of her average weekly wage. Petitioner alleges an average weekly wage based on her testimony that she earned \$16.22 per hour at the time of accident at 40 hours per week, resulting in an AWW of \$648.80. The record does not reflect that Petitioner earned \$16.22 per hour at the time of accident, but that she earned \$15.30 per hour.

The Arbitrator finds that Petitioner lost five or more calendar days of work during the 52-week period prior to her accident. Therefore, the Arbitrator finds that the appropriate method of calculating Petitioner's average weekly wage is by dividing the total gross earnings, excluding overtime wages and "other earnings", by the number of weeks and parts thereof. *Sylvester v. Industrial Comm'n.*, 314 Ill.App. 3d 1100 (2000). Petitioner worked 48-4/7 weeks for which she earned \$27,726.37 in regular hours, resulting in an average weekly wage of \$570.84.

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 did not dispute that Petitioner's current condition of ill-being was causally connected to the injury. Based upon the above finding as to accident, the Arbitrator finds that Petitioner is entitled to reasonable and necessary medical care and expenses. Respondent shall therefore pay the medical expenses outlined in Petitioner's Exhibit 3 pursuant to the medical fee schedule, as provided in Section 8(a) and Section 8.2 of the Act. Respondent shall pay directly to Petitioner out-of-pocket medical expenses in the amount of \$4,280.63. Petitioner testified that her group health insurer through her employment with Respondent paid her medical bills. Pursuant to the stipulation of the parties, Respondent shall receive credit for any and all medical bills paid through its group medical plan under Section 8(j) of the Act. Respondent shall hold Petitioner harmless from any and all claims or liabilities made by the group medical plan to the extent of such 8(j) credit.

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

Petitioner claims entitlement to temporary total disability benefits from 6/17/22 through 7/28/22. Petitioner testified that she was released with light duty restrictions on 7/28/22 and Respondent accommodated her one-armed restrictions. The medical records reflect that Petitioner was placed off work following the accident until PA Ray released her to return to work

with a 5-pound weight restriction of the left upper extremity on 7/20/22. There was no testimony as to what date Petitioner returned to light duty work.

Therefore, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits for the period 6/17/22 through 7/20/22, representing 4-6/7th weeks, at the TTD rate of \$380.56.

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 impairment rating. Therefore, the Arbitrator places no weight on this factor.
- (ii) **Occupation:** Petitioner was released at MMI on 6/21/23 and ordered to weight bear with her left arm as tolerated. She was not placed on permanent or specific restrictions upon release. Petitioner returned to her pre-accident position for Respondent assembling electronic parts in the production department. She testified that her arm and shoulder get sore and fatigued while working. The Arbitrator places some weight on this factor.
- (iii) **Age:** Petitioner was 68 years old at the time of accident and 70 years old at the time of arbitration. The Arbitrator places some weight on this factor.
- (iv) **Earning Capacity:** There is no evidence of reduced earning capacity contained in the record. Petitioner returned to full duty work without restrictions for Respondent and continues to work in her pre-accident position. The Arbitrator places some weight on this factor.
- (v) **Disability:** As a result of the accident, Petitioner sustained mildly displaced left humeral neck and greater tuberosity fractures. She underwent conservative treatment, including medications, activity modifications, a sling, and seven months of physical therapy. On 4/19/23, Petitioner reported that she continued to have stiffness and decreased range of motion and she was not able to reach her back pocket. She had pain in the anterior aspect of her shoulder. Petitioner was released at MMI on 6/21/23, at which time she reported difficulty with certain tasks at work. She rated her pain 0/10. Petitioner was not placed on specific restrictions but was ordered to weight bear with her left arm as tolerated.

Petitioner complained of persistent left rib pain following the accident. Although Petitioner was diagnosed with multiple left rib fractures, x-rays revealed no displaced rib fractures. On 7/6/22, Petitioner reported that her ribs and pulmonary issues were improving. There is no mention of Petitioner's rib symptoms following that visit.

Petitioner sustained contusions to her left cheek/face. On 6/28/22, Petitioner underwent x-rays of her facial bones that revealed no fractures. X-rays of Petitioner's right knee were also performed that day that revealed a small joint effusion with subtle lucency in the tibial plateau suggesting a nondisplaced fracture. There was no evidence that the recommended CT scan was performed or that Petitioner received additional treatment regarding her right knee. Petitioner testified that she wore a knee brace for approximately three weeks and had pain when standing from a seated position. Petitioner did not testify that she has any persistent symptoms in her left ribs, left cheek/face, or right knee.

Petitioner testified that she still has pain in her left arm, and she cannot use her arm like she did prior to the accident. Petitioner testified that she has difficulty lifting and has lost strength in her arm. Her arm and shoulder get sore and fatigued while working. Petitioner agreed that she can perform all of her job duties, but it takes her longer. Her pain level is activity driven and she takes Ibuprofen occasionally. Petitioner cannot raise her left arm above a right angle since the accident. She cannot pull her car door closed with her left arm and reaches across with her right arm to do so, which is consistent with what she reported to PA Ray on 4/19/23. Petitioner is not able to reach behind her back. She depends on her son and grandson to mow her lawn. The Arbitrator places greater weight on this factor.

Based upon the foregoing evidence and factors, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 1% loss of the person as a whole for injuries sustained to her left ribs and left cheek/face, as provided in Section 8(d)2 of the Act; 5% loss of use of a right leg for a nondisplaced tibial plateau fracture, as provided in Section 8(e) of the Act; and 7.5% loss of use of the person as a whole for mildly displaced left humeral neck and greater tuberosity fractures, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from 6/21/23 through 2/26/24, and shall pay the remainder of the award, if any, in weekly payments.



Arbitrator Linda J. Cantrell

April 29, 2024
DATE

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC020019
Case Name	INSURANCE COMPLIANCE v. BALTIC LINES II INC.
Consolidated Cases	
Proceeding Type	
Decision Type	Commission Decision
Commission Decision Number	25IWCC0497
Number of Pages of Decision	8
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Chase Riddle
Respondent Attorney	

DATE FILED: 12/18/2025

/s/Marc Parker, Commissioner

Signature

STATE OF ILLINOIS)
)
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Illinois Department of Insurance,	)	
Insurance Compliance Department,	)	
	)	
Petitioner,	)	
	)	
v.	)	20 WC 020019,
	)	17 INC 518
Baltic Lines II, Inc.; and Angele	)	
Ramute Simkiene and Asta	)	
Pasakinskiene, individually and as	)	
officers and agents of Baltic Lines II, Inc.	)	
	)	
Employers/Respondents.	)	

DECISION AND OPINION REGARDING INSURANCE COMPLIANCE

Petitioner, the Illinois Department of Insurance, Insurance Compliance Department, brings this action by and through the Office of the Illinois Attorney General, against the above captioned Respondents alleging they violated Section 4(a) of the Illinois Workers' Compensation Act by failing to procure mandatory workers' compensation insurance. Petitioner alleges that Respondents knowingly and willfully lacked workers' compensation insurance for 1,592 days. A hearing was held before Commissioner Marc Parker in Chicago, Illinois on September 24, 2025. Proper and timely notice was provided to Respondents (*Px1*). Petitioner was represented by the Office of the Attorney General. Respondents did not appear in person or through counsel. A record was taken.

Petitioner seeks the maximum penalty allowed under the Act, \$500.00 per day for each of the 1,592 days, from October 29, 2014, to March 8, 2019, when Respondents did business and failed to provide coverage for their employees, for a total of \$796,000.00. Petitioner also seeks reimbursement for payments which the Injured Workers Benefit Fund (hereinafter, "IWBF") has made to representatives of Respondents' employee's dependent children. In case number 17 WC 026533, the IWBF paid \$151,000.32. In case number 17 WC 027450, the IWBF paid \$151,000.32. Petitioner, therefore, seeks a total award of \$1,098,000.64 from Respondents.

The Commission, after considering the record in its entirety and being advised of the applicable law, finds that Respondents knowingly and willfully violated Section 4(a) of the Act and Section 9100.100 of the Rules Governing Practice before the Illinois Workers' Compensation Commission ("Rules") during the period in question. As a result, Respondents shall be held liable

for non-compliance with the Act and shall pay a penalty in accordance with Section 4(d) of the Act. For the following reasons, the Commission assesses a civil penalty against the Respondents under Section 4 of the Act in the sum of \$796,000.00, and orders Respondents to reimburse the Injured Workers' Benefit Fund in the amount of \$302,000.64, for a total award of \$1,098,000.64.

I. Findings of Fact

On August 19, 2025, a Notice of Insurance Compliance Hearing was sent to Respondents, Angele Ramute Simkiene at 10526 South 83rd Avenue, Palos Hills, IL 60465; Asta Pasakinskiene at 1692 Williams Drive, Romeville, IL 60446; and Baltic Lines II, Inc., at the addresses listed for the individual Respondents (*Px1*). The Notice of Insurance Compliance Hearing notified Respondents of a hearing to be held on September 24, 2025.

On October 29, 2020, Investigator Lolita Parham attempted personal service on Respondent, Asta Pasakinskiene, at 1692 Williams Drive, Romeville, IL 60446, which was believed to be her personal residence (*Px2*).

On November 4, 2020, Investigator Lolita Parham attempted personal service on Respondent, Angele Ramute Simkiene, at 8031 Janes Avenue, Apt #F, Woodridge, Illinois 60517, which was believed to be her personal residence (*Px2*).

In February of 2022, Investigator Edward McMahon attempted personal service on Respondent, Angele Ramute Simkiene, at 8031 Janes Avenue, Apt #F, Woodridge, Illinois, which was believed to be her personal residence. The Notice of Insurance Compliance Hearing which was contained therein informed Respondents of a hearing to be held on March 14, 2022 (*Px2*).

On February 21, 2025, the Office of the Illinois Attorney General served Baltic Lines II, Inc. through an affidavit of compliance for service on the Secretary of State of Illinois (*Px3*). The Notice of Insurance Compliance, contained in that exhibit, informed Baltic Lines II, Inc. and its agents, Angele Ramute Simkiene and Asta Pasakinskiene, of the Insurance Compliance Hearing to be held on March 24, 2025.

Antonio Smith, an Investigator working for the Illinois Department of Insurance, Insurance Compliance Department, testified at the hearing, and identified Petitioner's Exhibit 4 as a Notice of Non-Compliance mailed to Angele Ramute Simkiene at 10526 South 83rd Avenue, Palos Hills, IL 60465, both individually and as president and secretary of Baltic Lines II, Inc. The notice states that the Commission's records indicated that Baltic Lines II, Inc. and Angele Ramute Simkiene were not in compliance with the requirements of Section 4(a) for the period from October 29, 2014, to October 11, 2017, and any other periods that the employer operated in violation of the Act. The notice includes an affidavit indicating service by mail on November 20, 2017.

Investigator Smith identified Petitioner's Exhibit 5 as a notice to Baltic Lines II, Inc. of an informal conference regarding insurance compliance mailed to Angele Ramute Simkiene, individually and as president and secretary of Baltic Lines II, Inc. In the Notice, the Commission indicated that Baltic Lines II, Inc. and Angele Ramute Simkiene were not in compliance with the

requirements of Section 4 for the period from October 29, 2014, to October 11, 2017. The notice contains an affidavit of service by mail on November 20, 2017.

Investigator Smith identified Petitioner's Exhibit 6 as a Business Entity Search for Baltic Lines II, Inc., through the Illinois Secretary of State. The search results contained both the incorporation date of October 29, 2014, and the date of dissolution of March 8, 2019. The search results also listed Angele Ramute Simkiene as the registered agent and President.

Investigator Smith testified that in the regular course of their investigation, investigators request documents from the Illinois Secretary of State to facilitate the insurance compliance investigations. Investigator Smith identified Petitioner's Exhibit 7 as a report received in response to such a request. The report contained a Statement of Change of Registered Agent, dated December 14, 2015. This Statement named Asta Pasakinskiene as the registered agent for Baltic Lines II, Inc. and was signed by Asta Pasakinskiene as President of Baltic Lines, Inc. The report also contained a second Statement of Change of Registered Agent dated August 26, 2017, which named Angele Ramute Simkiene as the registered agent for Baltic Lines II, Inc. and was signed by Asta Pasakinskiene as President of Baltic Lines, Inc. The report contained an Annual Report for Baltic Lines II, Inc., filed August 26, 2017, which named Angele Ramute Simkiene as the President, Secretary, and Director for Baltic Lines II, Inc. and was signed by Asta Pasakinskiene as President of Baltic Lines, Inc. The report contained a Certificate of Dissolution dissolving Baltic Lines II, Inc. on March 8, 2019.

Investigator Smith testified that, based on his investigation, Baltic Lines II, Inc. was a trucking company in the business of moving products by land. He further testified that Petitioner requested information from the National Council of Compensation Insurance (NCCI) regarding Baltic Lines II, Inc. (Px8). The NCCI certified that it is the agent designated by the Commission for the purpose of collecting proof of insurance coverage information on Illinois employers; and further, that Baltic Lines II, Inc. did not file policy information showing proof of workers' compensation insurance at any time from October 29, 2014, to March 18, 2019.

Investigator Smith further testified that Petitioner's Exhibit 9 was a finding from the Workers' Compensation Commission's Office of Self-Insurance Administration, and was the type of document requested in the ordinary course of Petitioner's investigations. The document certifies that no certificate of approval to self-insure was issued to Baltic Lines II, Inc. from October 29, 2014, to October 11, 2017.

Petitioner's Exhibit 10 was the Arbitration Decision in case 17 WC 026533, Child of Kijuan Cosey (Deceased), Kathlyne Pach, mother of Kijuan Pach, v. Baltic Lines II, Inc. and Michael Frerichs, State Treasurer and *Ex-Officio* Custodian of the Injured Workers Benefit Fund. A hearing was held on August 8, 2023, and Respondent did not appear. The Arbitrator issued a decision on October 5, 2023, in which she found that Baltic Lines II, Inc. was operating under the Act as employer to the deceased individual, Kijuan Cosey, on August 14, 2017, when Cosey was involved in a motor vehicle accident. The Arbitrator found that the petitioner described work which brought respondent Baltic Lines II, Inc., within the automatic coverage of Section 3(15) of the Act. The Arbitrator further found that respondent Baltic Lines II, Inc., was uninsured on the accident date. The Arbitrator awarded the petitioner death benefits and burial expenses against both named

respondents. The Arbitrator expressly indicated that the IWBF is entitled to reimbursement of any compensation which it paid to the petitioner in that case.

Petitioner's Exhibit 11 was the Arbitration Decision in case 17 WC 027450, Jeanette Sepulveda, mother of Kenneth Cosey, Child of Kijuan Cosey, (deceased), v. Baltic Lines II, Inc. and Michael Frerichs, State Treasurer and *Ex-Officio* Custodian of the Injured Workers Benefit Fund. A hearing was held on August 8, 2023, and Respondent did not appear. The Arbitrator issued a decision on October 5, 2023, in which she found that Baltic Lines II, Inc. was operating under the Act as employer to the deceased individual, Kijuan Cosey, on August 14, 2017, when Cosey was involved in a motor vehicle accident. The Arbitrator found that the petitioner described work which brought respondent, Baltic Lines II, Inc., within the automatic coverage of Section 3(15) of the Act. The Arbitrator further found that the respondent, Baltic Lines II, Inc., was uninsured on the accident date. The Arbitrator awarded the petitioner death benefits and burial expenses against both named respondents. The Arbitrator expressly indicated that the IWBF is entitled to reimbursement of any compensation which it paid to the petitioner in that case.

Petitioner's Exhibits 12 and 13 were the checks tendered to the petitioners in the aforesaid cases. The IWBF paid \$151,000.32 to Kathlyne Pach as compensation in case number 17 WC 026533, and \$151,000.32 to Jeanette Sepulveda as compensation in case number 17 WC 027450.

Investigator Smith further testified that in the regular course of his investigation, Petitioner requested information regarding Baltic Lines II, Inc. from the Illinois Department of Revenue. Petitioner submitted Petitioner's Exhibit 14, the response from the Illinois Department of Revenue, which indicated that the Department of Revenue did not receive any tax returns from Baltic Lines II, Inc. for the years 2014 through 2017.

Investigator Smith further testified that Petitioner's Exhibit 15 contained certified records from the Illinois Department of Employment Security of Baltic Lines II, Inc.'s Quarterly Wage Reports from the first quarter of 2015 through the second quarter of 2017. These records do not name the deceased employee from cases 17 WC 026533 and 17 WC 027450.

Investigator Smith testified that based upon his investigation, Petitioner determined that Respondent did not have workers' compensation insurance for the period for which it now requests relief: October 29, 2014 to March 8, 2019.

II. Conclusions of Law

The Commission first considers whether Respondents are subject to the Act. Pursuant to Section 3 of the Act, certain employers and their employees are automatically subject to the provisions of the Act if they are engaged in the "[c]arriage by land, water or aerial service and loading or unloading in connection therewith[.]" 820 ILCS 305/3(3). Employers engaging in "business or enterprise in which electric, gasoline or other power driven equipment is used in the operation thereof" are also automatically subject to the provisions of the Act, as concluded by the Arbitrator in cases numbered 17WC026533 and 17WC027450.

The Commission finds that Respondents' business falls within subsections 3(3) and 3(15) of the Act. This finding is based on Antonio Smith's testimony that Respondents are a trucking company, as well as the decision in the IWBF cases, 17 WC 026533 and 17 WC 027450. Accordingly, the Commission finds that the work Respondents engaged in automatically subjected them to the provisions of the Illinois Workers' Compensation Act.

Pursuant to Section 4(a) of the Act, all employers who come within the auspices of the Act are required to provide workers' compensation insurance. See 820 ILCS 305/4(a). Section 9100.90(a) of our Rules similarly provides that any employer subject to Section 3 of the Act shall insure payment of compensation required by Section 4(a) of the Act, "by obtaining approval from the Commission to operate as a self-insurer or by insuring its entire liability to pay the compensation in some insurance carrier authorized, licensed or permitted to do such insurance business in Illinois." 50 Ill. Adm. Code 9100.90(a) (1986). Section 9100.90(d)(3)(E) of our Rules similarly provides that a certification from a Commission employee, "that an employer has not been certified as a self-insurer shall be deemed prima facie evidence of that fact." 50 Ill. Adm. Code 9100.90(d)(3)(D) (1986). Section 9100.90(d)(3)(D) of our Rules provides that, "[a] certification from an employee of the National Council on Compensation Insurance stating that no policy information page has been filed in accordance with Section 9100.20 shall be deemed prima facie evidence of that fact." 50 Ill. Adm. Code 9100.90(d)(3)(D) (1986). Section 4 of the Act requires that all employers of at least one employee who come within the provisions of Section 3 of the Act, and any other employer who shall elect coverage under Section 2 of the Act, provide workers' compensation insurance for the protection of their employees. 820 ILCS 305/4.

In this case, Petitioner submitted a certified finding from the Department of Self-Insurance that no certificate of approval to self-insure was issued to Baltic Lines II, Inc. from October 29, 2014, to March 8, 2019.

Petitioner also submitted the NCCI certification that Baltic Lines II, Inc. did not file policy information showing proof of workers' compensation insurance at any time from October 29, 2014, to March 8, 2019.

Investigator Smith testified that based upon his investigation, Petitioner determined that Respondents did not provide workers' compensation insurance for the period for which it requested relief, from October 29, 2014, to March 8, 2019.

Baltic Lines II, Inc. was also a named respondent in cases numbered 17 WC 026533 and 17 WC 027450, in which decisions were entered on October 5, 2023. The Arbitrator found that Baltic Lines II, Inc. was operating under the Act as employer to the deceased employee, that the employee's described work brought the respondent, Baltic Lines II, Inc., within the automatic coverage of Section 3 of the Act, and that the Baltic Lines II, Inc. was uninsured on the accident date. The Arbitrator awarded the petitioners death benefits and burial expenses. The IWBF has made a payment to each petitioner in these cases in the amount of \$151,000.32, for a total of \$302,000.64.

Respondents did not attend the hearing and thus presented no evidence indicating that they had secured workers' compensation insurance coverage of any kind during this period.

Accordingly, the Commission concludes that Petitioner has proved that Respondents failed to comply with the legal obligations imposed by Section 4(a) of the Act from October 29, 2014, to March 8, 2019.

Regarding the issue of penalties for failure to maintain workers' compensation insurance coverage, Section 4(d) of the Act states:

Upon a finding by the Commission, after reasonable notice and hearing, of the knowing and willful failure or refusal of an employer to comply with any of the provisions of paragraph (a) of this Section ***, the Commission may assess a civil penalty of up to \$500 per day for each day of such failure or refusal after the effective date of this amendatory Act of 1989. The minimum penalty under this Section shall be the sum of \$10,000. Each day of such failure or refusal shall constitute a separate offense. The Commission may assess the civil penalty personally and individually against the corporate officers and directors of a corporate employer, the partners of an employer partnership, and the members of an employer limited liability company, after a finding of a knowing and willful refusal or failure of each such named corporate officer, director, partner, or member to comply with this Section. The liability for the assessed penalty shall be against the named employer first, and if the named employer refuses to pay the penalty to the Commission within 30 days after the final order of the Commission, then the named corporate officers, directors, partners, or members who have been found to have knowingly and willfully refused or failed to comply with this Section shall be liable for the unpaid penalty or any unpaid portion of the penalty.

820 ILCS 305/4(d) ¶ 9.

Section 9100.90(b) of the Rules similarly provides that penalties may be assessed for non-compliance after reasonable notice and a hearing. 50 Ill. Adm. Code 9100.90(b) (1986). Section 9100.90(c) of the Rules describes the proper notice of non-compliance to be served upon the employer and provides that the employer may request an informal conference to resolve the matter. 50 Ill. Adm. Code 9100.90(c) (1986). Section 9100.90(d) of the Rules describes the manner of notice and service for an insurance compliance hearing and the procedure for conducting the hearing. 50 Ill. Adm. Code 9100.90(d) (1986).

In this case, Petitioner submitted into evidence the Notice of Non-Compliance mailed to Angele Ramute Simkiene and Asta Pasakinskiene, individually and as officer/agent of Baltic Lines II, Inc. in the form prescribed by our Rules and including an affidavit of service. Petitioner also submitted the notices for the insurance compliance hearing scheduled for September 24, 2025, in the form prescribed by our Rules, via certified mail to the last known addresses of Baltic Lines, II, Inc. and its agents, Asta Pasakinskiene and Angele Ramute Simkiene. The insurance compliance hearing allowed the Department of Insurance to introduce evidence and testimony and afforded Respondents the opportunity to do the same, had they chosen to attend personally or through counsel. Accordingly, the Commission concludes that reasonable and proper notice of hearing was provided to Respondents.

On the merits, the Commission has considered the following factors in assessing penalties against an uninsured employer: (1) the length of time the employer had been violating the Act; (2) the number of workers' compensation claims brought against the employer; (3) whether the employer had been made aware of his conduct in the past; (4) the number of employees working for the employer; (5) the employer's ability to secure and pay for workers' compensation coverage; (6) whether the employer had alleged mitigating circumstances; and (7) the employer's ability to pay the assessed amount. *See, e.g., State of Illinois v. Murphy Container Service*, Ill. Workers' Comp. Comm'n, No. 03 INC 00155, 7 IWCC 1037 (Aug. 2, 2007).

The Commission finds that the period of time during which the Respondents violated the Act by failing to obtain workers' compensation insurance was significant. The Respondents failed to have insurance for 1,592 days, from October 29, 2014, to March 8, 2019. There were at least two workers compensation decisions entered against Baltic Lines II, Inc. (*Px10; 11*). Those decisions found that employee Kijuan Cosey died as a result of the work assigned to him by Baltic Lines II, Inc. (*Id.*) Respondents still failed to obtain workers' compensation insurance. Petitioner notified Respondents of their noncompliance with the Act on November 20, 2017, but even after these decisions were entered, Respondents failed to secure workers compensation insurance. Moreover, having reviewed the record, the Commission finds no evidence as to Respondents' inability to secure and pay for workers' compensation coverage and no evidence of mitigating circumstances.

The Commission therefore concludes that Respondents knowingly and willfully failed to comply with the Act. The Commission assesses a penalty of \$796,000 for the 1,592 of non-compliance as well as reimbursement of the IWBF payout in the amount of \$302,000.64, for a total of \$1,098,000.64, against Respondents, Baltic Lines II, Inc. and Angele Ramute Simkiene, individually and as officer/agent of Baltic Lines II, Inc., and Asta Pasakinskiene, individually and as officer/agent of Baltic Lines II, Inc.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondents, Baltic Lines II, Inc. and Angele Ramute Simkiene, individually and as officer/agent of Baltic Lines II, Inc., and Asta Pasakinskiene, individually and as officer/agent of Baltic Lines II, Inc. pay to the Illinois Workers' Compensation Commission the sum of \$1,098,000.64, pursuant to Section 4(d) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that payment shall be made according to the following procedure: (1) payment of the total sum shall be made by certified check or money order made payable to the Illinois Workers' Compensation Commission; and (2) payment shall be mailed or presented within thirty (30) days of the final order of the Commission or the order of the court on review after final adjudication to:

Illinois Workers' Compensation Commission
Fiscal Department
69 W. Washington Street, Suite 900
Chicago, Illinois 60602

Alternatively, pursuant to Illinois Workers' Compensation Commission Rule 9015, an electronic format may be used to accomplish the requirements of this Decision. Respondent(s) may arrange to make an electronic payment by contacting:

Illinois Department of Insurance
Attn: Workers' Compensation Compliance
115 S. LaSalle Street, 13th floor
Chicago, Illinois 60603
Phone: (312) 814-8224

This decision may be judicially reviewed only as described in Section 19(f). This decision may be enforced in the same manner as a judgment entered by a court of competent jurisdiction and is a debt due and owing to the State and can be enforced to the same extent as a judgment entered by a circuit court. 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.

December 18, 2025

MP/mcp
r-09-24-25
068

/s/ *Marc Parker*

Marc Parker

/s/ *Maria E. Portela*

Maria E. Portela

/s/ *Christopher A. Harris*

Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	22WC006260
Case Name	Kelli M. Morris v. OSF Heart of Mary Medical Center
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	25IWCC0498
Number of Pages of Decision	30
Decision Issued By	Carolyn Doherty, Commissioner

Petitioner Attorney	Philip Peak
Respondent Attorney	Jessica Bell

DATE FILED: 12/19/2025

/s/ Carolyn Doherty, Commissioner

Signature

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

Kelli M. Morris,
Petitioner,

VS.

NO: 22 WC 6260

OSF Heart of Mary Medical Center,
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, temporary total disability, and 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.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 20, 2025, is corrected as stated herein. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under Section 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 remains 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.

December 19, 2025

d: 12/10/25

CMD/kcb

045

/s/ Carolyn M. Doherty
Carolyn M. Doherty

/s/ Raychel A. Wesley
Raychel A. Wesley

/s/ Frank J. Soto
Frank J. Soto

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	22WC006260
Case Name	Kelli M. Morris v. OSF Heart of Mary Medical Center
Consolidated Cases	
Proceeding Type	Request for Hearing
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	27
Decision Issued By	Linda Cantrell, Arbitrator

Petitioner Attorney	Philip Peak
Respondent Attorney	Jessica Bell

DATE FILED: 5/20/2025

/s/ Linda Cantrell, Arbitrator

Signature

INTEREST RATE WEEK OF MAY 13 2025 4.11%

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**

Kelli Morris
 Employee/Petitioner

Case # **22** WC **006260**

v. Consolidated cases:

OSF Heart of Mary Medical Center
 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 **Linda J. Cantrell**, Arbitrator of the Commission, in the city of **Urbana** on **3/10/25**. 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 17, 2021**, 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 **\$92,189.59**; the average weekly wage was **\$1,591.54**.

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

Respondent shall be given a credit of **\$7,000.00** for TTD, **\$0** for TPD, **\$0** for maintenance, and **\$0** for other benefits, for a total credit of **\$7,000.00**.

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

ORDER

Respondent shall pay all medical bills contained in Petitioner's Group Exhibits 12 through 25, pursuant to the Illinois medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall further reimburse Petitioner directly for out-of-pocket medical expenses paid in the amount of \$2,946.53. Respondent shall receive a credit for medical expenses paid in the amount of \$2,807.85.

Respondent shall pay Petitioner temporary total disability benefits of **\$1,061.03/week** for **83** weeks, commencing **11/27/21** through **1/12/22**, **1/24/22** through **2/7/22**, **6/7/22** through **7/26/22**, **8/25/22** through **2/15/23**, and **5/26/23** through **3/14/24**, as provided in Section 8(b) of the Act. Respondent shall receive credit of \$7,000.00 in temporary total disability benefits paid, pursuant to the stipulation of the parties.

Respondent shall pay Petitioner permanent partial disability benefits of **\$937.11 (Max rate)/week** for **175** weeks, because the injuries sustained caused **35%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from 3/21/24 through 3/10/25, 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.



MAY 20 2025

Arbitrator Linda J. Cantrell

ICarbDec p. 2

STATE OF ILLINOIS)
) SS
 COUNTY OF CHAMPAIGN)

**ILLINOIS WORKERS' COMPENSATION COMMISSION
 ARBITRATION DECISION**

KELLI MORRIS,	)	
	)	
Employee/Petitioner,	)	
	)	
v.	)	Case No.: 22-WC-006260
	)	
OSF HEART OF MARY MEDICAL	)	
CENTER,	)	
	)	
Employer/Respondent.	)	

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Urbana on March 10, 2025. On 3/8/22, Petitioner filed an Application for Adjustment of Claim alleging injuries to her right arm, right elbow, right hand, right shoulder, and neck as a result of repetitive trauma that manifested on 11/17/21. (AX2) At arbitration, Petitioner moved to voluntarily dismiss consolidated Case No. 22-WC-029465, which was granted on 3/13/25.

The issues in dispute are accident, causal connection, medical bills, temporary total disability benefits, and the nature and extent of Petitioner's injuries.

TESTIMONY

Petitioner was 62 years old, single, with no dependent children at the time of the alleged accident. She has worked as a nurse for Respondent for 21 years. She became a nurse in 1986 and worked in the ICU most of her career. She worked in a pediatric cardiology clinic, dialysis, and cardiac and pulmonary rehab. Petitioner began working as an ICU staff nurse for Respondent in June 2021, and worked in the ICU at Sacred Heart Medical Center for three months as a charge nurse. Her direct supervisors were the ICU's manager Jamie Dunn, and the day shift nurse Brittany Schweighart. Petitioner's job duties involved total patient care, including feeding, toiletry, changing linens, equipment management, and vital sign monitoring.

Petitioner testified that around November 2021 there were a lot of patients on antibiotics and tube feeding that caused liquid stool, which resulted in increased cleaning to prevent infection. She used her right dominant arm to hold the patient over to one side while she cleaned them and changed the linens with her left hand. She then moved to the other side of the bed and repeated the procedure. Petitioner stated it could take up to 30 minutes to clean a patient, and sometimes longer if a patient started stooling during cleaning. She stated that many of the

patients she rolled were sedated or very weak. Petitioner used her right dominant arm for most of the force required to perform her job duties. She held her right arm parallel along the patient's body and took all of the weight of the patient's body while they were at a 90-degree angle. She testified that her arm felt strained after cleaning a patient. Petitioner testified that she turned patients every two hours.

Petitioner testified that she cleaned ventilated and medicated patients at least 2 to 3 times per hour. She also assisted with toiletries for patients who were not ventilated, which included helping them onto a commode and wiping them. Petitioner estimated she spent 50% of her work shift cleaning patients. She testified that with COVID patients they had to perform a "burrito roll" every 8 to 10 hours, which involved 5 to 6 staff members to manage the equipment and patient. She explained that with COVID patients she slightly tilted them with her right hand and performed her cleaning duties. She typically had two COVID patients and cleaned them twice per shift. Petitioner estimated it took 30 to 45 minutes to perform a burrito roll. She stated that half of her patients were COVID patients.

Petitioner also transferred patients by using her arms to bearhug the patient into position. Petitioner worked three 12-hour shifts and transferred patients by bed once per three days, which involved getting the patient on and off the bed for testing. When transferring a patient to a commode she had to hold onto the patient, the commode, and move equipment. She estimated she spent 20% of her work shift performing transfers.

Petitioner testified that she noticed issues with her right arm about one month before she reported it. She noticed her arm getting a little weaker which she attributed to not having worked in the ICU in fifteen years. She did not have difficulty using her right arm with patient transfers. Petitioner spent the other 20% of her work shift performing other nursing duties, including documentation, medication and equipment monitoring, and housekeeping. Petitioner worked three days per week from 7:00 p.m. to 7:30 a.m. She testified that the days she worked varied and were not always consecutive. Petitioner testified that she worked in a cardiac rehab unit for 15 years and was a pulmonary rehab coordinator for the last 7 years. She testified that her job duties in ICU were more demanding because the patients were dependent. She stated that COVID patients needed a lot of attention and caring for them was more time consuming.

Petitioner sought medical treatment on 11/17/21 for her right upper extremity. She noticed that one month prior she had difficulty with dexterity and weakness, including opening pill packets and writing. She had an ache and numbness in the outer aspect of her right hand. Her fingers were numb, she had jolts that felt like lightening from her elbow into her hand, with an achy cold sensation. Petitioner stated that at the end of a 3-day work shift she carried a bag of linen out of a patient's room and involuntarily dropped it in the hallway because she lost her grip strength. She stated a bag of linen weighed 30 to 50 pounds and she emptied the bags up to two times per shift. She carried the bags 20 to 100 feet depending on which room she was cleaning.

Petitioner testified that her symptoms improved greatly on her days off work. She used heat, elevation, and ibuprofen for her symptoms. She initially sought treatment on 11/17/21 with NP Glenett Barrett at OSF Orthopedics. Petitioner attributed her symptoms to her job duties because she did not have them until she started working in the ICU and they improved when she

was off work. Petitioner provided her supervisor Jamie Dunn with an off work slip on 11/24/21 and she was instructed to fill out an incident report.

Petitioner underwent an EMG on 12/2/21 and followed up with Dr. Brett Keller on 12/16/21. Petitioner wore wrist and elbow orthotics that helped with stability. Petitioner underwent a right elbow MRI and was referred to Dr. Jerome Oakey. Dr. Oakey recommended a cervical spine MRI and referred Petitioner to Dr. Jason Michaels. Petitioner testified that although Dr. Oakey's office note states she was released to return to work without restrictions, she told him she did not feel safe taking care of patients because her arm was weak and he continued her off work pending an examination by Dr. Michaels. She is not sure if Dr. Oakey made a written record of continuing her off work.

Petitioner underwent a cervical spine MRI and Dr. Michaels ordered physical therapy and continued her off work. She underwent one physical therapy session for her neck and then transferred her care to SafeWorks Illinois because she was being referred to so many doctors without answers. Petitioner treated with Dr. Fletcher and provided him with a detailed description of her job duties. She underwent an EMG and used a TENS unit that did not improve her symptoms. Dr. Fletcher referred her to physical therapy at Savoy Therapy that helped her finger dexterity and strength. Petitioner testified that she was employed by Christie Clinic when she first treated with Dr. Fletcher and her restrictions were accommodated. Petitioner wore elbow pads that helped prevent increased nerve pain from hitting her elbow.

Petitioner treated with Dr. Stuart Baker who performed a right ulnar nerve surgery on 6/7/22. She stated that the surgery improved her pain, and her fingers were no longer in a claw position. Petitioner used a sustained acoustic medicine (SAM) device for one month and underwent physical therapy. Dr. Fletcher released Petitioner to return to work with restrictions at Christie Clinic as of 7/26/22.

On 8/25/22, Dr. Baker performed a right carpal tunnel release. Petitioner testified that the surgery improved the clawing of her fingers. She described her middle finger crosses over her ring finger when she closes her fist, and she is unable to make a full fist. Dr. Fletcher released her to return to work with restrictions on 2/15/23. Petitioner last saw Dr. Baker on 10/17/22 who did not recommend additional surgery. Dr. Fletcher released Petitioner at MMI on 3/14/23.

Petitioner returned to Dr. Fletcher on 5/26/23 with increased pain and numbness due to her computer keyboarding duties at Christie Clinic as a nurse manager. She stated she could only type for 1 to 2 minutes, and her fingers became numb and ice cold. Petitioner underwent another EMG and was placed off work. Dr. Fletcher recommended the SAM device, TENS unit, and cold compression again. He referred Petitioner to Dr. Greatting because Dr. Baker was retiring. Dr. Greatting performed a right elbow surgery on 11/8/23 that improved her claw grip, pain, and numbness.

Petitioner testified that her worst symptoms are her fingers getting cold that causes an achy and tingling sensation. She wears a wrap to keep pressure on her arm and a glove for coldness and to prevent people from shaking her hand. Petitioner uses a heating pad, a wrap, and massages her hand to alleviate her symptoms. Petitioner stated she has no sensation on the inside

of her right arm preventing her from feeling heat or pain. She stated she could cut herself and not feel it. She has hypersensitivity and nerve pain on the outside of her arm from her elbow to her fingers. Petitioner's right arm pain increases with movement, and she has to hook her right thumb in her waistband when she walks to prevent it from swinging free. She testified that her hand is weak, and she can tolerate carrying up to one pound. She does not feel her grip and avoids carrying anything fragile with her right hand. She has good range of motion in her wrist and elbow.

Petitioner testified that she cannot hold a knife to cut through meat or use scissors. She cannot carry a laundry basket or pick up her grandchildren. She cannot write certain letters and her writing is large and elementary because she cannot control the pen. Petitioner cannot open lids. She has to reach over her body and shift with her left hand when driving. Petitioner takes ibuprofen and Tramadol very sparingly from her last prescription filled by Dr. Fletcher.

Petitioner last saw Dr. Fletcher on 3/14/24 and was placed at MMI with permanent restrictions of no lifting or pulling greater than 5 pounds and no repetitive work. Petitioner last saw Dr. Greatting on 3/21/24 and was placed at MMI. She has not sought additional medical treatment since being released at MMI. Petitioner receives medical messages.

Petitioner testified that she had no issues with her right hand, elbow, or arm in the two years prior to 11/17/21, and she was working full duty without restrictions. Petitioner testified that she underwent an EMG on her right arm in 2015 because she had numbness and tingling when she woke in the morning. The doctor told her it was due to laying on her arm at night. She was provided with a splint to keep her from rolling onto her right side. Petitioner did not seek further treatment and her symptoms resolved. Petitioner testified that she has no issues with her left arm. She is not diabetic or obese and she does not have thyroid disease, arthritis, or cysts in her right arm. She does not have issues with alcohol and has never smoked.

Petitioner testified that she met with Section 12 examiner Dr. Biafora for approximately 45 minutes. She stated he did not ask her any details about her job duties, the frequency she performed tasks, or the forcefulness of any job task. Petitioner did not provide Dr. Biafora any details about transferring or cleaning patients. He did not review a job description with her.

Petitioner testified that she was initially placed off work on 11/17/21. She formally resigned her position with Respondent effective 2/7/22 because she attended a meeting where she believed she was going to be terminated and she did not want it on her resume. She began working at Christie Clinic in a supervisory position. After her second surgery she returned to work at Christie Clinic in a management position. She resigned from Christie Clinic on 5/27/23. Petitioner returned to work as a nurse for Fresenius Kidney Care in September 2023, but she had difficulty with typing. Petitioner has not been employed since Dr. Fletcher released her in March 2024. She is currently receiving social security disability benefits. She stated that the only type of nursing work she could perform is in TeleMed if she was provided adaptive equipment so she did not have to type. She did not receive any short or long-term disability through her employment with Respondent. Her medical expenses have been paid by BCBS and WebTPA through her personal insurance policies. Petitioner can no longer afford the personal muscle and joint massages she received for pain control.

On cross-examination, Petitioner testified that after she wore a splint in 2015, she had no problems at all with her right hand or arm until November 2021. She stated that prior to starting work in Respondent's ICU in June 2021, she worked in the cardiac rehab and was the director of pulmonary rehab for 15 years. She testified that the main job duty she attributed her right hand and arm symptoms to was holding patients up to clean them. She stated that many of the ICU patients were overweight or large.

Petitioner testified that she rolled patients by herself when other staff was unavailable to assist her, which was 40-50% of the time. She agreed that she used both hands to support patients who were able to get up and use the commode. Petitioner reviewed an email she sent to Jamie Dunn on 10/7/21 stating she was resigning on 10/21/21. She did not recall sending the email. Petitioner also sent the email to Staci Sutton on 10/7/21 because she received an out-of-office reply from Ms. Dunn's email. Petitioner stated in the email that she found a new job outside of OSF. Petitioner did not know if that was the job she took at Christie Clinic in January 2022.

Petitioner testified that she knew Dr. Fletcher prior to treating with him and socialized with him through a coworker. Petitioner testified that prior to 2021 she walked and did cardio exercises at the gym. She used a rowing machine a couple of times per week in 2021. Petitioner testified that Dr. Fletcher told her during one of her appointments to continue wrapping her hand and arm if it provided pain relief. She primarily wears a glove because her hand is cold, and she tries to avoid it being touched.

Petitioner testified that one reason she sought treatment in November 2021 is because she dropped the linen bag. She stated the linen was wet and weighed 30 to 60 pounds.

On re-direct examination, Petitioner testified that she used the splint in 2015 for 2 to 3 weeks until she learned not to sleep on her right arm. She stated that when she had assistance rolling patients over to clean them, she did not have as much force on her arm because she was sharing the burden. She stood with her right arm on the upper portion of the patient's body which is heavier. Petitioner stated that her email to Ms. Dunn mentioned the night shift was taxing on her body, which she meant that being new to the ICU after 15 years was wearing her out. Although she stated she was going to resign effective 10/21/21, she continued working for Respondent.

Staci Sutton testified on behalf of Respondent. Ms. Sutton is the Director of Nursing Practice and Operations for Respondent. She was hired by Presence Health in 2013, and continued to work at the same hospital after it was acquired by OSF in February 2018. From June through November 2021, she had direct observation and oversight of critical care, respiratory, and emergency services. Ms. Sutton was familiar with Petitioner and frequently saw Petitioner working in the hallways with patients when she worked in the cardiac rehab department. Ms. Sutton only saw Petitioner during evening team and staff meetings after she transferred to the ICU. Ms. Sutton did not work third shift and did not observe Petitioner perform her job duties in the ICU.

Ms. Sutton testified that Petitioner was hired to work in the critical care unit on 6/27/21. She underwent orientation for several weeks and started working in the ICU in July 2021. Ms.

Sutton testified that Petitioner had an abbreviated orientation due to her ICU nursing background and she was assigned to the lower-level progressive care patients. Petitioner was not taking care of open heart or COVID patients that required proning. She testified that at that time they had stepdown and ICU level patients, and Petitioner was assigned to stepdown patients, and she did not have the training to care for higher-level acuity patients. Ms. Sutton testified that she and Jamie Dunn did biweekly rounds and she observed Petitioner struggle to manage her assignments. She testified that Petitioner was a little challenged in maintaining her composure and managing the daily needs of higher-level patients, so they assigned her to lower-level acuity patients, which could include COVID patients that were not on ventilators, patients with diabetic ketoacidosis, and overdose patients. She stated that Petitioner struggled with caring for the critically sick patients.

Ms. Sutton testified that Petitioner did not care for patients that required a burrito roll. She testified that if a patient could not turn themselves or was completely immobile, they were deemed higher-level, which Petitioner was not assigned to. Ms. Sutton denied that Respondent was short staffed during the COVID pandemic. She testified that they had three traveling nurses and they staffed 4 to 5 nurses at night, with one nurse assigned to 2 or 3 patients. Ms. Sutton testified that Respondent had an increase in patients in March and April 2021, but the number significantly decreased by June 2021. In June 2021, they had nine COVID patients the entire month in the ICU, and 12 COVID patients in July, which had plummeted compared to March, April, and early May 2021.

Ms. Sutton testified that Respondent has turn teams and anytime a patient could not roll themselves over and hold on to the side rail during cleaning, two nurses would assist with one turning and holding the patient while the other nurse cleaned. She did not believe it was achievable for one nurse to push a patient up and hold them with one arm while cleaning the patient with the other arm.

Ms. Sutton testified that Jamie Dunn was the manger and is no longer employed by Respondent. Ms. Dunn reported directly to Ms. Sutton. Ms. Sutton identified the email Petitioner sent her on 10/7/21 regarding her resignation. She testified that she did not discuss the resignation with Petitioner because Petitioner decided to work on an as-needed basis after she sent the email. Ms. Sutton stated Petitioner could sign up to work whenever she wanted, and she did work a few shifts for a couple of weeks after she sent the email. Ms. Sutton identified Petitioner's work schedule and explained that "1900-12RN" meant Petitioner worked 12 hours on the night shift beginning at 7:00 p.m. She explained that the "\$" entry on 8/6/21 meant Petitioner worked an extra shift. Petitioner last worked for Respondent on 11/24/21. The shift schedule shows Petitioner was scheduled to work on 11/25/21 but she called off work after that and she was no longer placed on the schedule.

On cross-examination, Ms. Sutton explained there were two populations of patients in the critical care unit (CCU). The PCU (progressive care unit) patients could be managed by hospitalists, but the ICU (intensive care unit) patients needed the care of critical care doctors. She testified that COVID patients were managed by ICU-level nurses because the patients had to be in a prone position to improve oxygenation. She stated it took 7 to 8 staff members to prone an ICU patient, which could be any of the staff members in the CCU.

Ms. Sutton testified that Petitioner “struggled to manage any level of complex patients, keeping her composure, just not creating some sense of panic...”, which is why she was assigned to lower-level patients. She stated that the charge nurse informed Jamie Dunn of her concerns regarding Petitioner’s work abilities, and Ms. Dunn informed her. Petitioner acted like every night was a bad night and the world was caving in. She stated Petitioner had difficulty managing her emotions, time management, and appeared overwhelmed. Ms. Sutton admitted she had no written evidence of Petitioner’s work struggles.

Ms. Sutton testified that she met with Petitioner and Ms. Dunn at the human resource meeting when Petitioner was trying to decide if she should stay on an extended leave of absence or retire as a result of her right upper extremity issues. Ms. Sutton had discussions with Ms. Dunn about Petitioner alleging her injuries were related to her job duties and she needed time off. Ms. Sutton stated that if Petitioner returned to light duty work in mid-December it would not have been in the CCU. She agreed that the work schedule admitted into evidence was not through Petitioner’s resignation date of 2/7/22.

Ms. Sutton testified that the CCU is a 13-bed unit and even during the COVID pandemic they only averaged 9 to 10 patients at one time, 60% being stepdown patients and 40% being critical care patients. The hospital typically has 7 to 8 patients in the CCU, and the patient population was mixed throughout the unit and not segregated. She stated that patients who were ventilated and had feeding tubes were more prone to soiling so they had a fecal management system where the fecal is drained by a tube. Ms. Sutton did not believe that cleaning a patient was physically taxing if proper technique was used. She testified that it was not possible to clean a patient by yourself if the patient could not assist. She estimated that it took 5 to 6 minutes to clean a patient.

Petitioner was recalled to testify and stated she was not aware the CCU was partially a stepdown unit. She stated that she had approximately 50% lighter duty patients and 50% not lighter duty patients, which varied per day. Petitioner testified that she did care for COVID patients and assisted in turning them onto their stomachs. She also cared for open heart patients while working in the CCU. She stated that she transferred lighter duty patients, but she did not have to clean or turn them. Petitioner testified that she was able to clean a patient by herself and she did not always have assistance. Petitioner testified that she never saw Ms. Sutton in the CCU while she was working from June through November 2021.

Petitioner testified that her first interaction with Ms. Sutton was when her brother was admitted into the emergency room after drinking heavily and he called the suicide line. Her brother lives in a home and is mentally challenged. Petitioner is his power of attorney. The hospital discharged her brother home without an overnight mental health. Petitioner asked Ms. Sutton if it was protocol because she was concerned for her brother. Ms. Sutton stated that he did not qualify for an overnight stay. Petitioner admitted she was frustrated with Ms. Sutton because two days later her brother attempted it again. She stated she did not have harsh feelings toward Ms. Sutton, but she was frustrated over the situation.

Petitioner testified that she worked night shift for the COVID at-home program, so she was already acclimated to working nights when she started working in the ICU. She also worked nights for many years prior to working in cardiac rehab. She stated she was an old-fashioned nurse and she waited until after her shift to do documentation so she could be there for her patients. She stated that her “struggle” was with her documentation and staying late to complete it. She agreed she was paid to stay an hour or so after her shift to complete the documentation.

DOCUMENTARY EVIDENCE

Petitioner’s pre-accident medical records were admitted into evidence. (PX6) On 7/1/15, Petitioner presented to neurology at Christie Clinic for disturbance of skin. An EMG/NCS was performed of Petitioner’s right upper extremity that revealed right mild ulnar entrapment neuropathy at the elbow and right borderline carpal tunnel syndrome. (PX6, p. 2) On 8/11/15, Petitioner requested to switch neurologists from Dr. Wang whom she last saw on 7/14/14 for migraines, to Dr. Habib whom she saw on 7/1/15. She liked Dr. Habib because he offered several treatment options.

On 8/19/15, Petitioner was examined by Dr. Habib for migraine headaches. (PX6, p. 7) He noted Petitioner had intermittent numbness and tingling in her right 4th and 5th digits for which he recently performed an EMG/NCS. Petitioner was using an elbow splint that helped. Petitioner had 5/5 strength in hand grips and all four extremities. Dr. Habib recommended that Petitioner continue wearing a right elbow splint as-needed. On 10/13/15, Dr. Habib noted that since Petitioner switched from Topamax to Trokendi for her migraines, her symptoms of tingling and restlessness at night has improved significantly.

On 11/17/21, Glenett Barrett, APRN at OSF Medical Group entered a notation that she spoke to Petitioner about her carpal and cubital tunnel symptoms. (PX10) An EMG was ordered, and she was referred to an orthopedic surgeon. There was no supporting office note indicating Petitioner was examined or that provided a history of Petitioner’s injuries, symptoms, or job duties.

On 11/29/21, RN Barrett signed a leave of absence form indicating Petitioner would have difficulty with lifting, gripping, and pulling due to right cubital tunnel and bilateral carpal tunnel syndromes. The period of incapacity was noted from “11/27/21 until 2/27/21”. (PX10, p. 2)

On 11/30/21, Petitioner completed an incident report and alleged bilateral carpal tunnel syndrome and right ulnar nerve entrapment due to repetitive movement that manifested on 11/17/21. (PX27) It was noted Petitioner was hired on 6/27/21. She was authorized off work by a medical provider and her last date worked was 11/24/21.

On 12/2/21, Petitioner underwent an EMG at Christie Clinic for a history of numbness in the first two digits and now for the last two weeks numbness of last three digits of right hand with right elbow pain. The study revealed mild bilateral carpal tunnel syndrome, right worse than left, with no evidence of right ulnar neuropathy. (PX6, p. 13)

On 12/16/21, Petitioner was examined by Dr. Brett Keller for a chief complaint of bilateral carpal tunnel syndrome. (PX7, p. 1) Dr. Keller noted Petitioner had numbness/tingling mostly in the 3rd, 4th, and 5th fingers, with pain in the ulnar nerve region for 6 to 8 weeks. He noted that Petitioner worked as an ICU nurse that required her to do repetitive lifting of patients, sometimes large patients. Petitioner stated she could not push, pull, or lift due to pain and numbness and her elbow pain extended to her fingers. Dr. Keller noted Petitioner had previous treatment including a wrist and elbow orthotic and oral steroids with little relief. Her medical history was positive for right carpal tunnel syndrome and right ulnar neuropathy at the elbow on 11/12/19. Dr. Keller reviewed the EMG and noted bilateral carpal tunnel syndrome and right elbow ulnar neuritis with no evidence of ulnar nerve abnormality. His clinical diagnosis was cubital tunnel syndrome. Dr. Keller ordered an MRI of the right elbow and placed Petitioner off work. He prescribed Meloxicam and instructed Petitioner to continue wearing the wrist and elbow orthotics.

On 12/21/21, Petitioner underwent a right elbow MRI that revealed subcutaneous edema along the medial and lateral dorsal elbow. (PX11, p. 1)

On 1/6/22, Petitioner followed up with Dr. Keller for right elbow pain. Petitioner reported right elbow pain/trouble since before Thanksgiving. She stated she was a nurse and constantly used her arms. She used ice and heat daily, elevated her arm, and wore elbow and carpal tunnel braces daily to alleviate the pain. She could not lift, pull, or push anything over a few pounds and her pinky and ring fingers were numb. She was working light duty. Dr. Keller noted tenderness over the cubital tunnel and decreased sensation in the ulnar nerve distribution. He diagnosed a lesion of the ulnar nerve, strain of the extensor muscle, fascia, and tendon at the forearm, bilateral carpal tunnel syndrome, pain in both wrists and right elbow, right elbow ulnar neuritis, and right elbow common extensor tear. He instructed Petitioner to continue wearing the elbow brace and home exercises. He placed her off work pending an examination by Dr. Jerome Oakey. He ordered Petitioner to follow up as needed for worsening symptoms. (PX7, p. 5-9).

On 1/12/22, Petitioner was examined by Dr. Jerome Oakey for right elbow pain with an onset date of November 2021. (PX8, p. 4-9) Petitioner reported decreased strength at work as an ICU nurse when opening pill bottles and pulling up patients. She had severe pain from her elbow into her fingers, with numbness and tingling. Petitioner reported her symptoms started after an intense three days at work. Physical examination revealed tenderness at the ulnar nerve at the cubital tunnel, which did not recreate the numbness/tingling in the pinky and ring fingers, with full range of motion of the elbow. Dr. Oakey reviewed the MRI images that showed no osseous abnormalities, with possible increased signal in the ulnar nerve, with a structurally intact ligament. He reviewed the EMG and stated the needle examination of all muscles was normal. He noted Petitioner had normal motor latency on the left and right. Dr. Oakey stated the etiology of Petitioner's pain was unclear and certainly the pattern of numbness/tingling did not suggest cubital tunnel. Right elbow x-rays were normal. He discussed work restrictions, but opined that in terms of her elbow, wrist, and hand, there was no etiology for the weakness she described. Dr. Oakey took cervical spine x-rays that showed loss of disc height at C6-7, which he believed was the more likely etiology of Petitioner's symptoms. He referred Petitioner to Dr. Jason Michaels for cervical evaluation and opined Petitioner could return to full duty work pending the evaluation. (PX8, p. 8)

On 1/24/22, Petitioner was examined by Dr. Jason Michaels for evaluation and management of right arm discomfort with numbness, tingling, and weakness that was progressively worsening. (PX8, p. 1-4, 7) The record indicated a chief complaint of neck pain; however, Petitioner denied any radiating neck pain during examination. Dr. Michaels noted that Petitioner's pain began around Thanksgiving when she worked four 12-hour shifts. On the second shift she noticed difficulty opening a pill package due to loss of finger dexterity. She later assisted to lift a patient and her right arm was significantly weaker than her left. He noted Petitioner was right hand dominant. Petitioner experienced right arm discomfort that traveled from the right elbow, down her right ulnar forearm, ending in her 4th and 5th digits, and discomfort in her right thumb. Physical examination revealed diminished right forearm extension and negative Hoffmanns and Spurlings tests. Dr. Michaels noted the MRI showed a 9mm abnormal cord signal at C3, multilevel degenerative disc changes, moderate left foraminal stenosis at C5-6, severe right foraminal stenosis at C6-7, and moderate central canal stenosis at T1-2. He opined that Petitioner's right arm complaints were consistent with neuropathic pain and may be related to the cervical radiculopathy. He placed Petitioner off work pending a neurosurgical evaluation. He referred Petitioner to physical therapy, and prescribed Meloxicam, Tylenol, and Gabapentin.

On 3/2/22, Petitioner was examined by Dr. David Fletcher at Safeworks Illinois for moderate to severe right hand, elbow, and arm pain. (PX1, p. 1-13) Dr. Fletcher noted Petitioner had numbness/tingling and pain to her right arm/hand for over a year. Dr. Fletcher noted all of Petitioner's treating physicians to date and that Petitioner felt like she was being passed around without any solutions. Examination of Petitioner's cervical spine was positive for Spurling's maneuver and Lhermitte's sign was produced with flexion. Dr. Fletcher reviewed the cervical and right elbow MRIs. He diagnosed severe right ulnar neuropathy, and noted her muscles were twitching. She had hypothenar and interosseous muscle atrophy, with decreased interosseous hand strength. He noted Petitioner had features of radial tunnel which was not tested by Dr. Habib at Christie Neurology, nor did he do needle studies in Petitioner's neck to explore possible nerve compression in her cervical spine. Dr. Fletcher deferred to Dr. Stuart Baker for a hand surgical consultation and Dr. Trudeau for electrical studies.

Dr. Fletcher opined that at a minimum Petitioner would require a right ulnar nerve transposition and radial tunnel release once confirmed by updated diagnostics. He recommended a TENS unit, a cold compression machine, and elbow pads. He prescribed Lyrica and Tramadol and referred Petitioner to physical therapy. Dr. Fletcher opined that Petitioner's work activities in the short-staffed ICU at OSF HMMC during COVID caused her present condition. He prescribed work restrictions. Petitioner reported she was forced to retire from OSF because she exhausted her FMLA, and she was not allowed to work with restrictions. Petitioner was working at Christie Clinic who was accommodating her restrictions.

On 3/21/22, Petitioner underwent an EMG by Dr. Trudeau. (PX4, p. 1-9). He interpreted moderately severe cubital tunnel syndrome at the right elbow, mild-to-moderate right radial tunnel syndrome, mild right carpal tunnel syndrome, and no evidence of other entrapment neuropathy or cervical radiculopathy.

On 4/4/22, Petitioner was examined by Dr. Stuart Baker. (PX2, p. 1) He noted that Petitioner's biggest concern was numbness and loss of strength. He diagnosed severe nerve compressions in the right median, ulnar, and radial nerves. He recommended an ulnar nerve transposition which was performed on 6/7/22, and Petitioner was placed off work through 9/26/22. (PX2, p. 3, 11)

On 7/20/22, Dr. Fletcher noted Petitioner had significant relief from surgery. He discussed the possibility of dynamic splinting due to Petitioner's "claw hand", but he noted it had improved. He continued her off work and ordered a sustained acoustic medicine (SAM) that was a four-month rental.

On 8/9/22, Dr. Fletcher felt that dynamic splinting was unnecessary due to Petitioner's continued improvement. (PX1, p. 69) He released Petitioner to return to work in an administrative training role at Christie Clinic. (PX1, p. 73)

On 8/25/22, Dr. Baker performed a right carpal tunnel release and flexor synovectomy of Petitioner's right wrist and distal arm. (PX2, p. 15) On 9/19/22, Petitioner reported her symptoms were much improved, but her fingers were still tingling. (PX2, p. 2) Dr. Baker noted Petitioner was starting physical therapy tomorrow which was ordered by Dr. Fletcher. She was to remain off work until her next appointment. Petitioner followed up with Dr. Fletcher on 10/5/22 at which time she was continued off work through 10/27/22. (PX1, p. 86) On 10/17/22, Dr. Baker noted Petitioner had better sensation and was doing physical therapy three times per week. He noted that Dr. Fletcher increased her Lyrica and Tramadol as she still had achy symptoms.

On 10/27/22, Dr. Fletcher noted Petitioner was continuing physical therapy and had decreased tingling, but she had increased discomfort and little to no strength in her right hand and wrist. (PX1, p. 98) He noted Petitioner was still anxious about her future and she took a big financial hit because she could not work and was not receiving TTD. He recommended "acute physical therapy" until mid-December followed by work hardening. He anticipated Petitioner could return to work in February 2023. He did not believe Petitioner required additional surgery and he recommended observing the right carpal tunnel syndrome. He opined that Petitioner's current condition was related to her job duties at OSF from cumulative trauma. He recommended that Petitioner continue physical therapy and continued her off work.

On 12/6/22, Dr. Fletcher noted Petitioner stopped taking Lyrica due to weight gain. She was still taking Tramadol and undergoing physical therapy. Petitioner was tender over the right carpal tunnel and lateral epicondyle. Dr. Fletcher prescribed Gabapentin and continued Petitioner off work through 12/30/22. He recommended physical therapy through mid-January 2023, followed by work hardening. He instructed Petitioner to consult her primary care physician to switch from Restoril to Trazadone to help with sleep.

On 12/30/22, Dr. Fletcher noted Petitioner's treatment was delayed due to illness. Petitioner was improving with less interosseous muscle atrophy. He administered a Toradol injection for pain and continued her off work through 1/20/23, with a tentative full duty release on 3/1/23. He recommended treatment for her secondary depression and noted Petitioner applied for social security disability.

On 1/20/23, Petitioner returned to Dr. Fletcher and reported an overall decrease in pain since her last visit. She had increased catching in her right elbow. Dr. Fletcher planned to release Petitioner to restricted work on 2/15/23 and Petitioner advised she was lining up a job at Christie Clinic. He recommended acute physical therapy and work hardening. (PX1, p. 132)

On 2/15/23, Petitioner presented Dr. Fletcher with a form to complete for Christie Clinic outlining her work restrictions. He released Petitioner to light duty work effective 2/16/23. Dr. Fletcher anticipated releasing Petitioner from care at her next appointment. (PX1, p. 145)

On 3/14/23, Dr. Fletcher noted Petitioner had intermittent aching in her right elbow and hand. She complained of numbness and coldness in her hand while typing. He noted that Petitioner was doing well with improved functioning of her right upper extremity, but still had interosseous muscle atrophy and dexterity issues. He noted Petitioner was working within her restrictions at Christie Clinic, but the simple act of writing caused issues for her. Dr. Fletcher released Petitioner at MMI with permanent restrictions of no lifting greater than 30 pounds occasionally and 15 pounds frequently, no constant grasping, pulling, or carrying with her right upper extremity, and no vibratory activities. He ordered her to continue taking Tramadol and restarted Lyrica for neuropathic pain which he opined she would have to take indefinitely.

On 5/26/23, Petitioner returned to Dr. Fletcher with complaints of worsening pain in her right elbow, hand, and arm made worse by typing as a RN/Administrative Coordinator at Christie Clinic. (PX1, p. 160) Her right hand felt cold for the past couple of months. Dr. Fletcher placed Petitioner off work.

On 7/11/23, Dr. Fletcher ordered an updated EMG with Dr. Trudeau. Petitioner reporting doing better due to having less strain at work. Dr. Fletcher also noted Petitioner was unable to keep her new job because they exceeded her restrictions and she currently had no income. He refilled her Tramadol and Gabpentin and continued her off work through 8/4/23. (PX1, p. 169)

On 8/8/23, Dr. Trudeau performed another EMG that revealed moderate-to-severe right radial tunnel syndrome that was increased from the 3/21/22 study, moderately severe distal ulnar neuropathy/canal of Guyon syndrome that was new from the previous study, and right radial sensory neuropathy (Wartenberg syndrome) that was new from the previous study. (PX4, p. 10)

On 8/11/23, Dr. Fletcher noted Petitioner's symptoms were much worse. He referred her to Dr. Mark Greatting at Springfield Clinic for a surgical consultation. (PX1, p. 184) He placed Petitioner on restrictions of no lifting greater than 10 pounds with her right upper extremity. Dr. Fletcher opined that Petitioner's current condition was related to her job duties at OSF from cumulative trauma, and added that Petitioner further aggravated her condition at Christie Clinic. (PX1, p. 179-184)

On 9/14/23, Petitioner was examined by Dr. Greatting who noted she worked as an ICU nurse where she worked more hours and cared for more patients than normal during COVID. She reported that the patients required a higher level of care than normal during that time, and she developed pain, numbness, and tingling in her right hand. She had difficulty using her right hand

and developed a “clawing” deformity. Petitioner reported that typing for even five minutes caused cramping in her right hand and she still had difficulty touching her right pinky finger to her index finger. She had pain in her forearm and a cold sensation in her hand. Petitioner was wearing fingerless gloves to help with the cold sensation. Based on the EMG and physical examination, Dr. Greatting recommended a right radial tunnel release and right ulnar nerve release at the wrist, which was performed on 11/8/23. (PX3, p. 1-10)

On 11/21/23, Petitioner followed up with Dr. Greatting and reported improvement, with some numbness, tingling, and weakness in her right hand. Her ring and little finger still crossed over her middle and index finger. Petitioner was referred to occupational therapy. (PX3, p. 13)

On 12/11/23, Petitioner was notified by the Social Security Administration that she had been found disabled on 6/7/22. (PX28) Her disability benefits were paid retroactive to December 2022.

On 1/4/24, Dr. Greatting noted Petitioner had mild decreased sensation in all of her fingers which was unchanged since her last surgical procedure. The most recent surgery improved the pain in her arm she was having at night. She has an ongoing cold sensation in her hand, with mild atrophy and weakness of the first dorsal interosseous. Dr. Greatting anticipated that Petitioner should develop increased strength in the ulnar nerve distribution of the right hand over time. He anticipated some chronic constant sensory changes and cold sensation. She was scheduled to start occupational therapy tomorrow.

On 3/14/24, Dr. Fletcher released Petitioner at MMI with permanent restrictions of no lifting greater than 10 pounds. (PX1, p. 217) Petitioner was completing physical therapy and he refilled her Tramadol prescription.

On 3/21/24, Dr. Greatting released Petitioner at MMI. Petitioner continued to have some pain, numbness, and tingling in her right arm. She wore a compression sleeve on her arm that helped with discomfort. Petitioner took Tylenol and Advil as needed, and Tramadol 2 to 3 times per week with increased pain. He opined that Petitioner would have chronic symptoms in her right arm. Dr. Greatting did not prescribe permanent restrictions, but he opined that Petitioner would not be able to return to her job as an ICU nurse. (PX3, p. 19)

Dr. David Fletcher testified by way of evidence deposition on 11/12/24. (PX29) Dr. Fletcher is board-certified in occupational medicine and preventative medicine/public health. He served on the Illinois Workers' Compensation Medical Fee Advisory Board for six years. Dr. Fletcher testified that Petitioner's right upper extremity symptoms came on gradually and accelerated in November 2021 which she related to her job duties as an ICU nurse. Dr. Fletcher testified that Petitioner provided him with background of the short staffing in the ICU. He stated Petitioner was aware he was on the hospital leadership board, and he was very familiar with Respondent's staffing issues.

Dr. Fletcher testified that Petitioner described a significant amount of ergonomic stressors while working in a short staffed ICU. He testified that ergonomic stressors, such as forceful gripping, pressure on the elbow, and awkward positioning and posturing, can cause nerve

entrapment. He stated that a lot of the job duties Petitioner described fit within that criteria, especially sustained rolling of patients who were on ventilators called the “burrito technique”. He stated that the sustained torque motion on the elbow is a precursor to developing ulnar neuropathy. He also believed that awkward posturing while keyboarding and the cramped space of the ICU rooms while performing nursing duties contributed to her condition.

Dr. Fletcher testified that he is very familiar with OSF Heart of Mary. He has had admitting privileges at the hospital since 2001, he has served on the Hospital’s Board for a second term since 2017, and he interacts with the Chief Medical Officer and CEO frequently. He stated he is very familiar with the hospital’s problems getting proper staffing. At the time Petitioner worked in the ICU, he understood that the ICU was extremely short staffed, the staff had to work long shifts, and their capacity was stretched to the max. Dr. Fletcher testified that he knew Petitioner through OSF since around 2007 when she was the director of the cardiac rehab facility. He observed her working as a nurse in the cardiac rehab unit, but not in the ICU.

Dr. Fletcher testified that performing a burrito technique to roll a patient would present a similar risk factor for developing peripheral neuropathies. He stated that COVID patients had to be cleaned very frequently while in the ICU. He explained that radial tunnel syndrome is more of a clinical diagnosis because EMG’s do not provide a confirmatory diagnosis and is often masked as chronic tennis elbow. He believed that Petitioner had depression due to her chronic pain, but she did not pursue the recommended counseling.

Dr. Fletcher opined that Petitioner’s conditions were related to her work activities around November 2021 based on her not having any nonoccupational risk factors and her conditions presented in her dominant arm with no symptoms in her left. He testified that if Petitioner’s conditions developed idiopathically he would expect her to have bilateral symptoms. He testified that hospital work is a lot riskier than the general population experiences, and the overexertion by being short staffed during the pandemic exacerbates the condition. During his career, he has experienced 10 to 15 nurses develop similar peripheral neuropathies from the performance of their job duties.

Dr. Fletcher testified that peripheral nerve entrapment develops gradually and sometimes takes months to manifest electronically; therefore, he was not surprised that the November 2021 EMG did not show cubital tunnel syndrome. He stated that Petitioner had clinical evidence of the syndrome, but the first EMG was performed soon after she was symptomatic, and it takes additional time to present on diagnostic tests. Dr. Fletcher testified that Petitioner had a severe condition and surgery was necessary for her to regain function of her right upper extremity. He ordered a SAM device to facilitate healing as the elbow MRI showed epicondylitis and some partial tears.

Dr. Fletcher testified that when he released Petitioner at MMI she still had some loss of ulnar nerve function and tenderness over the lateral elbow, but the surgeries improved her condition. He testified that the March 2022 EMG showed right radial tunnel involvement that they decided to observe; however, when she returned to him in May 2023 it was very symptomatic and had to be addressed. The EMG performed on 8/8/23 showed successful ulnar and median nerve surgeries at the elbow, but it confirmed his clinical diagnosis of distal ulnar

neuropathy with compression and radial tunnel neuropathy at the wrist that had worsened. He testified that the ulnar neuropathy at the canal of Guyon was a new finding. He testified that the condition was a consequence of her original diagnosis of cubital tunnel with compression at the elbow that made her susceptible to developing compression in her wrist. He referred Petitioner to Dr. Greatting because Dr. Baker had some health issues.

Dr. Fletcher opined that Petitioner required permanent restrictions because despite three surgeries to address nerve entrapment she still had evidence of pathology that could worsen without activity modification. He opined that Petitioner's permanent restrictions would not allow her to return to work as a nurse which is in the medium physical demand level. He opined that Petitioner could have performed her administrative job duties at Christie Clinic. He recommended indefinite home exercises and massage to maintain function.

Dr. Fletcher reviewed the 2015 EMG and testified it showed right ulnar neuropathy which could have been aggravated by her job duties at OSF. The EMG did not show carpal tunnel or radial tunnel syndrome. He noted that Petitioner did not have any further treatment after 2015 until her underlying ulnar neuropathy was aggravated by her job duties for Respondent. He opined that Petitioner's treatment was reasonable and necessary and objectively resolved Petitioner's conditions. He opined that based on his last examination Petitioner is going to be symptomatic indefinitely, which would vary depending on activity. He did not anticipate Petitioner would regain full strength, function, or dexterity, but her symptoms would improve.

On cross-examination, Dr. Fletcher testified that he is not a surgeon and he is not board-certified in hand or upper extremity treatment. He has not performed a carpal tunnel release since the 1980's. Dr. Fletcher testified that he is very knowledgeable and treats hand and upper extremity injuries. He stated that Petitioner performed constant heavy lifting, pushing, and pulling, which he defined as two-thirds of the workday.

Dr. Fletcher testified that he did not know the exact frequency in which Petitioner transported patients. He stated Petitioner told him she did charting on a constant basis because they were short staffed, which was two-thirds of the day. He based his causation opinion on a combination of charting, pushing, and pulling that represented two-thirds of Petitioner's day. He believed that Petitioner performed the burrito technique 3 to 4 times per day, which required multiple staff and the amount of force required of each nurse differed.

Dr. Fletcher did not observe Petitioner perform her job duties in ICU, but he did visit the Hospital's ER during the pandemic. He agreed that when Petitioner returned to him in May 2023 she had new findings and symptoms of ulnar nerve symptoms at the wrist. He agreed that he opined in his office note that Petitioner's pain was worsened by her typing duties at Christie Clinic. He believed that Petitioner's new distal ulnar neuropathy findings were related to her prior ulnar issues as she was more susceptible. He opined that he would attribute Petitioner's development of distal ulnar neuropathy to Petitioner's work duties at Christie Clinic, but she would not have developed the condition but for her prior conditions. He testified that when he released Petitioner in March 2023, he recommended observation of the radial tunnel that could result in future treatment.

Dr. Sam Biafora testified by way of evidence deposition on 11/9/22. (RX2) Dr. Biafora is a board-certified orthopedic surgeon. He performed a Section 12 examination on Petitioner on 8/18/22, (RX1) Petitioner reported noticing difficulty opening packages and weakness in her right hand in November 2021. At the time of his examination, Petitioner complained of numbness and tingling in her elbow that radiated into her forearm and 4th and 5th fingers, and numbness and tingling in her first three fingers. She had no complaints with her left side and examination of her left arm was unremarkable. Petitioner wore a sling on her right arm. His physical examination revealed Petitioner's right ulnar nerve surgery at the elbow from 6/7/22, tenderness over the radial tunnel, no pain with bilateral wrist motion, mildly positive right carpal tunnel, some weakness in the first dorsal interosseous of the right hand, and weakness in flexion of the DIP joint of the small and ring fingers.

Dr. Biafora testified that the 12/2/21 EMG showed mild right carpal tunnel syndrome and no ulnar neuropathy at the elbow. The 3/23/22 EMG showed moderate-to-severe right ulnar neuropathy, mild-to-moderate posterior interosseous neuropathy evidencing radial tunnel syndrome, and mild carpal tunnel syndrome. His examination occurred one week prior to Petitioner's second surgery on 8/25/22 for radial tunnel syndrome. He diagnosed right cubital tunnel syndrome, operated right ulnar nerve decompression with submuscular transposition, right radial tunnel syndrome, and right carpal tunnel syndrome.

Dr. Biafora opined that Petitioner's conditions were not causally connected to her work duties as a nurse in the ICU. He testified that peripheral nerve entrapments required force through the elbow, wrist, or forearm on a sustained or repetitive basis for a prolonged period of time. He stated that nurses intermittently transferred patients and hauled or lifted linen bags on occasion. He opined that nursing is not a physically laborious position in which they are pulling forcefully on a consistent basis. Dr. Biafora stated that peripheral neuropathy entrapment is most commonly an idiopathic condition. He could not definitively say that his opinion would be impacted by the fact Petitioner had symptoms only in her dominant arm. Despite causation, Dr. Biafora testified that Petitioner's treatment through the date of his examination was reasonable and necessary, and she would have required restrictions as she was two months out from surgery.

On cross-examination, Dr. Biafora testified that he had no evidence that Petitioner treated for her right arm or hand between December 2019 and November 2021. He understood that Petitioner worked full duty as a nurse during that period. He understood that Petitioner had 36 years of experience as a nurse and worked for Respondent for 21 years. Dr. Biafora did not know how many hours a day Petitioner worked in 2021, but it would not affect his opinion. He had no knowledge of Petitioner's status since 8/30/22.

Dr. Biafora testified that he did not know how many COVID patients Petitioner cared for in 2020 and 2021. He was not aware that Respondent had any staffing issues in 2020 or 2021. Dr. Biafora testified that it is not unusual for a person to develop three separate maladies in one extremity idiopathically. He was not aware of any nonoccupational risk factors that may have contributed to Petitioner developing carpal, cubital, and radial tunnel syndrome. He opined that none of Petitioner's conditions were caused by her work duties, regardless of how many patients she cared for or how many hours a day she worked, because her duties were not consistent and were not forceful, strenuous, or laborious activities.

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?

In a repetitive trauma case, issues of accident and causation are intertwined. *Elizabeth Boettcher v. Spectrum Property Group and First Merit Venture*, 99 I.I.C. 0961. An employee who has suffered a repetitive-trauma injury must meet the same standard of proof as an employee who suffers a sudden injury. *City of Springfield v. Illinois Workers' Comp. Comm'n*, 388 Ill. App. 3d 297, 313 (4th Dist. 2009). "Petitioner need only prove that some act or phase of employment was a causative factor of the resulting injury." *Three D Discount Store v. Industrial Comm'n*, 198 Ill. App. 3d 43, 49 (4th Dist. 1989). Even if the employee had a preexisting condition which made her more vulnerable to injury, recovery for an accidental injury will not be denied if she can show that the employment was also a causative factor. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 205 (2003). An employee may establish a causal connection in such cases if she can show that a work-related injury played a role in aggravating or accelerating a preexisting condition. *Id.* at 204-05.

In *City of Springfield v. Illinois Workers' Comp. Comm'n*, the Appellate Court issued a favorable decision in a repetitive case to a claimant in which the claimant's work was "varied" but also "repetitive" or "intensive" in that he used his hands, albeit for different task, for at least five hours out of an eight-hour work day. *City of Springfield v. Illinois Workers' Compensation Comm'n*, 388 Ill. App. 3d 297, 314 (4th Dist. 2009). As was noted by the Commission and reiterated in the Appellate Court decision in the *City of Springfield*, "while [claimant's] duties may not have been 'repetitive' in a sense that the same thing was done over and over again as on an assembly line, the Commission finds that his duties required an intensive use of his hands and arms and his injuries were certainly cumulative." *Id.* "There is no legal requirement that a certain percentage of the workday be spent on a task in order to support a finding of repetitive trauma." *Edward Hines Precision Components v. Industrial Comm'n*, 356 Ill. App. 3d 186, 193-94 (2d Dist. 2005).

Petitioner testified she experienced increased pain, numbness, and tingling in her right upper extremity approximately one month before she reported her injuries. She had difficulty with dexterity and weakness that affected her job duties of opening pill packets, writing, and carrying linen bags. Petitioner initially attributed her symptoms to not having worked in an ICU setting for 15 years. She testified that she did not have symptoms before returning to work in an ICU setting in June 2021 and her symptoms improved when she was off work. Petitioner became a nurse in 1986 and had worked for Respondent for 21 years. She testified that at the end of a 3-day work shift she carried a bag of linen out of a patient's room and involuntarily dropped it in the hallway because she lost her grip strength, which prompted her to seek medical treatment.

Petitioner admitted that she had symptoms in her right hand/arm prior to November 2021. In 2015, an EMG/NCS of her right upper extremity revealed mild ulnar entrapment neuropathy at the elbow and borderline carpal tunnel syndrome. Petitioner treated with Dr. Habib on 8/19/15

for migraines and he noted she had intermittent numbness and tingling in her right 4th and 5th digits. Petitioner used an elbow splint that helped alleviate her symptoms. Dr. Habib recommended that Petitioner continue wearing the elbow splint as-needed. There is no evidence that Petitioner treated for any symptoms related to her right arm or hand from August 2015 until November 2021.

The Arbitrator notes that the Illinois Appellate Court recently held in *Tazewell County v. IWCC*, 2025 IL App (4th) 230754WC ¶ 31, that when a preexisting condition is asymptomatic and then becomes painful as the result of work-related activity, that symptomatic condition is compensable under the Act as an aggravation of the preexisting condition even in the absence of an organic or structural change in the preexisting condition. When a preexisting asymptomatic condition becomes painful for reasons other than an organic or structural change or natural progression, it follows that the preexisting condition was aggravated by something. *Id.* If the aggravation is work-related, and solely causes pain, we hold that the pain suffered is, in and of itself, a compensable aggravation of the preexisting condition. *Id.*

Petitioner was working her nursing duties on a full-time basis without restriction prior to November 2021. Although Petitioner's supervisor disputed the nature of her job duties, Ms. Sutton admitted she never observed Petitioner working in the ICU. There was no testimony by any witness that observed Petitioner perform her job duties in the ICU. There was minimal evidence to rebut Petitioner's testimony that she did care for higher-level patients that required cleaning, linen changes, and turning using the "burrito roll" technique. Although Ms. Sutton testified that Petitioner was not assigned to critical care patients because she could not mentally handle the job, her testimony was based on third hand knowledge from Petitioner's co-workers that communicated the allegation to Ms. Dunn, who conveyed the concern to herself. None of Petitioner's co-workers or Ms. Dunn testified at arbitration. No documentation of Petitioner's job assignments was admitted into evidence.

Ms. Sutton agreed that nursing can be physically challenging in circumstances where the facility is short-staffed or had higher level acuity patients. She denied that Respondent was short staffed during the COVID pandemic. She stated the ICU was a 13-bed unit and they had three traveling nurses and staffed 4 to 5 nurses at night, with one nurse assigned to 2 or 3 patients. Ms. Sutton testified that Respondent had an increase in patients in March and April 2021, but the number "plummeted" and by July 2021 they had 12 COVID patients. She did not testify what percentage the ICU patient population decreased, but her testimony supports Dr. Fletcher's opinion that during the pandemic the ICU capacity was "stretched to the max". Ms. Sutton's use of the word "plummeted" suggests that the ICU patient population was significantly more than the 12 COVID patients they had in July. Ms. Sutton then testified that during the pandemic they only averaged 9 to 10 patients at one time, 60% being stepdown patients, and 40% being critical care patients. She did not clarify which of the 12 COVID patients in July were stepdown versus critical, or how many additional non-COVID patients were in the ICU in July 2021 or in the months following.

Dr. Fletcher testified that he is very intimately familiar with OSF Heart of Mary. He has admitting privileges at the hospital since 2001, he has served on the Hospital's Board for a second term since 2017, and he interacts with the Chief Medical Officer and CEO frequently. He

stated he is very familiar with the hospital's problems getting proper staffing. At the time Petitioner worked in the ICU, he understood that the ICU was extremely short staffed and they had to work long shifts.

The Arbitrator is more persuaded by the opinions of Dr. Fletcher than those of Dr. Biafora. Dr. Fletcher is an occupational medicine specialist who is familiar Petitioner's job duties as an ICU nurse. He opined that a sustained torque motion on the elbow is a precursor to the development of ulnar neuropathy. He testified that Petitioner's preexisting neuropathic condition in her right upper extremity made her more susceptible and her job duties permanently aggravated the conditions. Dr. Fletcher found important the lack of evidence of any other explanation for the development of Petitioner's conditions outside of work. He did not believe that Petitioner's conditions developed idiopathically as she only had symptoms in her dominant right arm and hand and she had no nonoccupational risk factors.

Dr. Biafora testified that nursing is not a physically laborious position that requires force through the elbow, wrist, or forearm on a sustained or repetitive basis for a prolonged period of time. He did not testify as to the job duty description of a Registered Nurse admitted into evidence. The job description required Petitioner to in part, "Operates office and medical equipment constantly. Frequently lifts/moves/carries objects/persons up to 35 pounds or more...Constant coordination of hands, fingers, feet, and eyes..." (RX5) Dr. Biafora described Petitioner's job duties as "intermittent". There is no evidence that Dr. Biafora made an adequate inquiry into Petitioner's specific job duties in order to provide a persuasive causation opinion. He testified that he did not know, and it would not affect his opinion, how many hours a day Petitioner worked or how many patients she cared for because she did not perform consistent forceful, strenuous, or laborious activities. He was not aware that Respondent had any staffing issues in 2020 or 2021. Dr. Biafora's opinion that Petitioner's conditions developed idiopathically is not persuasive and appears to be based on his opinion that no nursing position could possibly cause peripheral nerve entrapment conditions.

Dr. Biafora was not aware of any nonoccupational risk factors that may have contributed to Petitioner's conditions, other than her age and gender. He had no evidence that Petitioner treated for her right arm or hand in the years leading up to November 2021, and agreed she was working full duty without limitation as a nurse. He could not definitively say that his opinion would be impacted by the fact Petitioner had symptoms only in her dominant arm. Despite causation, Dr. Biafora opined that Petitioner was properly diagnosed and her treatment was reasonable and necessary.

Based on the evidence as a whole, the Arbitrator finds that Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent on 11/17/21, and that her current conditions of ill-being are causally connected to her work injury.

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?

Based on Dr. Fletcher and Dr. Biafora's opinions that Petitioner's treatment was reasonable and necessary, and the Arbitrator's findings as to accident and causal connection, the Arbitrator finds that Petitioner is entitled to medical expenses. Therefore, Respondent shall pay all medical bills contained in Petitioner's Group Exhibits 12 through 25, pursuant to the Illinois medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall further reimburse Petitioner directly for out-of-pocket medical expenses she paid in the amount of \$2,946.53.

Petitioner testified that some of her medical bills were paid through her private health insurance coverage and not through Respondent's group health insurance. Therefore, Respondent is not entitled to a credit under Section 8(j) of the Act. Respondent shall receive a credit for medical expenses paid in the amount of \$2,807.85. (RX4)

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

Petitioner claims entitlement to temporary total disability benefits from 11/12/21 through 2/7/22, 6/7/22 through 7/26/22, 8/25/22 through 2/15/23, and 5/26/23 through 3/14/24. Respondent disputed liability for TTD benefits based on accident and causal connection.

On 11/29/21, RN Barrett signed a leave of absence form placing Petitioner off work from 11/27/21 until "2/27/21". It is unclear whether RN Barrett intended to place Petitioner off work through 12/27/21 or 2/27/22. Petitioner completed an Incident Report and stated her last day worked was on 11/24/21. On 12/16/21, Dr. Keller placed Petitioner off work. On 1/6/22, Dr. Keller continued Petitioner off work pending an examination by Dr. Oakey. Petitioner was examined by Dr. Oakey on 1/12/22 who referred her to Dr. Michaels for a cervical evaluation and opined Petitioner could return to full duty work pending the evaluation. Petitioner was examined by Dr. Michaels on 1/24/22 who placed her off work pending a neurosurgical evaluation. Petitioner testified that she voluntarily resigned her employment with Respondent on 2/7/22 and she claims entitlement to TTD benefits through this date. (AX1)

Petitioner was placed off work again on 6/7/22 when Dr. Baker performed a right ulnar nerve transposition. The Arbitrator notes that 6/7/22 was the effective date of Petitioner's disability determined by the Social Security Administration. On 7/20/22, Dr. Fletcher continued Petitioner off work through her next appointment on 8/9/22. However, Dr. Fletcher completed a work accommodation questionnaire from Christie Clinic on 7/26/22 and allowed Petitioner to return to work with restrictions effective 7/27/22, including no constant grasping or vibrational exposure, no lifting greater than 10 pounds occasionally and 3 pounds frequently, and no direct patient care. Dr. Fletcher advised that Petitioner could not lift 50 pounds per the job description for a cardiac diagnostics nurse. (PX1, p. 64-65) Petitioner testified that she returned to work for Christie Clinic and her restrictions were accommodated.

Petitioner was placed off work again on 8/25/22 when Dr. Baker performed a right carpal tunnel release and flexor synovectomy of Petitioner's right wrist and distal arm. She was continued off work through 2/15/23 at which time Dr. Fletcher released her with light duty restrictions. Petitioner testified that after this second surgery she returned to work at Christie Clinic in a management position. On 3/14/23, Dr. Fletcher released Petitioner at MMI with

permanent restrictions of no lifting greater than 30 pounds occasionally and 15 pounds frequently, no constant grasping, pulling, or carrying with her right upper extremity, and no vibratory activities.

Petitioner returned to Dr. Fletcher on 5/26/23 with worsening pain in her right elbow, hand, and arm made worse by typing as an RN/Administrative Coordinator at Christie Clinic. Dr. Fletcher placed Petitioner off work pending additional treatment. On 6/3/23, Dr. Fletcher completed another work restriction questionnaire from Christie Clinic. (PX1, p. 167) The questionnaire indicated “a copy of the team member’s job description” was attached, but said document was not contained in Dr. Fletcher’s records admitted into evidence. His restrictions, among others, included no typing more than one hour per day. There was no evidence what percentage of the day Petitioner was required to type or keyboard as an Administrative Coordinator, or that her restrictions would have been accommodated. Petitioner testified that she resigned from employment with Christie Clinic on 5/27/23, the day after Dr Fletcher placed her back off work.

On 7/11/23, Dr. Fletcher ordered an updated EMG and noted Petitioner was unable to keep her new job because they exceeded her restrictions. On 8/11/23, Dr. Fletcher referred Petitioner to Dr. Greatting for a surgical consult and allowed her to return to light duty work with restrictions of limited use of her right upper extremity and no lifting more than 10 pounds. There was no evidence that Petitioner could have performed her job duties as an RN/Administrative Coordinator or that Christie Clinic would have accommodated her restrictions had she not resigned. Petitioner testified that she began working as a nurse for Fresenius Kidney Care in September 2023, but she had difficulty with typing. Petitioner did not testify as to what dates she was employed by Fresenius Kidney Care and there was no evidence of income admitted at arbitration. On 11/8/23, Dr. Baker performed a right radial tunnel release and right ulnar nerve release at the wrist and Petitioner was placed off work. On 2/1/24, Dr. Fletcher released Petitioner to return to work with restrictions of limited use of her right upper extremity and no lifting over 10 pounds. Dr. Fletcher released Petitioner at MMI on 3/14/24 with permanent restrictions of no lifting greater than 10 pounds. On 3/21/24, Dr. Greatting released Petitioner at MMI and opined that Petitioner would not be able to return to her job as an ICU nurse.

Based on the Arbitrator’s findings as to accident and causal connection, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits. Therefore, Respondent shall pay Petitioner temporary total disability benefits of \$1,061.03/week for 83 weeks, commencing 11/27/21 through 1/12/22, 1/24/22 through 2/7/22, 6/7/22 through 7/26/22, 8/25/22 through 2/15/23, and 5/26/23 through 3/14/24, as provided in Section 8(b) of the Act. Respondent shall receive a credit of \$7,000.00 in temporary total disability benefits paid, pursuant to the stipulation of the parties.

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

The Arbitrator finds that an award under Section 8(e) of the Act does not adequately compensate Petitioner for the loss sustained. Rather, the Arbitrator finds that the appropriate award should be for loss of an occupation/trade as provided in Section 8(d)2 of the Act. The Arbitrator finds that Petitioner is not able to return to her usual and customary duties as an ICU

nurse. The Arbitrator is guided by the Commission's decision in *O'Leary v. City of Chicago*, 98-WC-8840, 07 IWCC 743 (2007), wherein the Commission affirmed the decision of the Arbitrator who awarded 40% loss to the person as a whole based upon Petitioner's loss of occupation as a result of a right ankle injury. The Commission Decision, which adopted the Arbitrator's award, discussed in detail a number of cases wherein an award under Section 8(d)2 was made for loss of occupation rather than Section 8(e). The *O'Leary* decision cited with approval *Barfell v. U.E. and C. Catalytic Inc.*, 96 IIC 1299, wherein a 37 year old pipefitter who suffered a left torn meniscus that required surgery was placed on permanent work restrictions. The employer in *Barfell* provided Petitioner with fulltime work as a welder and earned union scale wages as a pipefitter. Nonetheless, the Commission concluded that a 40% loss of use under Section 8(d)2 rather than loss of use of a leg under Section 8(e) was appropriate. The commission cited *O'Leary, supra* with approval in *Ridgeway v. TLC*, 02 IWCC 65692, 11 IWCC 0920, 2011 WL 5014274.

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 impairment rating. Therefore, the Arbitrator places no weight on this factor.
- (ii) **Occupation:** Petitioner was released to return to work with permanent restrictions. Dr. Fletcher and Dr. Greatting opined that Petitioner could not return to work as a nurse which was in the medium physical demand level. Dr. Fletcher opined that Petitioner could work as an administrative assistant. Petitioner has not obtained employment since Dr. Fletcher released her at MMI on 3/14/24 and she is currently receiving social security disability benefits. The Arbitrator places greater weight on this factor.
- (iii) **Age:** Petitioner was 62 years old at the time of accident. The Arbitrator places some weight on this factor.
- (iv) **Earning Capacity:** Petitioner was released to return to work with permanent restrictions that prevent her from returning to her pre-accident employment. Dr. Fletcher opined that Petitioner could perform administrative duties; however, Petitioner has not been employed since being released at MMI on 3/14/24 and she is currently receiving social security disability benefits. The Arbitrator places some weight on this factor.
- (v) **Disability:** As a result of the accident, Petitioner underwent three surgeries consisting of a right ulnar nerve transposition, carpal tunnel release and flexor synovectomy of the wrist and distal forearm, radial tunnel release, and ulnar nerve release at the wrist.

On 3/14/24, Dr. Fletcher released Petitioner at MMI with permanent restrictions of no lifting greater than 10 pounds. He opined that Petitioner could not return to work as a nurse. On 3/21/24, Dr. Greatting released Petitioner at MMI and noted Petitioner continued to have some pain, numbness, and tingling in her right arm. She wore a compression sleeve on her arm that helped with discomfort. She took Tylenol and Advil as needed, and Tramadol 2 to 3 times per week for increased pain. Dr. Greatting opined that Petitioner would have chronic symptoms in her right arm and she could not return to her job as an ICU nurse. Dr. Fletcher opined that Petitioner could perform administrative duties; however, Petitioner has not been employed since being released at MMI and she is currently receiving social security disability benefits.

Petitioner testified that her right hand gets cold with an achy and tingling sensation. She wears a wrap to keep pressure on her arm and a glove for coldness and to prevent people from shaking her hand. Petitioner stated she has no sensation on the inside of her right arm preventing her from feeling heat or pain. She has hypersensitivity and nerve pain on the outside of her arm from her elbow to her fingers. Her arm pain increases with movement, and she has to hook her right thumb in her waistband when she walks to prevent it from swinging free. Petitioner testified that her hand is weak, and she can tolerate carrying up to one pound. She has loss of dexterity making it difficult to write, use a knife or scissors, or open jars. She cannot lift laundry baskets or her grandchildren. She takes ibuprofen and Tramadol for her symptoms. The Arbitrator places greater weight on this factor.

Based upon the foregoing evidence and factors, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 35% loss of the person as a whole, as provided in Section 8(d)2 of the Act.



MAY 20 2025

Arbitrator Linda J. Cantrell

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	06WC021799
Case Name	Shelton L Loving v. United Airlines
Consolidated Cases	06WC021800 06WC021815 07WC002653
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	25IWCC0499
Number of Pages of Decision	58
Decision Issued By	Carolyn Doherty, Commissioner

Petitioner Attorney	Brian McManus, Jr., Donald Gallagher
Respondent Attorney	Karen Coon

DATE FILED: 12/19/2025

/s/ Carolyn Doherty, Commissioner
Signature

06 WC 21799

Page 1

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)
☐ Modify	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Shelton L. Loving,
 Petitioner,

vs.

No: 06 WC 21799

United Airlines, 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 causal connection, temporary total disability, maintenance, 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.¹

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 4, 2025, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under Section 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.

¹ Petitioner's Petition for Review refers to 06 WC 21799, which was tried together with the claims in 06 WC 21800, 06 WC 21815, and 07 WC 2653, and the Arbitrator issued four decisions. The Statement of Exceptions of both parties address the issues in all four claims. Accordingly, the Commission is issuing four separate decisions in this matter.

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.

December 19, 2025

O: 12/10/25

CMD/kcb

045

/s/ *Carolyn M. Doherty*

Carolyn M. Doherty

/s/ *Raychel A. Wesley*

Raychel A. Wesley

/s/ *Frank J. Soto*

Frank J. Soto

ILLINOIS WORKERS' COMPENSATION COMMISSION
DECISION SIGNATURE PAGE

Case Number	06WC021799
Case Name	Shelton L Loving v. United Airlines
Consolidated Cases	06WC021800; 06WC021815; 07WC002653;
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	55
Decision Issued By	Jacqueline Hickey, Arbitrator

Petitioner Attorney	Brian McManus Jr, Donald Gallagher
Respondent Attorney	Karen Coon

DATE FILED: 3/4/2025

/s/Jacqueline Hickey, Arbitrator
Signature

THE INTEREST RATE FOR THE WEEK OF MARCH 4, 2025 4.14%

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**

Shelton L. Loving

Employee/Petitioner

v.

United Airlines, Inc.

Employer/Respondent

Case # **06 WC 21799**

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 **Jacqueline Hickey**, Arbitrator of the Commission, in the city of **Chicago**, on **9/30/24**. 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 **11/4/05**, 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 **\$56,460.04**; the average weekly wage was **\$1,085.77**.

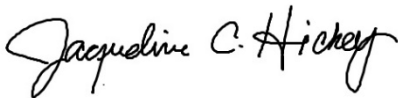
On the date of accident, Petitioner was 46 years of age, married with **4** dependent children.

ORDER

No permanent partial disability is awarded for this injury and this case. Permanency is awarded for Petitioner's 4/17/06 case only. Please see Decision in 07 WC 002653 and attached Rider to Decisions.

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 4, 2025

First Work Accident: 11/04/05

On November 4, 2005, the petitioner testified he was hooking up two containers for the luggage which weighed about 1,700 pounds. As he was going to clamp the container on the tug he was driving, he slipped on the ice, tried to catch himself and hurt his back (Tr. 24). The petitioner was seen at UIC Medical Clinic at O'Hare and was treated with muscle relaxers. The petitioner worked full duty until his second work accident and did not lose any time after this accident (Tr. 26-27).

Second Work Accident: 12/23/05

On December 23, 2005, the petitioner testified he was hooking up containers to a tug. He was hooking up two containers back-to-back and he injured his back, legs, and hips (Tr. 28). He once again was seen at UIC at O'Hare and then at Celar Chiropractic (Tr. 28). Petitioner testified he was also referred to and seen by Dr. McGinness, his primary care physician, by Celar. (Tr. 29). Again, the petitioner did not lose any time from work. (Id.)

Third Work Accident: 3/10/06

On March 10, 2006, the petitioner was handling luggage. As he was taking the luggage out of the containers to put on the belt, he felt something pop in his neck, arm and right shoulder (pp. 29-30). Petitioner sought treatment with Dr. McGinness, Celar Chiropractic, and Rush Oak Park Hospital (Tr. 31) but he continued working full duty (Tr. 31).

Fourth Work Accident: 4/17/06

On April 17, 2006, the petitioner was in the belly of a plane getting bags off the belt loader. Because he was working in an RJ jet, which was very tight, he was squatting to pick up luggage and heard something pop in his back (Tr. 33). He fell down and felt his neck pull because he was picking up the luggage and his back popped and went out and he fell (Tr. 33). He testified he could not move and the luggage started falling on him and he yelled for help. His coworkers stopped the belt and ran to get assistance (pp. 33-34). Petitioner was taken by ambulance to the hospital (Tr. 34). April 17, 2006 was the last day petitioner worked for Respondent, United Airlines (Tr. 35).

Petitioner's Testimony

After the ER, Petitioner was seen by his primary care physician Dr. McGinness who prescribed an MRI. (Tr. 35). After the MRI Mr. Loving was referred to Dr. Coe and Dr. Amin. (TR p 35). Petitioner was referred to Midwest Orthopedics at Rush and seen by Dr. Palmer a pain management doctor. (Tr. 36) Dr. Palmer eventually referred the petitioner to Dr. Goldberg for surgical consultation. (Id.) Petitioner also saw Dr. Nicholson from Midwest Orthopedics. (Tr.37) At Midwest Orthopaedics at Rush, Petitioner saw all of the following doctors: Dr. Nicholson, Dr. Goldberg, Dr. Palmer and Dr. April Fetzer (Tr. 36). Petitioner testified to the L4 through S1 fusion surgery performed by Dr. Goldberg but testified that it was a failed fusion and he got no relief from the surgery (Tr. 39). He subsequently followed up with Dr. Fetzer and got shots and pain management in his back, after the fusion. (Id.) He also received shots and physical therapy for his neck (Tr. 40).

Petitioner also testified that he relocated to Springfield in 2011 through 2014. (Tr. 40)

The petitioner began the vocational process with Joseph Belmonte at Vocamotive in September 2007 (Tr. 41). The petitioner had been released by Dr. Goldberg with lifting restrictions of 40 pounds from floor to waist, 25 pounds from waist to the middle of his chest and 10 pounds from his chest and up (Tr. 41-42). Petitioner testified he did not begin looking for jobs within those restrictions with Vocamotive as he was in a lot of pain and on a lot of heavy narcotics. (Tr. 42-43) He testified that he kept falling asleep with his head on the desk. He testified that he told Dr. McGinness he was having problems in class falling asleep due to the drugs and pain and that the doctor therefore took him out of school because of the narcotics (Tr. 44). The petitioner testified to the letter he received from Mr. Belmonte apologizing for the accusations regarding petitioner being called a liar and not getting hurt (Tr. 43-44) He testified that Vocamotive also had an employee who was less than professional and somewhat ill-will motivated with petitioner (Id.)

After stopping Vocamotive services, Petitioner testified that he treated with Dr. McGinness, in the basement of Oak Park Rush Physical Therapy Athletics in Countryside and did self-rehabilitation. (Tr. 52-53)

Petitioner testified in 2008 he was struck from behind in a car accident. The paramedics were called and an ambulance took him for medical treatment (Tr. 55). He was provided a pain shot and he began seeking treatment at West Suburban (Tr. 55). With reference to the auto accident in 2008, petitioner confirmed he was stopped at a stop sign and a lady ran into him going 35 to 40 miles per hour (Tr. 89). When he was seen at Loyola Hospital ER following the auto accident, he complained of pain to his neck, back, chest, and right shoulder (Tr. 90). He also treated for his neck and back with West Suburban Medical Center following the automobile accident (Tr. 90). He was unable to recall how much money he received in a monetary settlement from the auto accident (Tr. 91).

Petitioner testified that he initially saw Dr. Song in the hospital on November 15, 2022 at Hinsdale Hospital ER (Tr. 59). He testified that he went to Rush the day before and was given a shot of Toradol which did not improve his condition (Tr. 59). He felt he could not move his legs and was in excruciating pain. He reported he had to crawl to the front room to get to a phone to call paramedics, as he could not move (Tr. 60). Petitioner testified that he has not seen any doctor since Dr. Song performed the second lumbar surgery (Tr. 57). Before seeing Dr. Song petitioner was treating with Dr. Salvador in Springfield, Dr. Ross in Savannah, GA, and Rush Oak Park Hospital. (Tr. 61). Since the surgery, he testified that both legs are numb (Tr. 57).

The petitioner testified to prior education at Moody Bible Institute, National Technical Institute, and DeVry Technical Institute. In addition, he went to Malcom X College for three years. He previously worked as a forklift operator, and did manufacturing and palletizing. He also worked security for Arch and Bright Security at ORD and did temp work for Manpower. Lastly, he testified that he worked for the U.S. Postal Service (pp. 93-94). Mr. Loving was asked about his desire as expressed to Mr. Belmonte to move to California and become a script writer and becoming an alderman or congressman (Tr. 94). He stated he talked with Mr. Clint Eastwood a couple times and another black star, but they were not interested in his scripts (Tr. 95).

He also suggested that when working with Mr. Belmonte they showed he was getting As and Bs on the testing, but that he was asleep and they went into his computer and put the As and Bs in there for him (Tr. 96).

Mr. Loving testified that Dr. McGinness, his PCP and current physician, at the present still has petitioner temporarily and totally disabled, and completely off work. (Tr. 51-52) Presently, Petitioner testified that both of his legs go numb. (Tr. 57) Petitioner testified he has not looked for work within the restrictions given, as his body is no good (Tr. 64). The petitioner testified that currently he has ongoing pain and does not sleep at night. He is unable to clean and he has a maid from the State who comes to clean his house and cook his dinners (Tr. 69). He also received Meals on Wheels in Countryside, Illinois. (Tr. 69). Presently Petitioner stated he does not really feel like a man without being able to work and being infirmed. (Tr. 70) Mr. Loving is currently on Medicare and social security disability. (Tr. 73) Mr. Loving testified that he knows he cannot work and just underwent another back surgery in 2022. (Tr. 74) Petitioner stated he still has 10 rods and two brackets still in his lumbar spine. (Tr. 75) Petitioner has fallen to the ground twice after his second back surgery with Dr. Song. (Id.) Mr. Loving testified he has never, not been able to work until these four work related injuries occurred. (Tr. 104

On cross examination, the Petitioner testified he did not recall being seen on multiple dates in the years prior to the work accidents for low back pain. (Tr. 1-85) He did testify he previously suffered from migraines but did not recall who he had seen for them (Tr. 81). When presented with the medical records of prior low back pain complaints, he stated, "To me, it seems like there is consistency of going to the doctor for my back. I don't remember if it was" (Tr. 86). Petitioner was specifically asked about seven prior doctors' visits from March 1999 through August 2004, with/at St. Luke's, Dr. Leavitt, Dr. McGinness and Dr. Lenhardt for complaints relating to the low back, migraines and right upper arm. (Tr. 81-85).

Testimony of David Aranda- Respondent witness

The respondent introduced the surveillance video evidence with the testimony of David Aranda, the investigator. The petitioner was surveilled on March 5 and March 7, 2020. (RX 8a/8b) The petitioner is seen going on several errands. On March 7, 2020 the petitioner went to a church for an event. The video shows him walking freely and without pain. He is seen lifting and moving two traffic cones and lifting and carrying a piece of luggage. This is all done without any apparent limitation.

Medical Record Summary

On November 16, 1999 the petitioner was seen by Dr. J. Leavitt where he complained of both lower and upper back pain. Dr. Leavitt ordered an x-ray of the right hip and pelvis and suggested taking Motrin. As is noted by Dr. Leavitt in a visit with the petitioner on March 7, 2000, the petitioner never went to get the prescribed x-rays and he never took the suggested Motrin. Petitioner was still complaining of lower back pain at this time.

On August 23, 2002 petitioner presented to Anchor Medical Group complaining of chest pain, kidney pain, and right lower abdomen pain. The report is handwritten but petitioner was assessed in part with mechanical back pain. (Rx. 5)

On November 4, 2002 petitioner presented to Anchor Medical Group again complaining of back pain that appeared to be causing pain in his right upper arm. (RX 5, Pg. 8)

On April 6, 2004 Dr. Kurtzman authored a letter to Dr. McGinness for referring petitioner to him. Dr. Kurtzman recommended petitioner see a neurologist and obtain an MRI of the brain because of his history of migraine headaches that recently increased.

Petitioner went again to Oak Park Anchor Medical Group with complaints of back pain again on May 17, 2004. (RX 5, Pg. 13)

On June 28, 2004 petitioner complained of back pain and difficulty breathing during his visit at Anchor Medical Group. (RX 5, Pg. 14)

On July 12, 2004, petitioner was seen in follow up. (RX 5, Pg. 15-16) An x-ray of the dorsal spine was taken that showed apparent generalized increased sclerosis throughout the lower thoracic spine. A bone scan was recommended by the radiologist. On July 31, 2004 a bone scan showed no abnormalities.

On August 12, 2004 Dr. Lernhardt authored a letter to Dr. McGinnis regarding a recent evaluation of right posterior pleuric discomfort and back pain that petitioner stated was ongoing the prior 10 weeks. Dr. Lernhardt opined petitioner's back pain was very likely related to musculoskeletal discomfort and the mild pleuritic component was related to the same. He recommended petitioner continue analgesics and minimize heavy lifting.

On November 4, 2004 petitioner complained of right pelvic, hip, and back pain. (RX 5, Pg.8)

On April 15, 2005 petitioner complained severe headaches with dizziness during his visit at Anchor Medical Group. (RX 5, Pg. 21)

Petitioner was seen at UIC Medical Center at O'Hare November 4, 2005. (PX 20) He reported lifting heavy bags on his knees in the pit when he twisted the wrong way with a heavy bag. He reported feeling pain in his low back area.

The petitioner was seen on December 23, 2005 at UIC at O'Hare. (PX 20). He reported he had a lumbar sprain November 4 and was sent back to full duty on the date of accident but reported continued pain with lifting since that time and acute increase in low back pain and radiation into left thigh when lifting a heavy bag this afternoon. He reported no pain distal to the knee and no numbness, weakness or tingling. Neurological testing was normal. Petitioner was ordered to do light duty work and prescribed tramadol and naproxen.

The petitioner was seen again at UIC at O'Hare on December 29, 2005. He reported his pain was worse and he had trouble getting out of bed this morning. The impression was lumbar strain and he was referred to an ortho. (PX 20).

Petitioner was seen on January 10, 2006 at Rush Oak Park Physician's Group complaining of back pain, left abdominal pain and left ear pain. He reported that he injured himself at work on December 8, 2005 when he pulled something in his back. (RX 5, Pg. 28)

Petitioner then sought treatment at Celar Chiropractic with Dr. Celar beginning on January 11, 2006. Petitioner continued to be seen at that facility on a weekly basis for low back pain, left shoulder pain, and upper back pain. (PX 10)

On January 11, 2006 an x-ray of the lumbar spine was taken and showed: (1) spinal biomechanical alterations; (2) facet tropism; (3) facet arthrosis; and (4) degenerative disc disease at L5.

On February 22, 2006 Dr. Celar completed a work status form that indicated petitioner was to work full duty. Petitioner continued attending chiropractic sessions.

Petitioner was seen at Celar Chiropractic on March 14, 2006 for a new injury. On March 14, 2006, Dr. Celar opined petitioner had an acute rotator cuff/deltoid sprain/strain from the work injury and might need an MRI. He reported he was injured while lifting up and tossing a heavy bag. Petitioner reported pain in the right arm and upper back. PX 10.

On April 13, 2006 petitioner followed up at Rush Oak Park Physicians Group for pain in his right arm. (RX 5, Pg. 32)

On April 17, 2006, the petitioner was taken by Chicago Fire Department Ambulance to Resurrection Medical Center. The fire department ambulance records specifically note he had no neck or upper back pain. (Px 7)

The petitioner was seen at Resurrection Medical Center on April 17, 2006 for low back pain while lifting a suitcase. (PX 7). A pain diagram also indicates pain only in the low back. Petitioner stated he bent over to pick up a luggage bag and felt something pull in his back. He was ambulatory. Petitioner again reported he felt something in his lower back go crunch after he bent over and lifted a piece of luggage out of a small cargo area. (PX 7). At the time of petitioner's discharge, he reported his pain was much better. X-rays of the lumbar spine were normal with vertebral heights and intervertebral spaces maintained.

On April 18, 2006, the petitioner presented for evaluation of low back pain at Rush Oak Park Physicians Group after claiming he hurt his back at work on April 17, 2006. (RX 5, Pg. 34) He reported that while bending over to pick up some luggage, he felt a crackle in his right lower back.

An MRI of the right shoulder was performed on April 18, 2006. (RX 6, Pg 240) The study showed a possible Hill-Sachs deformity and associated marrow edema compatible with subacute injury. There was no conclusive evidence of a Bankart lesion. There were findings suggesting a strain of the distal aspect of the common tendon of the rotator cuff, however, it was noted a partial thickness tear could give a similar appearance

Petitioner was seen again by Dr. McGinness on April 26, 2006 for right lower back which radiated to the thigh with numbness to the right kneecap. (RX 5, Pg. 38)

On May 2, 2006, the Anchor Medical notes reflect that the injury was most likely a muscle sprain in the lower back. They refilled his hydrocodone and gave petitioner a prescription for Flexeril. An MRI was ordered.

Petitioner was seen on May 4, 2006 by Dr. Trish Palmer for evaluation of injuries to the left low back and right arm. (Rx 6, pg 46) Petitioner reported on March 10, 2006 he was lifting a heavy bag in his job as luggage handler. When he went to place it on the belt, he felt immediate pain. He complained of pain over the lateral anterior aspect of the right shoulder. Petitioner stated the low back pain began on April 17, 2006 while lifting a very heavy bag in a forward flexed position. Dr. Palmer diagnosed radicular back pain and right shoulder pain due to rotator cuff irritation or partial tear of the supraspinatus. As there was no frank tear, Dr. Palmer recommended a subacromial cortisone injection and physical therapy for the shoulder and the back. Dr. Palmer performed an injection into the subacromial space.

An MRI of the lumbar spine was performed on May 9, 2006 and demonstrated spondylitic and degenerative changes, a broad-based mild disc herniation at L4-L5, and a less pronounced herniation at L5-S1 to the right with associated right foraminal stenosis. (RX 6, pg 237)

When the petitioner returned to Dr. Palmer on May 15, 2006, he reported that the shoulder injections had completely relieved his pain for three days. (Rx 6, pg 44) His back symptoms were fairly consistent with the MRI results and Dr. Palmer recommended continued physical therapy. The petitioner was referred to Dr. Nicholson for further evaluation of the shoulder and was referred to Dr. April Fetzer for consideration of an epidural injection. Dr. Palmer continued monitoring the petitioner's Lyrica and Vicodin dosing, but noted she was limited as to what further she could offer the petitioner. The petitioner was seen in follow up by Dr. Palmer on June 12, 2006 with similar findings and recommendations. (Rx 6, pg 42)

The petitioner was next seen on June 19, 2006 by Dr. Palmer. (Rx 6, pg 40) He reported improvement in his back pain but was still complaining of a catching sensation with forward flexion in the shoulder. His back was improving with PT and he was referred to Dr. Nicholson for the shoulder. (Rx 6, pg 41)

A physical therapy progress note dated June 27, 2006 indicated that petitioner continued to have stiffness in his right upper extremity with continued decrease in range of motion. Overall though, petitioner felt his trunk range of motion and lumbar symptoms had improved. Active range of motion of the upper extremity was still limited which caused overhead activity deficits. On July 17, 2006, petitioner saw Dr. Palmer who opined petitioner might have a SLAP tear which did not show up on the MRI. (Rx 6, pg 38) Dr. Palmer referred petitioner to a shoulder specialist.

The petitioner was seen by shoulder specialist, Dr. Gregory Nicholson on August 1, 2006. (Rx 6, pg 86) Dr. Nicholson noted that as he started to examine the petitioner, he jumped out of the chair. The petitioner could not even tolerate even simple motion or isometrics. In reviewing the MRI, he noted there was a high signal within the bursa, however there did not appear to be a Hill Sachs deformity. The doctor noted the possibility of a small interior partial tear of the supraspinatus. He found the petitioner's pain to be out of proportion to his physical findings in the right shoulder. Dr. Nicholson noted the petitioner had a subacromial pathologic process including a small partial tear and subacromial bursitis. That being said, his pain was tremendously out of proportion to the physical findings. Dr. Nicholson opined that it would be dangerous to institute physical therapy or treatment until his back issues were sorted out. Dr. Nicholson was concerned about the petitioner's symptom magnification, as it was out of proportion to his physical findings for this type of pathology. (Rx 6, pg 87)

The petitioner was evaluated by Dr. April Fetzer on August 4, 2006. (Rx 6, pg 35) Petitioner reported that he initially injured himself on November 4, 2005 with right-sided axial low back pain and right thigh symptoms. He was treated by a United Airlines physician with a muscle relaxant and chiropractic treatment, however his symptoms never fully resolved. He continued working and reinjured himself on April 17, 2006. Dr. Fetzer diagnosed right L4 and L5 radiculopathy and recommended epidural steroid injections. Mr. Loving did not want to undergo same, and instead requested surgery. The petitioner was referred to Dr. Edward Goldberg for evaluation.

On August 14, 2006, Dr. Palmer noted a positive Spurling test on the right for reproduction of shoulder pain. (Rx 6, pg 33) This was noted to be a new finding. As this suggested that the shoulder pain may be originating in the neck, an MRI of the cervical spine was recommended. Id.

Dr. Goldberg evaluated the petitioner on August 18, 2006. (RX 6, pg 80) Dr. Goldberg opined that the petitioner sustained a disc herniation and aggravated his degenerative disc disease with the work-related accident. He recommended a laminectomy and discectomy at L4-L5 and posterolateral fusion at L4-L5 and L5-S1 with iliac bone crest and pedicle screw instrumentation.

Correspondence was issued by Dr. Nicholson on August 29, 2006 indicating that while petitioner may need physical therapy for his shoulder, he felt it would be counter-productive to have him get into the program and aggravate his low back condition. Dr. Nicholson noted that he had examined the patient and that his pain was out of proportion to his physical findings. (RX 6, pg 77) His complaints were noted to be "quite histrionic." The doctor further noted he was an extremely difficult gentleman to examine. Dr. Nicholson advised that he did not feel that there was a rotator cuff tear and suggested they instead address the lumbar situation.

On September 19, 2006 Dr. Goldberg performed the right L4-L5 hemilaminotomy and discectomy, and posterolateral spinal fusion at L4-L5 and L5-S1. The diagnosis was degenerative disk disease L4-L5 and L5-S1 with superimposed central herniated nucleus pulposus L4-L5. (RX 6, pg 117)

Following surgery, petitioner followed-up with Dr. Goldberg on October 4, 2006. (Rx 6, pg 75) Overall he was doing well. Petitioner's chief complaint was difficulty with sexual function. The doctor explained that it was extremely unlikely that this was caused by the spine surgery due to the fact that this was a posterior approach.

The petitioner was seen by Dr. Goldberg on October 23, 2006 at six weeks status post surgery. He was doing well and was neurologically intact. X-rays showed the instrumentation to be well positioned at L4-S1 with good fusion mass.

The MRI of the cervical spine was performed on November 10, 2006 and demonstrated C4-C5 right bulging disc, C5-C6 central broad-based bulging disc abutting the anterior border of the spinal canal producing mild to moderate spinal stenosis with mild to moderate narrowing of the intervertebral foramina, and C6-C7 central broad-based bulging disc with mild narrowing of the spinal canal. (RX 6, pg 234)

On November 13, 2006 petitioner met with Dr. Palmer to discuss the cervical MRI. (Rx 6, pg 26) As it was possible petitioner's shoulder pain was derived from disk problems in his neck, on December 4, 2006, Dr. Palmer suggested he see Dr. Fetzer for a cervical injection.

On December 6, 2006 Dr. Goldberg noted petitioner was doing quite nicely with respect to his low back. (Rx. 6, pg 67) He recommended six more weeks of therapy for the lumbar spine after which it was possible that light duty could be started. (Px 16)

The petitioner was seen by Dr. Fetzer on December 8, 2006. (Rx 6, pg 22) He had full active range of motion of the cervical spine in all planes and the cervical Spurling's maneuver was negative bilaterally. While he stated he could not actively raise his right arm above his head, on examination, he raised it to approximately 110 degrees of abduction. The doctor explained that Neer's, Hoffman's and supraspinatus testing were all positive. Shoulder internal and external rotation was both 5/5. She felt that the petitioner's symptoms may be somewhat exaggerated on exam. The differential diagnosis could include right C5 radiculopathy versus right rotator cuff pathology. A diagnostic right C5 selective nerve root injection was ordered.

The petitioner underwent a right C5 selective nerve root block on December 19, 2006. (Rx 6, pg 19) The petitioner was seen by Dr. Fetzer on January 16, 2007 after undergoing a right C5 selective nerve root block. (Rx. 6, pg 17) He denied any further radicular symptoms. As he had improved, Dr. Fetzer recommended they hold off on any additional epidural steroid injections and instead recommended work conditioning.

On January 17, 2007, four and one-half months status post-fusion L4 to S1, the petitioner's only complaint was pain over the left iliac crest donor site. (Rx. 6, pg 63) X-rays showed a very good fusion forming. His radicular pain and back pain had markedly improved. Dr. Goldberg recommended work conditioning for six weeks for the cervical and lumbar spine.

IME- Dr. Wehner

An IME was performed by Dr. Wehner on February 9, 2007. (Rx. 1, Dep Ex. 2) Dr. Wehner noted the history of treatment and provided a diagnosis of low back pain. She noted he had a fusion for some degenerative disc disease at L4-L5 and L5-S1. He was progressing slower than would be anticipated. She did not see anything in the cervical spine warranting surgery. He was not at maximum medical improvement and should continue with physical therapy prior to any work hardening. She cautioned against any other surgery given his fairly high pain complaints despite the fairly minor MRI findings and the overall response to surgery.

The petitioner was seen in follow up on February 13, 2007 by Dr. Fetzer. (Rx 6, pg 13) While the doctor had previously recommended a work conditioning program, Mr. Loving had not undergone any work conditioning. He instead reported that he had opted to do home exercises on his own. He reported a past history of migraines for which he would take Imitrex provided by his primary care physician Dr. McGinnis. Examination of the cervical spine was negative/normal. The doctor recommended a six-week course of work conditioning followed by a functional capacity evaluation and a second right C5 nerve root block. A right C5 selective nerve root block was performed on February 20, 2007. (Rx 6, pg 11)

On February 26, 2007 an initial baseline Physical Performance Test found petitioner demonstrated functional ability between the light and light to medium work demand levels. (Px 24) Work conditioning was prescribed.

Petitioner began work conditioning on February 27, 2007. A progress note dated March 7, 2007 reported petitioner had made “inappropriately slow progress in Work Conditioning due to the client’s refusal to perform resistive activities due to subjective complaints of pain without correlating clinical objective findings.” (RX 6, pg 215) Additionally, it was noted he required verbal cues and supervision to remain on task. The therapist asserted this was an “invalid” performance in work conditioning and noted petitioner had been given verbal warnings for non-compliance after receiving specific instructions in the proper conduct for participation. The petitioner demonstrated poor body mechanics and the therapist noted that “One would expect a client with a high level of low back pain to perform this activity with proper body mechanics to minimize the stress in the low back and to maximize the efficiency of the lift.” (RX 6, pg. 216) An FCE with emphasis on validity was recommended.

Dr. Goldberg saw the petitioner on March 7, 2007. (Rx. 6, pg 61) After additional work hardening, the doctor noted he could now lift 40 pounds occasionally from floor to waist, 25 pounds waist to shoulder, and overhead 20 pounds occasionally. Some invalidity was noted by the examiner during his evaluation. Dr. Goldberg authorized the petitioner to return to work within the work conditioning recommendations. Dr. Goldberg opined he was at MMI with respect to the lumbar spine and should see Dr. Fetzer regarding the cervical condition.

The petitioner was seen by Dr. Palmer on March 12, 2007. (Rx 6, Pg. 59) Petitioner reported that he had three injections to the neck with Dr. Fetzer. Due to an increase in pain from the right lateral neck to the superior shoulder into the forearm and fingers, Dr. Palmer referred him back to Dr. Goldberg for evaluation of the neck and shoulder.

The petitioner was seen at Accelerated Rehabilitation Center for a functional capacity evaluation on March 26, 2007 ordered by Dr. Fetzer. (RX 6, Pg. 207) A physical demand level could not be determined due to petitioner failing eighteen out of twenty-five objective validity criteria. The results were found to be invalid due to the submaximal effort given by petitioner. Notably, he also scored positive on four out of five Waddell's signs for low back pain. It was felt that he was capable of functioning at a higher category of work than he demonstrated in the testing.

The petitioner was seen on April 3, 2007 again by Dr. Fetzer after undergoing the functional capacity evaluation. (RX 6, pg 8) Dr. Fetzer noted that it was found to be an invalid study secondary to sub-maximal effort with 4/5 Waddell's nonorganic signs being positive on this evaluation. On physical examination, Dr. Fetzer noted, "Mr. Loving exhibits some Waddell signs today including overreaction simulation and he does not participate in our exam." (RX6, pg 8) The doctor noted that based on his failure of all reported treatment in combination with his multiple non-organic signs and the invalid functional capacity evaluation, the doctor believed he was at maximum medical improvement for his symptoms at this time. He was released to return to work full time and full duty. (Rx 6, pg 8)

The petitioner was seen at Rush Oak Park Outpatient Physical Therapy for a lumbar, cervical and spine evaluation on April 5, 2007. It was noted that his back pain began in 2004 when he hurt himself at work while lifting luggage. His neck pain began in 2007 and was of insidious onset. The petitioner reported he was depressed and unable to perform activities. He was on medication for depression and had significant difficulty performing almost any activity. It was recommended they do physical therapy three times a week for eight weeks.

Petitioner was seen by Dr. Palmer on April 11, 2007. (Rx 6, pg 57) The doctor noted he had not gone back to work, although he had been advised to do so. He rated his pain at 9/10, but on physical examination the petitioner was in no acute distress. He had no psychomotor agitation and neurological examination revealed give-way weakness. Dr. Palmer reviewed the notes of Dr. Fetzer and Dr. Goldberg and noted that he had multiple non-organic signs and an invalid FCE. **He was at MMI for the cervical spine and lumbar spine. Dr. Palmer recommended he return to work with restrictions per Dr. Fetzer for his neck and per Dr. Goldberg for his back.**

Dr. Fetzer evaluated the petitioner on April 13, 2007. (RX 6, pg. 127) On exam, he exhibited some waddell signs today including overreaction simulation and he did not participate in the exam. He would not actively range his arms above 70 degrees. Motor testing showed give-way throughout the bilateral upper extremities. She noted that given the failure of all reported treatment attempts in combination with his multiple nonorganic signs that are present and the invalid functional capacity evaluation, she placed the petitioner at MMI and released him to return to work at full time, full duty. (RX 6, pg 127)

On May 15, 2007, the petitioner presented to Rush Oak Park Physicians Group with complaints of low back pain and shoulder pain. (RX 5, Pg. 42) . He was noted to be currently taking Atarax and Vicodin. The petitioner returned to the Rush Oak Park on June 21, 2007 with continued complaints of back pain with radiation down his right leg. (RX 5, Pg.44)

On July 9, 2007, Dr. Sandeep Amin on referral from Dr. McGuinness, discussed various options including medical management versus surgical re-evaluation or repeat epidural injections. The petitioner was not interested in considering surgery, a stimulator implant, or an epidural injection. He was started on Topamax.

The petitioner was seen for back pain at Rush Oak Park Physicians Group on August 28, 2007. (RX 5, Pg. 48) The petitioner was next seen at Rush Oak Park on December 20, 2007 for complaints of back pain and left first finger pain. (RX 5, Pg. 48)

On February 21, 2008, petitioner underwent MRI of lumbar spine with and without contrast. The study showed spondylotic changes of with degenerative disks at L4-L5 and L5-L1. Also noted was the posterior fusion with fixation devices in place extending from L4-L1 and central protrusion of the disc at L5-L1. The was a moderate degree of stenosis at L2-L3 and L3-L4, mild stenosis at L4-L5

The petitioner returned to Rush Oak Park on May 16, 2008 complaining that his back pain started worsening in the past 3-4 days despite his medication. (RX 5, Pg.54) The petitioner was referred for steroid injections. At additional visits on July 1, 2008 and August 14, 2008, the petitioner complained of back and neck pain.

Motor Vehicle Collision

The petitioner was involved in an auto accident where he was rear ended on August 19, 2008. Following the automobile accident, the petitioner was seen at Loyola Hospital ER. (RX 7) The petitioner presented on August 19, 2008 as a restrained driver who was rear-ended injuring his neck, back, chest and left jaw. (Rx. 7, Pg. 175) He reported he was thrown forward, hitting his chest on the steering wheel. He was restrained, but the seat belt did not lock and he hit the steering wheel. In addition to pain in the chest, the petitioner also complained of worsening low back pain, neck pain and right shoulder pain. He also had complaints of pain in the hips. A CT scan of the cervical spine showed no evidence of acute fracture or subluxation. Imaging of the shoulder/hip/spine was negative for acute fracture or dislocation X-rays of the lumbosacral spine showed a posterior spinal fusion L4 to S1 with trace retrolisthesis L5-S1. X-rays of the cervical spine showed slight right convex curvature, which may be related to muscle spasm or patient positioning. There was also straightening of the cervical spine likely related to muscle spasm or cervical collar. CT scans of the lumbar and cervical spine were suggested if the petitioner remained symptomatic. The petitioner was admitted to general medicine for a workup of chest pain, evaluation of back mass and pain control.

The hospital discharge summary reflects that the petitioner is a 49-year-old male with primary history of chronic low back pain, status post laminectomy, who presented to the emergency department with chest pain following a motor vehicle accident. (RX 7, Pg.150) He was restrained, but the seat belt did not lock and he hit the steering wheel. The air bag did not deploy. The petitioner complained of non-radiating numbness and a burning sensation in the left side of the chest. This was relieved with oxygen in the field and morphine was provided in the emergency department. The petitioner also complained of worsening low back pain, neck pain and right shoulder pain. He denied any focal weakness or loss of motion. Imaging of the shoulder/hip/spine was negative for acute fracture or dislocation. A CT of the neck incidentally noted a soft tissue nodule. The petitioner was discharged with Flexeril and Vicodin for musculoskeletal pain. He was referred to physical therapy which was scheduled to begin on August 22, 2008.

Dr. McGinnis completed a cervical spine residual functional capacity questionnaire, headache residual functional capacity questionnaire and lumbar spine functional capacity questionnaire on August 24, 2008. (PX 19) The cervical spine functional capacity questionnaire indicated the petitioner had cervical radiculopathy with chronic pain and paraesthesias. The headache, residual functioning capacity questionnaire indicated he had migraines, cervical radiculopathy and lumbar radiculopathy for a period of six years. He would get headaches lasting three days. The doctor felt he was unable to work because of these and again noted he was incapable of even a low stress job. The lumbar assessment similarly indicates that it has been present for six years and that the petitioner is unable to work. (PX 19).

Following the auto accident, the petitioner was seen at West Suburban Medical Center on August 28, 2008. (PX 28) He reported pain in his head, chest, hips and back. He reported he was sitting at a red light when he was rear-ended by a driver going 35 to 40 miles per hour. He was in Loyola Medical Center for two days and was still having significant low back pain and shooting pain down the right leg, as well as into the right neck and shoulder pain. This was constant with numbness and tingling into the hands and fingers. He was on Fentanyl and Darvocet and his pain was noted to be more intense since the auto accident. It was also noted the petitioner had a history of migraine headaches and was requesting an Imitrex refill. He was diagnosed with upper and lower back muscle spasms following a motor vehicle accident and musculoskeletal chest pain. Physical therapy was ordered, as well as Valium and Norco. He was directed to continue Fentanyl, Darvocet and Norco. He had continued pain on September 9, 2008.

Petitioner was next seen for a follow up at Rush Oak Park on August 29, 2008. (RX 5, Pg. 60) He complained of back pain, right shoulder pain, neck pain, and migraine headaches. Additionally on August 29, 2008 Dr. McGinness completed a Lumbar Spine Residual Functional Capacity Questionnaire. This indicated petitioner back pain was ongoing for six years and he was diagnosed with lumbar radiculopathy.

On September 8, 2008 petitioner was assessed by Dr. Lenny Cohen, a neurologist of Rush Oak Park. (PX 19) Petitioner reported a history of chronic back pain in the lumbar and cervical spine. Dr. Cohen recommended an EMG of the upper and lower extremities, trigger point injections, stopping temazepam, cyclobenzaprine, diazepam, propoxyphene, fentanyl, and limiting Vicodin. A prescription for Amrex was recommended.

A CT of the neck with contrast was performed September 24, 2008 for a left neck nodule, which had been identified on the prior cervical CT done following the auto accident on August 19, 2008. Resolution was limited below C4 and there was concern for a disc herniation in the lower cervical spine. Further evaluation was advised. There was no evidence of acute fracture or subluxation.

When he was seen in follow-up at West Suburban Medical Center on September 26, 2008, he reported ongoing neck, shoulder and back pain. (PX 28) He also reported depression since the auto accident. It was noted he had been seeing a therapist and psychiatrist and had been started on Cymbalta. He reported passive suicidal ideation and thoughts of ending his life on occasion. The records of this date also indicate the petitioner was no longer using a cane. was status post MVA with depression and the patient acknowledged a "long road ahead" to recovery. (PX 28)

He again followed up at West Suburban Medical Center on October 3, 2008 for his motor vehicle accident and resulting neck and back pain. (PX 28) It was noted that he was moving slowly, with his gait slightly forward at waist. He continued to follow up for neck and back pain related to his motor vehicle accident, including cervical, thoracic and lumbar somatic dysfunction, for which he underwent manipulation through at least February 26, 2009. In March of 2009, he was referred for functional capacity testing. (PX 28)

On October 23, 2008 Dr. Goldberg prescribed physical therapy for lumbar range of motion and strengthening for three times a week for six weeks. Dr. Goldberg had assessed status post lumbar fusion at L4-5 and L5-S1.

The petitioner continued to follow up regularly at West Suburban Medical Center status post motor vehicle accident through March 2009. (PX 28)

Second IME- Dr. Wehner

The respondent obtained an independent medical evaluation from Dr. Julie Wehner on January 7, 2009. (Rx 1, Dep Exhibit 3) At the IME evaluation, the petitioner reported his pain level at 9/10. His pain complaints and abnormal posturing were not explained by the radiographic findings or the surgery that was performed. Dr. Wehner opined that the petitioner had reached maximum medical improvement for any work injury and could return to work with a 25-pound lifting restriction. She also agreed that he should be weaned off narcotic pain medications due to the high predilection for addiction.

Petitioner followed-up at Rush Oak Park on January 19, 2009, February 17, 2009 and March 24, 2009 but the Arbitrator notes the reports are not entirely legible. Petitioner also followed up at Rush Oak Park on August 3, 2009 and October 6, 2009 with complaints of neck and back pain.

On January 7, 2010 petitioner received a Partially Favorable decision from the Social Security Administration for disability benefits. (PX 40)

On August 26, 2010 the petitioner called Dr. McGinness' office and stated that he needed an order for an MRI.

On September 2, 2010 an MRI of lumbar spine suggested the mild diffuse disc protrusions at the L5-S1 and L4-L5 were stable. There was spinal stenosis at L3-L4, milder at L2-L3 with no significant change since earlier examination. An MRI of cervical spine showed a disc protrusion with spinal stenosis and C3-C4, C5-C6, and C6-C7. There was relative spinal stenosis at C4-C5 and a tiny benign cyst within the central spine canal at the T4 level.

The petitioner was seen by Dr. Edward Goldberg on September 8, 2010 after a significant gap in treatment with the doctor, for complaints involving his neck and right arm. (Rx. 6, pg 55) The petitioner complained of central neck pain radiating down the top of the right shoulder and the lateral aspect of his upper arm into his forearm as well as the third and fourth digits. He reported that he had been constantly in pain for the last three weeks. Dr. Goldberg noted he had some prior treatment relating to a C4-C5 disc herniation in the past and had been treated with epidural steroid injections. The doctor reviewed the MRI of September 2, 2010 and felt he had multi-level cervical spondylosis causing radiculopathy and cord stenosis. As he exhibited a clinical picture of myeloradiculopathy, Dr. Goldberg recommended an anterior cervical discectomy and fusion at C3-C4 and C4-C5. Dr. Goldberg noted that they discussed the natural course and history of his myelopathy.

IME-Dr. Lami

On January 5, 2011 petitioner attended an IME with Dr. Lami to address the proposed cervical surgery. (RX 2, Dep Ex. 2) After a review of petitioner's medical history, Dr. Lami opined petitioner had subjective neck pain and right anterior shoulder pain with degenerative changes seen on the MRI. Dr. Lami opined that the cervical issues were not related to the work accident and opined that he did not need cervical surgery. Petitioner only needed a home exercise program. Regarding the cervical spine, Dr. Lami opined petitioner needed no work restrictions. Regarding the lumbar spine, Dr. Lami noted the invalid FCE and opined that a lifting restriction of 25-30 pounds would be reasonable. Petitioner was at MMI.

On February 28, 2011, petitioner met with Dr. Riley for a tender lymph node. Petitioner was assessed with lymphadenopathy and Dr. Riley noted petitioner did not complete his antibiotics as prescribed. Of note, petitioner mentioned back pain and stated his pain was 10 out of 10 but Dr. Riley opined he did not show evidence of this.

On October 19, 2011 Dr. McGinness prescribed petitioner Norco. This was again prescribed along with Tagamet on February 28, 2012. Another prescription of Norco was made on May 2, 2012. More medication refill requests were made on August 1, 2012; November 15, 2012; January 15, 2013; and February 18, 2013.

The petitioner saw Dr. McGinnis on March 14, 2013 complaining of back pain, chronic neck pain and depression. He now complained of facial and dental pain and an ache in his left forearm. He also had back pain and cramping in his left leg. He complained of depression which they noted they had treated him for in 2008 with Cymbalta. The doctor prescribed Fentanyl patches, Viagra and Cymbalta. Petitioner was living in Atlanta but was in town this week for an IME.

Second IME- Dr. Lami

On March 15, 2013, petitioner attended another IME, with Dr. Lami who opined petitioner's current symptoms were unrelated and out of proportion to the report injury on April 17, 2006. (RX 2, Dep Ex. 3) Dr. Lami opined petitioner was at MMI for the sprain he sustained on April 17, 2006. Dr. Lami also opined any complex regional pain syndrome was not related to his work injury and neither would be the proposed neck surgery. Dr. Lami could not support that petitioner was totally disabled because of the invalid FCE and psychosocial factors at play. He opined a lifting restriction of 25-30 pounds again would be reasonable. No further treatment was recommended.

On March 18, 2013, Dr. Goldberg authored a letter to petitioner's attorney, Mr. Gallagher. (RX 6, pg 53) Petitioner complained of posterior neck pain that radiated into the right shoulder, cramping in all four extremities, low back pain, and bilateral lower extremity paraesthesias. Dr. Goldberg suggested a possible assessment of cervical myelopathy and recommended another cervical MRI. Additionally, he recommended another lumbar MRI to determine if there was an adjacent level problem.

On May 22, 2013, Dr. McGinness prescribed Norco and Tagamet again. Norco was again prescribed on July 10, 2013. The petitioner requested medication refills on: August 15, 2013; August 28, 2013; September 27, 2013; November 8, 2013; December 2, 2013; January 9, 2014; February 3, 2014; and February 26, 2014.

Third IME- Dr. Lami

Dr. Lami issued a report on August 15, 2013. (RX 2, Dep Ex. 4) He opined he could not support surgery for myelopathy to be related to any of the work accidents. That would be a chronic compression of the spinal cord and no sign of same was found by Dr. Goldberg in 2010. A cervical MRI would be reasonable if Dr. Goldberg truly found myelopathic symptoms at this time. The requested lumbar MRI was not reasonable as petitioner showed a solid lumbar fusion without any neurologic deficit and only subjective pain. Additionally, Dr. Lami opined petitioner's spinal fusion was unrelated to the work accidents and his work restrictions were due to that. His work restrictions were not causally related to any of the work accidents.

Dr. Goldberg authored a March 7, 2014 letter responding to the petitioner's attorney's request for a summary of treatment. (Rx 6, pg 49) Dr. Goldberg opined petitioner's work accidents aggravated his degenerative disease of the lumbar spine and that the lumbar spine surgery and therapy were appropriate to relieve petitioner of the effects of his work accident. Dr. Goldberg did not comment on petitioner's right shoulder complaints and deferred to Dr. Palmer's and Dr. Nicholson's opinions.

On March 7, 2014 the petitioner returned to Dr. McGinnis for assessment of back pain, cervical radiculopathy, depression, migraines, gastroesophageal reflux disease, palpitations, erectile dysfunction, prostatitis and fatigue.

On July 3, 2014 petitioner presented to SIU Center for Family Medicine and met with Dr. Khattak. An x-ray of the lumbar spine was stable from previous imaging. After examination, Dr. Khattak diagnosed petitioner with chronic lower back pain that was likely secondary to arthritis. Petitioner refused physical therapy. Dr. Khattak advised petitioner to treat with exercise, stretches, heating pads, and Meloxicam. (Px. 11)

On August 4, 2014 petitioner was initially evaluated for physical therapy at Koke Mill. His diagnoses included lumbago, back pain, and neck pain. Therapy was planned for 1-3 times a week for twelve weeks. Petitioner attended physical therapy which included aqua therapy. Petitioner underwent occupational therapy at Memorial Rehabilitation Services at Koke Mill from August 6, 2014 through November 3, 2014. (PX 3).

Petitioner saw Dr. Khattak on September 4, 2014 and complained of low back pain and neck pain. Examination showed tenderness to palpation over the C4-5 area and lower lumbar area. Petitioner had full range of motion and full strength. He ambulated with a cane. Dr. Khattak ordered MRIs of the cervical and lumbar spine and provided an orthopedic referral. (Px. 11)

On September 19, 2014, petitioner presented to Memorial Medical Center for an MRI of his cervical and lumbar spine. The cervical spine MRI revealed multilevel degenerative changes with mild central canal stenosis at C5-C6 and C6-C7 and multilevel moderate to severe neural foraminal encroachment. The lumbar spine MRI revealed multilevel degenerative most severe at L2-L3 and L3-L4 with severe central canal stenosis. There was also multilevel moderate to severe neural foraminal encroachment. (Px 11)

Petitioner presented to Dr. Venkat Ganapathy on September 24, 2014 with complaints of neck and back pain. (PX 12) The assessment was cervical myelopathy at C6-C7, posterolateral disc herniation at the right C4-C5 disc space, multi-level degenerative disc disease at the cervical spine and central stenosis, lateral recess and foraminal stenosis at L2-L3 and L3-L4 as well as multi-level degenerative disc disease and facet hypertrophy in the lumbar spine. The recommendations were an anterior cervical decompression and fusion and a subsequent posterior lumbar decompression and fusion. Petitioner was directed to obtain a lumbar spine CT due to a question of pars fractures at L2-L3 and L3-L4 and an EMG of the upper extremities for possible carpal tunnel syndrome on the left.

An EMG performed by Dr. Trudeau found right C5 and C7 radiculopathy which was moderately severe, but which was characterized as an older or chronic finding. There were also moderately severe bilateral median neuropathies at the wrist, moderately severe on the left and mild on the right. There was no current evidence of cervical radiculopathy, brachioplexopathy, or mononeuritis multiplex. (PX 21)

The CT of the lumbar spine performed on September 26, 2014 showed the prior fusion from L4-S1. (Px. 11) It was noted that unless there were prior CTs to demonstrate stable position, the short fixation screws which were threaded into the posterior aspect of each pedicular screw were displaced. (Dr. Goldberg later testified the loose screws were not causing any symptoms.)

On November 8, 2014, petitioner underwent an MRI of the cervical spine, which revealed: (1) minimal change since the earlier examination; (2) spinal stenosis was stable at C3-C4, C5-C6, and C6-C7; (3) left neural foraminal stenosis stable at C5-C6 and milder neural foraminal narrowing on the right at C5-C6 and bilaterally at C4-C5 as well as narrowing related to uncovertebral joint degenerative change; (4) osseous and disc degenerative changes; and (5) straightening of the cervical spine.

The petitioner was seen in follow up by Dr. Ganapathy on November 18, 2014. (PX 12) The doctor noted the petitioner had a difficult problem with long term opioid use, multiple sources of pain with axial as well as radicular pain. He also had myofascial pain which was non-dermatomal and pressure point pain. X-rays of the cervical spine showed mild degenerative disc disease from C4-C5 to C6-C7 with no change in alignment to suggest instability. The doctor noted he may still have radiculopathy, but it was difficult to assess in this setting as there were multiple other pain generators. The doctor also bolded the statement that, “I am not convinced that he has myelopathy as today’s exam was not in keeping with the exam finding from last visit.” Dr. Ganapathy felt they needed to understand which of the discs were causing the problems. He therefore recommended a C5 root block injection and a bilateral C7 selective root block injection, performed at separate times, to determine which of these was the offending level.

The petitioner was seen by Dr. Paul S. Smucker on November 21, 2014 on referral from Dr. Ganapathy to perform the root block injection. (PX 3, pg 4) The doctor noted that his “symptoms of pain and paresthesias were not consistent during the time of my discussion with him”. The neurologic exam showed no upper or lower extremity atrophy and balance and coordination were normal. Lower extremity neural tension signs were negative bilaterally. His lumbar range of motion was limited, but there was no focal mechanical reproducible pain. Cervical range of motion was normal. Shoulder impingement was inconsistently positive on the left. Motor strength testing featured break away weakness through the proximal and distal bilateral upper and lower extremities. Straight leg raising was negative bilaterally, as was Tinel’s at the carpal and cubital tunnels. The doctor reviewed the cervical radiographs which showed multi-level mild spondylosis but well preserved intervertebral disc space heights throughout the cervical spine. The cervical MRI from September 19, 2014 showed mild degenerative disc disease at multiple levels. There was moderate to severe neuroforaminal narrowing on the right at C4-5 and bilaterally at C5-C6. There was no severe significant canal stenosis at any level. Lumbar X-rays showed post-operative changes with hardware fusion at L4-L5 and L5-S1. The lumbar MRI of July 3, 2014 showed multi-level degenerative disc disease with facet arthropathy. These combined to create severe canal stenosis at L2-L3 and L3-L4. There was bilateral neuroforaminal narrowing at L2-L3 and L3-L4 as well.

Dr. Smucker noted the petitioner had non-physiologic findings with diffuse inconsistent breakaway weakness on exam. There was diffuse muscular tenderness consistent with myofascial pain syndrome. There was mild to moderate cervical degenerative disc disease with mild central stenosis at C5-C6 and C6-C7. The petitioner was status post L4-S1 fusion with multi-level neuroforaminal stenosis. There was a possible element of neurogenic claudication, although this was difficult to discern through the diffuse complaints he had to offer.

The doctor did not see evidence on his overall presentation including physical exam of cervical myelopathy. Dr. Smucker did not believe that the requested diagnostic cervical selective nerve root blocks would be valid in this individual given the widespread inconsistency of exam and described symptoms. Included with the records of Dr. Smucker is a note in which the petitioner called the office on December 8, 2014 to discuss the November 21, 2014 visit with Dr. Smucker. (PX 3, pg 8) He was frustrated that Dr. Smucker changed the procedure plan suggested by Dr. Ganapathy. The petitioner was advised that the dictation by Dr. Smucker would not be changed, as it was the doctor's medical opinion after the evaluation. The petitioner also requested no records were to be released without his prior approval. A right C5 selective nerve root block was performed on January 22, 2015 and a left C7 selective nerve root block was performed January 23, 2015. A final injection/nerve root block at the right C7 was performed February 11, 2015.

Dr. McGinness saw the petitioner on June 19, 2015. Petitioner stated that he had been seen by a neurosurgeon and was told surgery would not get rid of his pain, therefore he was not planning to undergo surgery.

The petitioner returned to Dr. Goldberg on September 9, 2015, with ongoing cervical and lumbar complaints. Dr. Goldberg recommended MRIs of the cervical and lumbar spine, as well as a functional capacity evaluation. As the petitioner continued to be myelopathic, Dr. Goldberg continued to recommend cervical surgery.

The MRI of the cervical spine, performed on September 11, 2015, re-demonstrated degenerative changes causing mild spinal canal stenosis at C3-C4, C4-C5, and C5-C6, with mild to moderate stenosis at C6-C7. There was severe right foraminal stenosis at C4-C5, which was more pronounced than the prior study. The lumbar MRI was read as showing moderate canal stenosis with massive hypertrophy causing lateral recess and neural foraminal stenosis at L2-L3 and L3-L4. Following review of the MRIs on October 2, 2015, Dr. Goldberg felt that the petitioner was now having an adjacent level breakdown due to the prior lumbar fusion. He therefore recommended decompression at L2 through L4 with laminectomy and/or possible fusion to address the low back pain. In addition, Dr. Goldberg continued to recommend the cervical fusion from C3 through C7. Mr. Loving, however, did not want to consider surgical treatment at this time, and instead the doctor recommended pain management. The petitioner advised Dr. Goldberg that he would be spending the winter in Savannah, Georgia, with his brother. The doctor provided him with a referral to take to Georgia to obtain pain management physician there as well. The recommendation included epidural steroid injections and chronic pain management.

The medical records document physical therapy performed at Saint Joseph's/Candler Health System in Savannah, Georgia from October 6, 2015 through November 19, 2015. (PX 18) The notes of November 2, 2015 indicate the petitioner washed, waxed and detailed his car this weekend. On October 21, 2015, the petitioner reported feeling well and "I feel like I could play football." At the time of discharge, the petitioner reported a significant amount of improvement and was excited that he was feeling better in time for the holidays. He made excellent rehab progress meeting all short and long term goals with the exception of hip extension range of motion.

Petitioner returned for 12 sessions of aquatic/physical therapy at St. Joseph's/Candler in Savannah from March 17, 2016 to April 28, 2016. (PX 18)

Dr. McGinness treated petitioner on September 21, 2016 for continued all over pain. He reported new pain and popping in the right shoulder for two weeks. At the time of the appointment, petitioner ambulated without a cane, but requested a form for a disability card for transportation. Dr. McGinness updated petitioner's diagnosis to include acute right shoulder pain.

Petitioner followed-up with Dr. McGinness on November 3, 2016 with complaints of worsening neck and back pain since August. Petitioner reported pain down the arm to the hand and down the leg and around the groin. Physical therapy was not helping his pain. Dr. McGinness provided petitioner with a prescription of Oxycodone and Lidoderm patches and referred petitioner to the pain clinic for treatment.

Petitioner was seen by Dr. Matthew Jaycox on January 19, 2017 for pain in the low right back and pain in the upper and lower extremities. He was assessed with cervical radiculopathy, degenerative disc disease, myelopathy and facet arthropathy in the cervical spine. He was to be scheduled for cervical epidural steroid injections at C7 through T1. If no relief, they would refer him for surgery.

On January 26, 2017, Dr. Dennis Gumbrecht treated petitioner at the Rush University Medical Center Department of Anesthesia Pain Service. Petitioner reported pain in the cervical spine, specifically midline pain that radiated into the bilateral upper extremities to the fingers. A cervical epidural steroid injection was performed.

Petitioner was seen by Dr. McGinness on January 26, 2017 and reported continued neck and back pain and stated that his right leg buckled several times a week. A left trigger finger diagnosis was also noted. Dr. McGinness refilled petitioner's pain medications.

Dr. Gumbrecht performed a cervical epidural steroid injection on March 9, 2017. A second cervical epidural steroid injection was performed on May 11, 2017.

Petitioner presented to Dr. McGinness on January 16, 2018 and reported pain in his back, neck and right knee.

Petitioner presented to Dr. McGinness on May 8, 2018 and reported continued neck and back pain and that he did not feel the lumbar surgery improved his function enough so that he would contemplate neck surgery. Petitioner reported he had as much lumbar pain as he had prior to surgery.

On October 18, 2018, petitioner returned to Dr. McGinness for back and neck pain and reported he was taking long lasting hydrocodone only when his pain is at a 10/10. Mood was noted as okay on an anti-depressant. Petitioner reported he was going to the gym. According to this note the history of a fall was on June 21, 2018. The assessment was lumbar radiculopathy, depression and cervical radiculopathy. The plan was a refill of hydrocodone.

Petitioner started a new course of physical therapy on January 24, 2019 at NovaCare on referral by Dr. McGinness with a diagnosis of lumbar radiculopathy and cervical radiculopathy. Petitioner reported the pain started in 2006 when he felt pain in his low back and neck when carrying and pushing many bags and containers at work which weighed over 100 pounds. Petitioner attended 11 sessions through March 4, 2019.

The petitioner was seen again by Dr. Jaycox on March 19, 2019 for pain in the right shoulder up into his head and back pain with shooting pain down his right leg and migraines. It was noted the petitioner had returned after an 18 month absence. He was living in Savannah, Georgia and had since returned to Illinois with a return of his neck and arm pain with radiation at the right upper extremity as well as occasional low back pain into the right leg.

The petitioner underwent cervical epidural steroid injections on March 21, 2019 and April 25, 2019 at C7-T1. The petitioner was seen on May 30, 2019 in follow up and reported feeling approximately 75% better with increased activity levels. It was noted he gets out of the house to walk and exercise three to four times per week.

Petitioner was seen at Rush Oak Park Physical Therapy for a spine evaluation on October 9, 2019. It was recommended he continue physical therapy twice a week for six to eight weeks. The physical therapy progress note from October 28, 2019 indicated significant self-limiting tendencies, and noted "observed movements and behaviors inconsistent with subjective reports." The notes of November 4, 2019 again indicate the self-limiting tendencies and inconsistent observed movements and behaviors which were inconsistent with subjective reports. He also performed all activities in a slow and deliberate manner. By November 6, 2019, he had improved neck symptoms and wished to focus on the low back pain.

The petitioner was seen by Dr. Jaycox on December 18, 2019 for a follow up of upper back and neck pain. His pain had been 7/10 and worse on the right side with radiation into the arm. He also described weakness in the grip on the right side. The petitioner underwent cervical epidural steroid injection on December 31, 2019.

The petitioner presented on March 9, 2020 to the Emergency Department at Rush Oak Park Hospital. He stated he had low back pain which was uncontrollable with Norco. He was given an injection of Toradol. He was given a prescription for physical therapy on discharge.

The petitioner was seen by Dr. Jaycox on May 28, 2020 for follow up after cervical epidural injections performed in December 2019. He felt about 50% better, but had not increased his activity levels. He reported that he gets out to exercise two to three times per week. The pain in the right arm and hands was unchanged and the remaining pain was now in the neck. It was recommended that they perform bilateral cervical facet injections from C3 through C7.

On June 20, 2020, the petitioner underwent bilateral cervical facet joint injections at C2-C3, C3-C4, C4-C5 and C5-C6.

Respondent Records Review- Dr. Mather

An orthopedic surgeon, Dr. Steven Mather, issued a records review report on August 5, 2021. (Rx 3, Dep Exh 2) The petitioner was a status post L4-L5-S1 fusion with unrelated lumbar spinal stenosis at L2-L3 and L3-L4. Dr. Mather found the lumbar stenosis was not work related. Dr. Mather found the petitioner sustained disc herniations at L4-L5 and L5-S1, but the appropriate surgery would have been a simple discectomy, and it is unclear why the patient underwent a fusion as this did not meet the standard criteria for such a procedure. There was no evidence of instability, advanced, degenerative disc disease or any condition that would require a fusion.

Dr. Mather also found the cervical spine showed typical degenerative changes/osteophytes which were also unrelated to any work injury. The C3-C4 disc herniation was first noted on the September 5, 2017 MRI. While the petitioner may have sustained an aggravation of the right C4-C5 osteophyte/stenosis, this would've resolved by April 3, 2007 when his exam had returned to normal and he was released to return to work by Dr. Fetzer. Further, Dr. Fetzer had noted he had multiple positive Waddell findings at the time of his discharge from care, and he had no signs of any ongoing neurologic compression as his neurologic exam had completely returned to normal. Dr. Mather noted there were demonstrated inconsistencies and nonorganic pain findings when presenting to his treating physician, Dr. Fetzer and Dr. Nicholson. This indicated many of his symptoms were simply subjective in nature and not supported by clinical physical examination. Patients with multiple positive Wadell signs almost always have psychogenic sources of pain rather than objective organic sources of pain, and he felt this case was no exception. He also noted the patient provided maximum effort and exaggerating his complaints. (Rx 3, Dep Exh 2)

Petitioner presented to U Chicago Medicine Advent Health Hinsdale November 8, 2022 for progressive worsening of his low back pain with increased lower back pain becoming progressively worse over the last few days. Dr. Song in neurosurgery was consulted. An MRI showed severe central stenosis at L2-L3 and L3-L4 which was thought to be causing his complaints. The petitioner was admitted and Dr. Song performed L2-L4 PSF surgery. (PX 2, p. 10). On November 15, 2022, x-rays of the lumbar spine showed the hardware in the lower lumbar spine to be in proper position. At the time of the November 22, 2022 discharge, post-operative back pain had improved but was still present.

On December 6, 2022, petitioner presented to Dr. Song for his first post-operative visit. The numbness, tingling and weakness in his anterior thighs and ankle were unchanged. Petitioner was overall happy and reported his chronic low back pain had essentially resolved. Petitioner was discharged on December 7, 2022. (PX 2, p. 4). (PX 3)

At the next follow up on December 20, 2022. He reported his strength was improving in his bilateral lower extremities. Petitioner reported numbness in his right thigh and complained of a strong burning sensation in his calves and shins bilaterally. Dr. Song recommended he continue physical therapy and opined his neuropathic complaints may take time to improve.

Petitioner presented for his third post-operative visit on February 7, 2023. Petitioner opined his leg symptoms were 90% resolved and the right leg symptoms were 63% resolved. A diagnosis was made of spinal stenosis of the lumbar region.

On February 14, 2023, petitioner returned to Dr. Song to review his legal case and the request sent by his attorney. Dr. Song could not make comment until it passed through the Adventist legal team. Dr. Song opined petitioner had adjacent segment disease related to prior lumbar fusion which was “apparently” causally related to his work injury in 2006 and 2014. Petitioner also complained of neck pain and severe right arm pain that radiated down the arm to the hand and was complicated by petitioner’s carpal tunnel surgery. X-rays of the cervical spine were ordered for a diagnosis of cervical radiculopathy.

Petitioner underwent an MRI of the cervical spine on February 24, 2023 at UChicago Medicine. The study showed hypertrophic degenerative changes with moderate spinal stenoses at C3-4, C4-5, C5-6 and C6-7 levels and moderate to severe foraminal narrowing on the left at C3-4, bilaterally at C4-5, C5-6 and C6-7 levels and on the left at the C7-T11 level.

Petitioner returned to Dr. Song to discuss imaging results on March 7, 2023. He continued to complain of neck pain with numbness, tingling and weakness into the right deltoid and into his arm. The numbness in his fingers had resolved after his bilateral carpal tunnel surgery. Dr. Song was uncertain whether petitioner would have any relief with surgery but if petitioner wished to proceed, Dr. Song would consider a C4-5 and C5-6 ACDF. Dr. Song noted it was hard to determine if his findings on his cervical spine were normal degenerative changes or related to his work injury that happened 17 years ago. An assessment was made of spinal stenosis of the lumbar region and cervical radiculopathy and petitioner was instructed to return to the office as needed.

IME- Dr. Mather

Dr. Mather performed an independent medical evaluation on March 28, 2024 (RX 3, Dep Exh 3) Dr. Mather opined that the recent fusion surgery was due to normal degenerative changes and that as it had been 16 years since the previous surgery therefore, in his opinion, the need for same was unrelated to that original fusion done L4-L5-S1.” (Rx 3, dep exh 3) The petitioner also had positive Waddell’s signs. Upon examination, the petitioner had no tenderness to lumbar spine, but with any simulated axial rotation, he would wince and yell out loudly and nearly collapsed to the floor. However, he had was found to have no real pain with actual axial compression of the spine. The doctor also found him to have diffuse non-dermatomal numbness in the right lower extremity.

Deposition Testimony

Testimony of Dr. Goldberg- treating surgeon

Dr. Edward Goldberg testified on **April 11, 2016** regarding the 2006 discectomy and fusion. (Px 41, pg 11) The doctor testified after review of the MRI he felt Petitioner had some disk degeneration of both L4-5, L5-S1 with an annular tear at both levels. He also felt that he had a central herniation at L4-5. (Px41, pg. 10) On 9/19/06 Dr. Goldberg performed the following: a discectomy at L4-5 for the herniation and then an instrumented fusion at L4-5 and L5-S1 with pedicle screw instrumentation and iliac crest bone graft. (Px41, pg 13-14) As of 8/18/06, the doctor had petitioner off of work and following surgery as well through 3/7/07 when he was released with permanent restrictions. (Px41, pg 11 & 29) As of 12/6/06, Petitioner was enrolled in physical therapy and was reporting some low back pain and stiffness to Dr. Goldberg, but denied any radicular or leg pain. (Px41, pg 19) The doctor found him to be neurologically intact, and the fusion to be healing nicely at both this visit and the January 2007 visit, following x-rays performed. (Id at 24)

Regarding the history reported to him, Dr. Goldberg testified petitioner initially injured his low back on 11/4/05 when he lifted and developed acute right sided low back pain and then pain into the anterior thigh on right side. Then petitioner suffered a reinjury on 4/17/06 again “after lifting and twisting”. (Px41, pg9) The only information Dr. Goldberg had as to how the petitioner was injured working on a ramp was that he was lifting. (PX 41, pg 16) At no time from August 18, 2006 to January 7, 2007 did the petitioner mention any other than his back and at no time did the petitioner have any complaints about his cervical pain. (PX 41, pg 24-25) When asked if it was possible to have cervical pain that was masked by shoulder pain, the doctor said it was unlikely as they were very independent body parts. (PX 41, pg 25-26)

On the 3/7/07 last visit following the fusion, Dr. Goldberg wrote that Petitioner testified to finishing work conditioning and since then had increasing neck pain and reported some low back pain. He denied radicular pain, he had good lumbar motion but limited painful range of motion in his cervical spine. (Px41, pg 28) Regarding work capabilities, Petitioner was now capable of lifting 40 pounds occasionally from floor to waist, overhead 20 pounds, frequent basis lift 20 pounds floor to waist and 10 pounds overhead; when reviewing the work conditioning note it indicated petitioner was required to lift 70 pounds for his original work position. (Px41, pg 28) At this point in time, 3/7/07, Dr. Goldberg testified he was at MMI for the lumbar spine and could go back to work within the work restrictions as well as follow up with Dr. Fetzer for the cervical spine she was treating him for. (Id. at 29)

Dr. Goldberg testified the petitioner injured both the cervical and lumbar spine at work. (PX 41, pg 52-53) He was aware of only the November 4, 2005 and April 17, 2006 accidents. (PX 41, pg 58) When asked about whether his current conditions were related to the work accident, Dr. Goldberg seemed to equivocate and stated only that he had an injury was seen by his partners, had some temporary improvement and it had not progressed. (PX 41, pg 54) **Dr. Goldberg placed the petitioner at maximum medical improvement and released him to return to work with restrictions consistent with the work hardening reports on March 7, 2007. (PX 41, pg 62)**

He did not see him again until September 8, 2010 when he saw him for cervical complaints. Petitioner reported neck pain radiating to the top of the right shoulder and that the pain was constant for past 3 weeks. He reviewed an MRI and given the findings on his exam, discussed surgery. Specifically, the doctor found he had disk herniations at C3-4 and C4-5 and smaller ones at C5-6 and C6-7, and that the C3-4 and C4-5 herniations were causing some impingement on the spinal cord. (PX 41, pg 32-34) Dr. Goldberg discussed possibility of cervical spine surgery due to the change in symptoms and herniations on MRI but the petitioner did not wish to proceed with surgery. (PX 41, pg 34 and 52)

Regarding his history with petitioner, Dr. Goldberg testified that for the initial treatment starting in August 2006, he was primarily treating petitioner's back however he did previously review the cervical spine MRI in November 2006. (Px41, pg 35) The doctor opined that the prior MRI showed there were disk herniations at C3-4 and C4-5; at C3-4 it was central, at C4-5 it was central to the right; and there was a smaller herniation at C5-6 and C6-7. (Id.) Regarding prior cervical treatment in 2006, the doctor testified that Dr. Fetzer had done an epidural which provided good relief and that second epidural was not done since there was good relief. (Id.) From March 2007 through September 2010, Dr. Goldberg was not aware whether petitioner was working and he did not comment on petitioner's ability to work. (Px41, pg 36).

As of the 3/18/13 visit, that was the last examination of petitioner where he reported posterior neck pain, cramping in all four extremities from neck into right shoulder, low back pain and bilateral lower extremity paresthesia's; he had been seeing Dr. McGinness and taking hydrocodone, Cymbalta for depression and using Fentanyl patch; not been working; reported unsteadiness with ambulation; he had limited lumbar range in motion, cervical range was 50 percent normal; x-rays of lumbar spine showed healed fusion but a locking nut at L4 appeared to disengage from screw but incidental finding; cervical x-ray showed disk narrowing particularly at C5-6." (Px41, pg 37-39) Dr. Goldberg testified that he was concerned petitioner had some cervical cord involvement called myelopathy, recommended new MRI of lumbar spine to assess whether was any adjacent, meaning next level pathology, because when the doctor treated petitioner for the lumbar spine in 2006-2007, his radicular pain had resolved and now petitioner was having bilateral lower extremity new complaints. (Px41, pg, 39) As of the 3/18/13 visit, Petitioner had not been working. (Px41, pg.41)

Dr. Goldberg testified that in his March 2014 report (requested by Petitioner's lawyers), he noted that Dr. Palmer reflected in her notes, neck, right shoulder and back pain and that as of April 2006 Dr. Palmer gave work restrictions. (Px41, pg 42-43) He understood that Dr. Palmer was treating petitioner's cervical and right shoulder complaints prior to his involvement with petitioner in August 2006. (Id.) He testified that in his report where he wrote "I do believe that his lumbar condition is due to the work accident as well as the cervical condition based upon my review of these records", refers to Dr. Palmer and Dr. Fetzer's records from his office. (Px41, pg43-44). Specifically, he testified that Dr. Palmer thought it was a shoulder injury from March 2006, refers patient to Dr. Nicholson for injection with no improvement then refers to Dr. Fetzer who does a C5 selective nerve root block which improves neck pain such that the doctor recommended work conditioning. (Id.) Dr. Goldberg testified that he formulated the opinion that

both the lumbar and cervical conditions were related to work based on the record review mentioned above. (Id.)

On the December 2014 visit, the doctor found 5 out of 5 strength in upper and lower extremities but unsteady gait which could be due to spinal cord compression, which petitioner was using a cane; petitioner had abnormal Hoffman's signs; and he recommended cervical surgery again. (Px41, pg 45-46). The doctor opines at this visit that the cervical and lumbar conditions are due to the work accident and encouraged treatment and discussed signs and symptoms of myelopathy, or spinal cord compression. (Id. at 46) At the September 2015 visit, Petitioner presented with lumbar and cervical complaints for which the doctor recommended a MRI. (Id. at 47) Dr. Goldberg testified that there was significant stenosis at C4-5, C5-6 and C6-7; lumbar MRI showed no ongoing compression from L4 to S1 where original surgery was but "there was some moderate spinal stenosis at L2-3 and L3-4...in other words, adjacent level problems." (Px41, pg.48). Surgery was once again recommended but never scheduled. (Id.)

The last visit was on October 2, 2015 where cervical surgery was recommended but not approved, and petitioner was referred to pain management and he was not working, on disability. (Px41, pg. 50) Dr. Goldberg testified that he reviewed the new cervical and lumbar MRIs as of September 2015 and he felt there was significant stenosis at C4-5 and C5-6 and C6-7; he felt the lumbar spine showed no going compression L5-S1 where the original surgery was but did note at L2-3 and L3-4 there was some moderate spinal stenosis centrally and in the lateral recesses, in other words adjacent level problems. (Px41, pg 48) The doctor testified when he saw petitioner last he did not wish to proceed with cervical surgery. (Px41, pg52)

Dr. Goldberg testified that regarding the lumbar spine petitioner had two injuries in November 2005 and he continued to work then exacerbation in April 2006. (Px41, pg. 52-53) Specifically, petitioner had low back right leg radicular type symptoms that the doctor felt was due to the work accident and then regarding the cervical spine, his opinions were predicated upon notes from Drs. Palmer and Fetzer. (Id.) He testified that the records do reflect that petitioner did injure his shoulder and neck and that his treatment for back and neck since November 2005 was reasonable, necessary and related to the work accidents. (Id.) Further, Dr. Goldberg testified the subjective complaints consistent with objective findings as well (Id.) However, the doctor stated that "it's not until a few years later where he's getting bilateral leg pain now and there's new pathology at other levels"; regarding cervical complaints, "he had neck towards right shoulder originally, over the course of time it appeared to progress into some early myelopathic findings." (Px41, pg 54) He thought petitioner's symptoms were what MRIs showed. (Id.)

Regarding causation for the back and neck and whether Petitioner's present condition of ill being is caused in whole or in part by any of the four work related accidents, the doctor testified the lumbar yes in whole part because "unfortunately he developed adjacent level problems." (Px41, pg. 54) Regarding the neck, he testified "all I can state is he did have an injury, he was treated by some of my partners, had some temporary improvement its not progressed." (Id.)

On cross examination, Dr. Goldberg testified he did not review any medical records from prior to the work accidents and he did not have any information regarding the 3/10/06 or 12/23/05 work accidents. (Px41, pg. 57-58) He opined the lumbar spine injury appeared to be caused initially on 11/4/05 and an exacerbation on 4/17/06. (Id.) Regarding the 3/10/06 accident, all Dr. Goldberg had was Dr. Palmer's notes which included that patient works as luggage handler and he has pain in the right anterior aspect of his right shoulder from accident on 3/10/06. (Px41, pg. 58) Regarding Dr. Nicholson, Dr. Goldberg doesn't know why he did not review his records but testified he does know that Dr. Nicholson did not feel petitioner's complaints were related to the shoulder. (Id. at 59). Dr. Goldberg acknowledged that Dr. Nicholson found pain complaints to be out of proportion to physical findings regarding the shoulder. (Id. at 60). Dr. Goldberg had not seen the FCE results at the time he released petitioner with restrictions as the FCE was after; but he did note that work conditioning showed some concerns about invalidity. (Px41, pg. 62). He then saw petitioner three years later and then again on 9/8/10. (Id.)

In the 6 year period between March 7, 2007 and March 18, 2013, the petitioner was seen by the doctor, only on September 8, 2010. (PX 41, pg 32,36,37) The doctor testified that he did not have any information regarding his symptoms or treatment during those periods, other than petitioner reporting he saw Dr McGinness who was prescribing Norco and Darvocet. (PX 41, pg 65 & 67) Dr. Goldberg also did not have any information regarding the automobile accident which occurred in 2008 and testified petitioner did not report the auto accident to him when he saw him in September 2010. (PX 41, pg 66) The doctor agreed an automobile accident could cause or aggravate his cervical and lumbar conditions. (Id.) The doctor testified that the cervical MRI from 2006 showed abutting the cord at C3-4 and C4-5, resulting in stenosis. (Id.)

The doctor acknowledged he saw petitioner on 3/18/13 at the request of his attorney and he was not aware of any treatment petitioner had from September 2010 through March 2013. (Px41, pg. 67). Dr. Goldberg did not review any 2008 records regarding the automobile accident and could not say to what extent that accident or injury aggravated petitioner's cervical or lumbar conditions. (Px41, pg 70) The doctor did not review records from Dr. Smucker, did review some records from Dr. Ganapathy, but was not aware the doctors noted that petitioner did not have findings consistent with cervical myelopathy in November 2014; however this did not alter his opinions because when Dr. Goldberg examined petitioner, he did "find some hyperreflexia, some Hoffman's, consistent with some myelopathy but myelopathy as we stated can wax and wane." (Px41, pg 71) He further testified he did not think the dislodged locking nut had any bearing on petitioner's clinical symptoms and are in the soft tissue nowhere near spinal canal/nerves; and that he had good decompression of the levels of the fusion. (Id. at 72) .

Testimony of Dr. Lami- Respondent IME

The deposition of Dr. Lami, the respondent's IME examiner, was completed on **January 18, 2017**. (RX 2) Dr. Lami is a board-certified orthopedic spine surgeon. (Rx 2, pg 5) Dr. Lami testified that the petitioner's condition of ill being in the cervical spine was not causally related to the work accident of April 17, 2006, or to any of the other work accidents. (Rx 2, Pg 9-10)

Dr. Lami explained that he personally reviewed the MRI findings from November 9, 2006, which failed to show myelopathy, traumatic findings or other significant pathology, but did show: some bulging of the disc with no compression at C4-5; at C5-6 a central disc protrusion which was degenerative in nature, C6-7 protruding disc without any significant compression of the cord. (Rx. 2, Pg. 8-9) In addition, on examination, the cervical spine exam was negative for any significant abnormalities or signs of injury. Based on the doctor's exam of March 15, 2013, he was unable to support any need for cervical surgery related to the April 17, 2016 Work accident. (Rx. 2 Pg. 14)

The petitioner described to Dr. Lami that at the time of the April 17, 2006 accident he felt a crack in his lower back. The notes from the emergency room showed no cervical spine issues or did the records of the initial providers. It wasn't until later in the medical records, where there was a suggestion of right shoulder pain which developed overtime into cervical spine type issues. (Rx 2 Pg. 10) In addition, doctor opined the MRI from 2006 showed no significant pathology only degenerative changes. (Rx 2, Pg 10) Regarding work restrictions, Dr. Lami opined that given the two level lumbar fusion, he recommended maximum lifting from 25 to 30 pounds. (Rx2, pg 11) Dr. Lami also agreed with the treating physicians that he was at MMI on 4/3/07. (Id.) The doctor opined that the need for any cervical surgery would not be related to the 4/17/06 work accident because he did not feel petitioner suffered a cervical spine injury on 4/17/06. (Rx2, pg14) The doctor did not find evidence of myelopathy on the MRIs or on examination of petitioner but did agree with Dr. Goldberg that it can be a progressive condition. (Rx2, pg 15) On cross examination, the doctor acknowledged that a neck injury can have pain in the arm and that sometimes cervical injuries causing pain in the arm can be misdiagnosed as a shoulder injury, "if it is evaluated by an appropriate doctor, its not likely". (Rx2, pg 23) When asked if the shoulder symptoms could have masked the neck injury in the case of Mr. Loving, Dr. Lami testified that it could not. (Rx 2, Pg. 32-34) If the petitioner had a neck injury which resulted in myelopathy; this would be traumatic and would be obvious at the time of the injury. This did not occur in Mr. Loving's case. On redirect, Dr. Lami was asked about Dr. Fetzer's December 2006 report where petitioner stated he was moving luggage at his job, moving forward with arms extended and he felt a pop in his right shoulder. (Rx2, pg 35) The doctor opined this is not something that would cause an injury in your neck. (Id.)

Testimony of Dr. Wehner- Respondent IME

Dr. Julie Wehner is a board-certified orthopedic spine surgeon who testified on **February 17, 2017**. who performed an IME on February 9, 2007 and January 7, 2009. (RX 1) On exam, Dr. Wehner found was no clonus or positive Hoffman's or Babinski signs to support a diagnosis of cervical myelopathy. (Rx 1, Pg. 10) The doctor opined that after review of the medical records and her first examination of petitioner, she gave a diagnosis of low back pain and that he was status post-fusion for degenerative disk disease at L4-5 and L5-S1 (Rx1, pg 8) Regarding the cervical spine, the doctor did not see anything on the MRI that warranted surgery and that the MRI findings did not match clinical findings for level of pain petitioner was demonstrating. (Id.) Dr. Wehner opined Petitioner did not need cervical surgery because petitioner has degenerative findings at C4-5, C5-6 and C6-7, they were not causing cord or nerve root impingement and because "the level of his pain complaints on clinical exam did not correlate with this mild degree of finding." (Rx1, pg. 9) The doctor did not find that petitioner had myelopathy but that he should complete post operative therapy. (Rx1, pg.10)

The doctor testified that the two-level lumbar fusion performed by Dr. Goldberg in 2006 was not appropriate and that the surgery performed was unlikely to provide a good outcome for petitioner, for the MRI findings that were present. (Rx 1, Pg. 12, 30) She indicated that the patient had symptom magnification and pain complaints which were out of proportion to the diagnostic findings at the 2009 exam. (Rx 1, pg 14-15) As such, she felt that he did not have a good prognosis and surgery was unlikely to provide a good outcome. (Rx 1, Pg. 9,10-12) In addition, Dr. Wehner testified that the petitioner exhibited signs of symptom magnification. (Id.) Further the doctor reviewed the 2008 lumbar spine MRI and diagnosed petitioner with chronic pain syndrome following the 2009 IME. (Rx1, pg.15) Specifically, she explained petitioner has ongoing pain that's usually longer than six months duration and that pain complaints were much higher than one would expect after this type of surgery, petitioner was two years out from surgery, high doses of pain medications that are not medically appropriate at that point, normal neurological exam, symptom magnification behaviors and a MRI that did not show any problems with actual surgery performed, (Id.) Regarding the narcotic usage, the doctor testified that is was not medically appropriate and that petitioner was taking Doxepin- anti depressant, Abilify, and Cymbalta which were different mood stabilizing drugs. (Rx1, pg.16) Then petitioner was on Hydrocodone- narcotic, Fexofenadine- narcotic, Fentanyl – very strong narcotic pain medication, Celebrex- anti-inflammatory, then he had patches; petitioner also was on Topmax probably for headaches (Id.) Dr. Wehner opined that it is strongly discouraged that people use this type of doses of narcotics and mixing all different classes of medications. (Id.)

Dr. Wehner as of the last IME recommended Petitioner go back to work with no lifting more than 25 pounds and that he did not need any further medical treatment for his back and that he should be weaned off his narcotic pain medications. (Rx1, pg. 17) The doctor did not believe that the petitioner had any condition of ill-being with respect to the cervical or lumbar spine that was related to the work accident other than a lumbar strain. (Rx 1, Pg. 18,19) Further the doctor found petitioner did not need further treatment for the neck. She testified that his pain levels did not correlate to the radiographic findings. (Rx 1, Pg. 19) She noted there were no acute findings on the first lumbar MRI and that Petitioner had pre-existing degenerative changes of the lumbar spine (Rx. 1 Pg. 18) Despite having a invalid FCE, Dr. Wehner acknowledged petitioner still required the 25 pound permanent restriction because he underwent surgical intervention, and based on the type of surgery done and his age, some people might need restrictions to get back to work in some capacity. (Rx1, pg. 20)

The petitioner had a cervical injection which was a diagnostic tool to ascertain if pain complaints were stemming from the cervical spine or shoulder. (Rx. 1, Pg 33, 37) Dr. Wehner testified that as he did not improve with the injection, this would signify that there was not a problem stemming from the cervical spine. (Rx 1, Pg. 37) As of the date of the deposition, the doctor had not seen petitioner since January 2009. (Id.)

Testimony of Dr. McGinnis- Treating physician

The deposition of Dr. Catherine McGinnis was completed on **December 2, 2016**. (PX 42) Dr. McGinnis testified that she is board certified in family medicine not orthopedic medicine and does not perform any surgeries. (PX 42, Pg 6) Further, she testified she referred petitioner to various other doctors for his back and shoulder/neck. (Px42, pg. 86)

It is Dr. McGinnis' opinion that the petitioner's neck and back pain was causally related to the injuries sustained at work. (Px 42, pg 83) The doctor testified that Petitioner saw her office for low back pain after a work injury on 4/17/06 and petitioner stated he was loading luggage on the plane when he felt a crackle in his right lower back. (Px 42, pg 15) Her assessment at that time was muscle sprain and she refilled his pain medications. (Id.) However, when cross-examined, the doctor testified she had no information regarding any accidental injuries other than the injury to his arm throwing luggage which he reported at the visit on April 13, 2006. (Px 42, pg 99) She specifically denied having any information regarding the accident on November 4, 2005 or the injury on December 23, 2005. (pg. 100)

Dr. McGinness testified that at the 12/20/07 visit Petitioner had severe low back pain and back muscle spasms and needed an x-ray for his finger. (Px42 pg. 26) She treated him for erectile dysfunction and "wrote a letter for work that he was not able to do his job. (Id.) Specifically, the letter she wrote was for "back pain relating to the herniated disc, not being able to participate in his retraining classes at this time because his narcotic medication put him to sleep and because his back pain requires him to get up and walk around frequently." (Px42 pg. 27) Dr. McGinness testified she wrote this letter "based upon his complaints". (Id.)

The Arbitrator notes that the doctor appears to have mentioned neck pain for the first time in her records, in her testimony, following receipt of a letter from pain doctor, Dr. Amin, around March 2008. (Px42, pg 29) When asked about keeping Petitioner off of work, she testified that both the specialists and herself kept petitioner off of work during this period of time prior to March, 10, 2008. (Px42 pg. 30) The doctor testified that Petitioner "now developed pain in the neck radiating down the left arm and right arm" as of 7/1/08 visit she had with him. (Px42, pg. 33)

On the 6/5/09 visit, Dr. McGinness notes that Petitioner would no longer be employed by United and that he understood United would not take back an employee with duty restrictions and that he would never be able to return to unrestricted duty. (Px42, pg 42). Dr. McGinness testified to numerous refill phone call notes for pain medications for the back, migraines, depression and stomach issues from August 2012 through March 2014, where petitioner was not seen in the office (Px42, pg 56) There was only one visit during this time, in March 2013, that the doctor appears to have seen/examined Petitioner. (Id.) The Arbitrator notes that this corresponds with the time period that Petitioner testified to be living out of state, as documented by Dr. McGinness as well.

Dr. McGinness opined that Petitioner's problems to his neck and back are the direct result of his work injuries and that his treatment received was reasonable and necessary. (Px42, pg82) She testified that his subjective complaints were always consistent with her objective findings, specifically with his neurologic exam, physical exam and MRI clearly show targets. (Px42, pg. 83)

When asked why she opined that Petitioner's present condition of ill being as it relates to both the back and neck (as of the deposition date of 12/2/16) was caused in part or by any of the four work related incidents, Dr. McGinness testified: "This --this is a man who'd been seeing us for decades and prior to his injuries he was not what you would call a frequent flier, he was in--- he did have occasional musculoskeletal complaints s a results of hard, physical labor prior to these injuries but you would not see him for months at a time, he was never drug seeking, he would occasionally need a statement for work, and then he had the injuries and he had pain ever since." (Px42, pg. 83-84)

When asked about work restrictions, the doctor testified she believed he was never able to return to work after April 2006, and that she thinks they tried to send him back with restrictions but Petitioner was not able to. (Px42 pg. 84) Dr. McGinness, also opined that Petitioner was permanently and totally disabled and the basis for the opinion was "He has limited strength. He can't get his arms above his head. Baggage handlers have to be able to lift a suitcase that if it doesn't have a heavy tag on it, it weighs 100 pounds and stack it into awkward positions; they may be in a squat, they may be on their knees. The nature of his job is not something you can do with weakness in both hand and both legs due to nerve compression." (Px42, pg84-85)

On cross examination, the doctor acknowledged she did not have all the Midwest Orthopedic records and that she was not aware or did not see that Dr. Fetzer released petitioner to return to work full time and full duty on 4/3/07 given the results of the FCE, positive Waddell's findings, and multiple nonorganic signs. (Px42 pg 87) The doctor also testified that she didn't know Dr. Palmer also reviewed the records and on 4/11/07 released petitioner to return to work in accordance with recommendations from Dr. Fetzer and Dr. Goldberg. (Id.) The doctor was also not aware that Dr. Goldberg, the orthopedic surgeon he was referred to for his back, placed him at MMI and released him to return to work lifting 40 pounds occasionally on 3/7/07. (Px 42, pg88)

Dr. McGinness testified she disagreed with Petitioner's orthopedic treating doctors, Dr. Fetzer, Dr. Palmer, Dr. Goldberg and Dr. Nicholson, who believed Petitioner could return to work full duty or with a 40pound lifting restriction in 2007. (Px42, pg88) She stated she disagreed because of the nature of his job and that he cannot do it with nerve compression. (Px42, pg89) Dr. McGinness opined that even if the orthopedic doctors released him to work with the 40 pound restriction, Petitioner could not return to work in some capacity. (Px42, pg 89) She opined she was in a better position than the orthopedic doctors to make that determination because she looks at Petitioner's total body and level of function and Petitioner could not work.(Id.) On cross exam, the doctor further admitted she was not aware of the inconsistencies in the work conditioning reports by the physical therapists, or in the examinations by Dr. Nicholson and Dr. Fetzer. (Px42 90) Despite not knowing about the above or the invalid FCE, Dr. McGinness testified that her opinions regarding work ability and restrictions remain the same because "given the nature of his job and abnormal MRIs and abnormal nerve conduction studies it is my belief that this man is never able to return to work." (Px42, pg 90)

Dr. McGinness opined that the right shoulder complaints were related to the neck after “looking at how it was evolving over time. But the nerve- but his MRI of his neck demonstrates things that certainly cause shoulder pain.” (Px 42, 90) The doctor discussed in her direct testimony that she “certainly did enough letters” regarding his work status; however, when it was pointed out on cross examination that there are only two letters authorizing petitioner off work at any time, she suggested that off-work notes were instead being written by his orthopedic physicians. (Px. 42 pg 91) The doctor testified migraines preexisted the work accident. (Px42, 97)

The doctor testified that she continued to refill her patient’s medication with phone calls while the petitioner was living in Georgia and she did not see any records from Georgia during this period. After 2009, the petitioner saw Dr. McGinnis for annual medical visits on October 6, 2009, August 17, 2010, June 16, 2011, July 25, 2012, March 14, 2013, March 7, 2014, and September 11, 2015. While he did at some appointments complain of neck and back pain, he was seen for medication refills, swollen glands, abdominal pain and gastrointestinal issues.

Dr. McGinnis testified that prior to the work accidents, she had seen him for back pain on November 4, 2002. (PX 42, pg 101) She saw him May 17, 2004 for neck , muscle spasms and back pain (PX 42, pg 103), and upper back pain June 28, 2004 (PX 42, pg 104), back and hip pain on November 25, 2004 PX 42, pg 104).

Dr. McGinness also admitted on cross examination that she was not aware of Petitioner’s automobile accident in August 2008. She also did not review the medical records from the ER for this automobile accident. (Px42, pg 104-105).

Testimony of Dr. Song- treating surgeon

Dr. Song is a board-certified neurosurgeon. (Px. 45, pg 6) The doctor initially saw the petitioner as an inpatient at Hinsdale Hospital on **November 15, 2022**. He performed a laminectomy from L2 to L4 with fusion. (Px 45, pg. 9) **When asked about whether the prior low back surgery, had any effect on his need for a low back surgery in 2022, the doctor stated, “I don’t have a strong opinion on that. As I said, I could opine on what could have caused the patient’s most recent problems. But whether or not the previous fusion was involved, I can only say possibly.”** (Px 45, pg 13) **When asked to specify his opinion as to what caused his most recent problems, the doctor stated, “well, the differential, as we said, could have been the previous surgery. It could have been any other injury he had in the intervening 15 years or just normal degenerative changes.”** (Px. 45, pg 13) Dr. Song testified he was unaware of the auto accident in 2008. (Px 45, pg 13-14, 24)

On cross examination, Dr. Song did confirm that an automobile accident could be a competent cause of an injury to the low back. (Px. 45, pg 24). The doctor was asked about his report of February 14, 2023, which stated that his lumbar fusion was “apparently causally related” to the adjacent segment disease from his prior lumbar fusion (Px 45, pg. 18), however when asked about that statement on cross examination, the doctor stated that information “must have been from a direct interview with the patient.” (Px 45, pg. 27)

The doctor described adjacent segment disease as “this is a condition where people...had a prior fusion...so over time the remaining segments that were not operated on theoretically can develop more – you know, have to do more work to get the same range of motion. So if they do more work, theoretically, they can wear out quicker.” (Px45, pg.17) Dr. Song testified that he performed a laminectomy from L2 to L4 associated with a posterior lumbar fusion and that he last saw Petitioner on March 7, 2023. (Px45, pg. 19-20) The doctor did not address petitioner’s ability to work in his notes and testified he would defer to Dr. Goldberg or whoever originally gave petitioner the work-related restrictions. (Px45, pg.20)

On cross examination, Dr. Song testified he did not think he had any information specifically written in his notes about what petitioner alleges occurred at work in 2005 or 2006. (Px45, pg. 23) He had not reviewed any prior medical records and testified his opinions regarding a work-related injury or whether it caused any condition of ill being with the neck and back were based on what the petitioner told him about the causal relationship and not from any independent information. (Px 45, pg. 23-24) The doctor had no independent knowledge of the alleged work related injuries or the petitioner’s medical treatment prior to coming under his care. (Px 45, Pg 23-24) Dr. Song did not have any opinion as to whether there was any injury to the cervical spine as a result of any work related accident in 2005 or 2006. (Px 45, pg. 24.)

Dr. Song testified that did not review any medical records regarding an automobile accident Petitioner had in 2008 and that an automobile accident could be a competent cause of injury to the lower back. (Px45, pg 24) In reviewing the medical records from the petitioner’s admissions to the hospital in November 2022, the doctor testified the diagnosis would be low back pain and findings would have been lumbar stenosis and a lumbar degenerative spondylosis. (Px 45, pg. 25) The doctor explained that stenosis is narrowing of the spinal canal or neural foramen can be a degenerative condition but could also be narrowed for any reason. Degenerative spondylosis is arthritis. (Px 45, pg. 26) Following the surgery, the petitioner did well and the doctor’s note of December 6, 2022 stated the petitioner was happy and his chronic low back pain had essentially resolved. (Px 45, pg. 26) On February 7, 2023, the petitioner reported that his left leg symptoms were 80 to 90% resolved and his right leg symptoms were 63% resolved page (px45, pg. 26–27). **Dr. Song testified that he had not issued any work restrictions and would defer to the 25 lb. restriction issued by Dr. Goldberg in 2007.**

Dr. Song was asked about the statement made that the prior lumbar fusion was “apparently causally related” to his work injury in 2006 and also 2014. The doctor explained he did not review any records so the opinion of “ “apparently causally related” must have been from a direct interview with petitioner. (Px45, pg. 27) The doctor also testified regarding petitioner having right arm symptoms and possible right C5-C6 radiculopathy that was complicated by bilateral carpal tunnel surgery he also had. (Px45, pg28)

Dr. Song testified that if the prior lumbar fusion was related to a work accident or injury, and the doctor diagnosed petitioner with adjacent segment disease and that led to the most recent surgery, then the surgery does appear to be causally related to a work injury. (Px45, pg. 30). Even if the prior fusion was not related to a work injury, the doctor testified that “the current issue or most recent issues are still related at least partially to the prior lumbar fusion.” (Id.)

Dr. Song testified that he did not review any of the medical since the prior fusion, did not review Dr. Goldberg's records or prior operative report and has not issued any work restrictions at any time. (Px45, pg.31) The doctor was asked "so, hypothetically, if Dr. Goldberg has stated that the reason why he did the fusion in the first place was a work-related injury, my hypothetical is correct, then. Your causal connection opinion is correct where you say it's causally related because I'm fixing an adjacent segment disease that was caused by a work-related fusion. The doctor answered "I think... As I said before, I believe it is a factor. But, again, is it a major factor? I'm not sure if that's significant. It is a factor, but with so much time in between, it's hard to say how big of a role that played." (Px 45, pg. 32-33)

Testimony of Dr. Mather- Respondent IME

Dr. Steven Mather is a board-certified orthopedic surgeon who testified on **September 5, 2024**. (Rx 3, Pg. 5) Dr. Mather opined that based on the diagnostic films he reviewed, the petitioner had a right L4-L5 and L5-S1 disc herniations. For this condition, if conservative treatment failed, the standard recommended by the American Board of Orthopedic Surgery would be to perform a discectomy. (Rx 3, Pg. 8) He testified fusions are only used to stabilize something or if the patient had an unusual history of chronic back pain for many years which continued and then ruptured the disc. (Rx 3, Pg. 8) **Dr. Mather testified that with respect to the cervical spine, the petitioner sustained only a cervical soft tissue strain or a temporary aggravation of Petitioner's right C4-C5 stenosis which had resolved itself at least by April when his symptoms resolved.** (Id.) The MRI showed only normal degenerative changes of the cervical spine. (Rx 3, Pg. 7-8)

Dr. Mather testified that he found the petitioner to have positive Waddell findings. (Rx 3, Pg. 9) These maneuvers are not supposed to provoke pain and are done to determine if there are any inconsistencies, symptom magnification or functional pain that cannot be medically explained. (Rx 3, Pg.10). Dr. Mather testified that many of the work restrictions were imposed purely based on what the patient said they could do, however, this would be suspect when a patient has a positive Waddell findings as the patient is magnifying their symptoms. (Rx 3, Pg. 13) Dr. Mather also pointed out that the petitioner would go to IMEs and show up with a cane, but then when he was seeing his regular treating doctors, he would not have the cane. He felt this was a clear example of the patient grossly magnifying symptoms. **Despite this, Dr. Mather agreed as a result of the first fusion surgery, the petitioner should have a 25 pound lifting restriction with bending no more than eight times per hour based on the lumbar fusion performed.** (Rx 3, Pg. 13) **In accordance with petitioner's treating physicians at the time, Dr. Mather agreed the petitioner was at maximum medical improvement for the lumbar spine in March 7, 2007 and for the cervical spine on April 3, 2007.** (Rx 3, Pg. 12) The doctor also testified that cervical was non occupational because his own treating physicians placed him at MMI back in 2007 as he didn't really have any significant clinical findings. (Rx3, pg18)

Dr. Mather testified the fusion performed by Dr. Song in 2022 was not related to the work accident and was instead just normal age appropriate or age-related degeneration. (Rx 3, Pg. 19) **In support of this, he pointed out that three years after the original fusion, the patient was already showing stenosis two levels away which strongly indicates it was present to some degree prior to the fusion and progressed in a typical fashion for type of**

degeneration. (Rx 3, Pg. 19) Dr. Mather did agree that as a result of the initial lumbar fusion in 2007, the petitioner required permanent 25 pound lifting restrictions with bending and twisting only eight times per hour. This restriction would preclude his returning to work as a ramp serviceman.

Dr. Steven Mather testified with respect to the cervical spine, the petitioner suffered only a cervical strain or aggravation of the pre-existing stenosis at C4-C5. The petitioner was at maximum medical improvement by April 3, 2007. He did not agree that cervical surgery would be appropriate as there were no indications of myelopathy or any neurological impingement stemming from the cervical pathology at C4-C5. Specifically, he found that even though petitioner has a C3-4 herniation, Petitioner does not have myelopathy or C4 radiculopathy because Petitioner did not have certain positive findings and that the herniations cause tingling as opposed to real pain. (Rx3, pg. 11)

The petitioner was at maximum medical improvement for the lumbar spine as of March 7, 2007 consistent with his treating physicians who initially placed him at MMI. He does not believe petitioner required any further treatment after that date for the lumbar spine. He testified that the fusion surgery performed by Dr. Song in 2022 was due to ongoing degenerative pathology and stenosis noted previously on the MRI done in 2010.

On cross examination, Dr. Mather agreed that petitioner would not be able to return back to work as a baggage handler after a two level fusion and the weightlifting requirements for a baggage handler was at least 50 pounds. (Rx3, pf 26)

David Patsavas- Vocational Rehabilitation counselor

The deposition of David Patsavas, the petitioner's vocational expert, was taken on September 9, 2022. (PX 43) Mr. Patsavas testified he prepared a report in 2019 with medical records reviewed, the petitioner's employment history and his opinion is that there is no stable labor market for Mr. Loving. (Px 43, pg 20-22) He testified that Petitioner could not return as a baggage handler nor could he have returned to any kind of employment as of the time of his assessment, because of petitioner's "lack of transferrable skills, required medication levels, and physical limitations. (Px43, pg21-22). Mr. Patsavas did not perform a labor market survey or do any vocational testing, nor did he perform any computer testing. (Px 43, pg 24-25). When asked what functional restrictions he used in determining there was no stable labor market for Mr. Loving, he appeared to have difficulty answering the question. (Px 43, pg 28-29). He indicated that one of Mr. Loving's physicians indicated he was permanently and totally disabled; he incorrectly suggested another indicated that he should have sedentary restrictions, while he suggested the invalid FCE found he should have a 25-pound restriction. When asked which of these restrictions he used, he could not clearly answer the question and appeared to use various restrictions of light category restrictions and also sedentary restrictions (Px 43, pg 29). He testified that Mr. Loving has not, at any time, looked for alternate employment or provided job search logs. (Px 43, pg 28). In meeting with the petitioner, Mr. Loving also did not express any desire to find employment. (Px 43, pg 28).

Mr. Patsavas' report indicated that the petitioner had a police record. When questioned, Mr. Patsavas did not have any further information regarding that issue. He testified that having a

criminal record could impact types of jobs the petitioner might be able to perform but he did not ask the petitioner to ascertain the impact on any vocational prospects. (Px 43, pg 26-27). When asked what jobs he considered for the petitioner, Mr. Patsavas answered, “none.” (Px 43, pg 30).

Testimony of Joe Belmonte- Vocational Rehabilitation counselor

Joseph Belmonte was retained by Respondent to provide vocational services to the petitioner in 2007 following his discharge from care by the physicians at Midwest Orthopedics at Rush. (RX 4.) Mr. Belmonte testified on **November 11, 2022**. Dr. Goldberg the treating surgeon had provided restrictions of 40 lbs. floor to waist, frequent lift of 20 lbs floor to waist, frequent lift of 15 lbs waist to shoulder, occasional lift of 20 lbs. overhead and frequent lift of 10 lbs. overhead. (Rx 4, pg. 51) Mr. Belmonte testified that the petitioner was eligible for employment in a stable labor market at that time within his restrictions. (RX4, Pg. 35) The anticipated likely wage range was \$10 to \$14.50/hour (Rx. 4, Pg. 16)

Following the initial interview and in accordance with the petitioner’s restrictions and employment history, a number of different positions were identified which it was felt the petitioner could likely perform. (PX 44, Pg. 15) These included truck dispatcher, aircraft dispatcher, assembler, newspaper circulation clerk and security guard supervisor. (Rx. 4, Pg. 15-16) After administering various tests to identify the petitioner’s strengths and weaknesses, additional potential employment opportunities were identified which were a match with the petitioner’s abilities. These included charge account clerk, shipping order clerk, route delivery clerk, nutritional aide, electronics utility worker, security gate guard, stock control clerk, information clerk, expeditor, service order expeditor. (RX 4, Pg 23-24)

In addition, Mr. Belmonte testified regarding concerns which were raised as to the petitioner’s compliance, interest and motivation in finding work. Mr. Belmonte issued correspondence to Mr. Loving on December 21, 2007 addressing the lack of compliance in the vocational process. (Rx 4, Pg. 29) The concerns centered around three issues. The first involved issues of cooperation, timeliness, attendance, absences and early departures. In addition, there were inappropriate verbal and written comments in response to guidance given to him in good faith by the Vocamotive staff. Finally, there was inappropriate identification of job targets such as Hollywood script writer, congressman or alderman coupled with no apparent effort to identify meaningful job targets consistent with his work history and educational level. (Rx 4, pg 30) Mr. Belmonte requested that Mr. Loving verify whether he was actually willing to cooperate with the job search process and provide an answer by December 26, 2007. (Rx 4, Dep Exh 3)

Mr. Belmonte testified he told the petitioner that “it was my professional opinion that he was not motivated to participate in the service, getting a job was not a priority and that he wasn’t cooperating and that I felt that he should be discharged from the service.” (Rx 4, Pg. 30) They were willing to give him another chance, however, he Mr. Belmonte laid out that he needed to be realistic in understanding job targets. Mr. Belmonte informed petitioner that he was clearly employable in jobs such as order picking, security, cashier, entry level customer service, mailroom clerk and other jobs. (Rx 4, pg 31)

Mr. Belmonte admitted that during his work with the petitioner, a report was issued prematurely commenting on petitioner's honesty and Mr. Belmonte issued an apology to the petitioner and his attorney on December 21, 2007. (Rx 4 pg 33) They included raw notes which should have been edited down and reviewed by Mr. Belmonte, though through administrative error that did not happen in this case. (Rx 4 pg 33-34)

The records introduced regarding the vocational placement indicate multiple issues raised by Mr. Loving in connection with his efforts. They include that "Mr. Loving stated that he had decided that he wanted to relocate to California and become a Script Writer" (Rx 4, Dep Exh 2) At one point Mr. Loving indicated that he left his last employer as the business was closed. He was questioned on this as United Airlines had not closed, to which he responded, "You told me to answer the questions; I didn't know you wanted the truth." The petitioner is noted not to have completed job search leads or applied to the jobs he was directed to apply for. (Rx 4, Dep exh 2).

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim *O'Dette v. Industrial Comm'n*, 79 Ill. 2d 249, 253 (1980) including that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 63 (1989) It is well established that the Act is a humane law of remedial nature and is to be liberally construed to effect the purpose of the Act - that the burdens of caring for the casualties of industry should be borne by industry and not by the individuals whose misfortunes arise out of the industry, nor by the public. *Shell Oil v. Industrial Comm'n*, 2 Ill.2nd 590, 603 (1954).

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). 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 demeanor of the witness and any external inconsistencies with his/her testimony. Where a claimant's testimony is inconsistent with his/her 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). The Arbitrator, as the trier of fact in this case, has the responsibility to observe the witnesses testify, judge their credibility, and determine how much weight to afford their testimony and the other evidence presented. *Walker v. Chicago Housing Authority*, 2015 IL App (1st) 133788, ¶ 47.

In the case at hand, the Arbitrator observed Petitioner during the hearing and finds him to be only a partially credible witness and his overall testimony is not entirely reliable or credible. He was also a poor historian. The Arbitrator notes Petitioner denied prior low back injuries despite evidence of multiple prior doctor visits for the back pain. Petitioner clearly had some prior back complaints however his work accident on 4/17/06 created a significant change and worsening of Petitioner's lumbar spine. The Arbitrator also finds it important that Petitioner's own treating physicians, including multiple physicians at various medical institutions throughout the years, note

petitioner to have subjective complaints that do not match objective findings or noted symptom magnification.

The Arbitrator further notes that Petitioner is seen on 2020 surveillance video in evidence (Rx8 a, b), volunteering or working with his church, carrying items of unknown weights including clothing, a suitcase and construction cones. The petitioner testified these items and his conduct on surveillance are nonetheless within Dr. Goldberg's permanent restrictions from 2007. The Arbitrator tends to agree that the items are likely within the weight restrictions for carrying/lifting, but notes that this also shows Petitioner is somewhat more active than he testified and likely capable of working within those same restrictions despite testifying that he never attempted to find work within said restrictions. The Arbitrator does not find it reasonable based on the facts of the case and medical evidence, that Petitioner never attempted to find work within the permanent restrictions he was given by Dr. Goldberg in 2007.

Petitioner is and was likely able to do more than be completely off work following his examinations and release from care by Dr. Goldberg and Dr. Fetzer in March and April 2007. However, Petitioner testified that he relied on his PCP, Dr. McGinness, not his orthopedic surgeon and specialists, that he is completely off of work and unable to work. The Arbitrator does not afford the findings and opinions of Dr. McGinness much weight as they are not supported by the record as a whole in this matter. The Arbitrator also notes that despite testifying that he was under doctor's care and/or relying on Dr. McGinness regarding his ability to work from the first date of accident through present, the Arbitrator notes there are also numerous gaps in treatment with Dr. McGinness as elaborated on below: October 2009- August 2010, September 2010- October 2011, October 2011- March 2013 (other than prescription refills with Dr. McGinness), October 2015- March 2016, April 2016-September 2016, May 2017-January 2018, only three visits total in 2018 with Dr. McGinness, May 2019- October 2019 and June 2020 through November 2022. The Arbitrator does note that Petitioner did move a handful of times during this time period which could possibly explain some gaps in care but not all.

Further, the Arbitrator notes Petitioner claims lumbar spine, cervical spine and right shoulder injuries as it relates to his work injuries. The Arbitrator finds petitioner to be credible enough regarding the work accidents and injuries initially sustained, however the Arbitrator has not been convinced that Petitioner's ongoing and current cervical spine, lumbar spine and or right shoulder/arm complaints and progressively worsened conditions, are causally related to the original accidents at work. Despite petitioner's testimony, the Arbitrator finds it to be significant regarding causation, that there was an intervening 2008 rear end motor vehicle collision that occurred, injuring petitioner's low back and neck among other injuries, as well as a large 15 year gap from Dr. Goldberg's issuance of permanent restrictions and Petitioner's necessitating a second lumbar fusion surgery with Dr. Song. It is clear from the medical evidence that petitioner's cervical spine and lumbar spine were injured in the motor vehicle collision requiring medical care. The Arbitrator finds it important that Petitioner's own PCP Dr. McGinness also determined petitioner was injured to the extent following this collision, to be completely taken off a work within a week after that collision.

Regarding the medical witnesses and experts in this case, the Arbitrator finds that overall, the treating physicians, Section 12 examiners and vocational rehabilitation counselors, except for Dr. McGinness, are credible witnesses, however, only finds the opinions of Dr. Goldberg and Drs. Palmer and Fetzer regarding the lumbar spine and cervical spine, Dr. Mather regarding the lumbar spine in part, as well as Mr. Belmonte regarding work capabilities, to be persuasive in making her findings and award as further explained below. The Arbitrator is not persuaded by the opinions of Dr. McGinness, Dr. Song, Dr. Wehner, Dr. Lami and Mr. Patsavas. See below for further discussion.

Issue F, whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds as follows:

To obtain compensation under the Act, a claimant must prove that some act or phase of his employment was a causative factor in his ensuing injuries. It is not necessary to prove that the employment was the sole causative factor or even that it was the principal causative factor, but only that it was a causative factor. *Tolbert v. Ill. Workers' Comp. Comm'n*, 2014 IL App (4th) 130523WC, ¶ 1, 11 N.E.3d 453. "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 Com.*, 93 Ill. 2d 59, 63 442 N.E.2d 908 (1982). Proof of the state of health of an employee prior to and down to the time of the injury, and the change immediately following the injury and continuing thereafter, is competent as tending to establish that the impaired condition was due to the injury. *Kress Corp. v. Industrial Commission*, 190 Ill. App. 3rd 72, 82 (1989).

Therefore, based on a chain of events analysis the evidence shows a causal relationship between the 3/10/06 incident at work and the cervical spine and right shoulder injuries only. Further, based on a chain of events analysis the evidence shows a causal relationship between the 4/17/06 incident at work and the lumbar spine injury that necessitated a fusion surgery and permanent restrictions. The Arbitrator further notes that Petitioner sustained minor lumbar spine injuries at work for Respondent on 11/4/05 and 12/23/05 as well. Petitioner was working full duty without restrictions for Respondent until his first work accident on 11/4/05. Following the 4th accident of 4/17/06, his lumbar spine condition significantly worsened requiring him to seek medical care, be taken off work etc. Regarding the cervical spine, there are clearly some degenerative changes noted on the MRI as well as on the lumbar MRI, however, Petitioner appears to have injured his cervical spine or aggravated it at a minimum, per the Midwest Orthopedic doctors, following the 3/10/06 work accident. Overall, the Arbitrator concludes Petitioner sustained work-related injuries to the lumbar spine and cervical spine but does not find petitioner's current condition of ill-being for both injuries to be causally related. Petitioner reached MMI for all work-related injuries on 4/3/07, per Drs. Goldberg, Fetzer and later Mather.

For the case at hand, Petitioner clearly had prior back pain and some visits with doctors or chiropractors before his four work accidents occurred. The Arbitrator acknowledges that the 2006 lumbar and cervical MRI findings after his work accidents also show some degenerative findings as well but it is still clear to the Arbitrator that the last two work accidents at a minimum, aggravated and worsened Petitioner's cervical and lumbar spine to the point that he required extensive medical treatment for the lumbar spine and needed to be taken off work by his doctors. Even though petitioner was not entirely credible on this issue at trial, medical evidence supports there was some prior back medical history for Petitioner. However, Petitioner was nonetheless working full duty without restrictions for Respondent at the time of first work accident of 11/4/05, and there is no evidence to the contrary. Petitioner also returned to work three times for Respondent before his final work accident on 4/17/06.

The Arbitrator notes that there are questions regarding how the first three accidents occurred. In each case, the accident as testified to by the petitioner does not entirely correlate with the medical history in the contemporaneous medical records.

The petitioner testified that on November 4, 2005, he was hooking up containers for the luggage which weighed about 1,700 pounds. As he was going to clamp the container on the tug he was driving, he slipped on the ice, tried to catch himself and hurt his back (Tr. 24). The medical records from that date at UIC Medical Center at O'Hare indicated instead that he reported lifting heavy bags on his knees in the pit when he twisted the wrong way with a heavy bag. (PX 20)

For the December 23, 2005 accident, the petitioner testified he was hooking up containers to a tug when he injured his back, legs, and hips (Tr. 28). The medical records from December 23, 2005 at UIC at O'Hare instead reflect the petitioner reported continued pain with lifting since the prior injury and acute increase in low back pain and radiation into left thigh when lifting a heavy bag this afternoon. (PX 20).

On March 10, 2006, the petitioner testified that as he was taking luggage out of the containers, he felt something pop in his neck, arm and right shoulder (pp. 29-30). The medical records reflect the petitioner was seen at Celar Chiropractic on March 14, 2006 reporting a new injury while lifting up and tossing a heavy bag. He reported pain in his right shoulder at that time and a shoulder MRI was ordered shortly thereafter.

The foregoing accident issues notwithstanding, the petitioner did not lose any time from work and sought more minimal treatment until the fourth alleged accident in April. On April 17, 2006, the petitioner was in the belly of a plane lifting luggage when he felt a crackle in his low back. He collapsed and was taken by Chicago Fire Department Ambulance to Resurrection Medical Center. The arbitrator finds that the first two accidents of November 4, 2005 and December 23, 2005 involved lumbar strains and the March 10, 2006 accident involved a right shoulder strain and aggravation of cervical spine injury. The injuries from these accidents were superseded by the April 17, 2006 accident.

In reviewing the medical records, they are replete with concerns about symptom magnification and the petitioner falsifying his presentation to his examining physicians. From the first visit with Dr. Nicholson on August 1, 2006, there were concerns about the petitioner's symptom magnification, as his presentation was out of proportion to his physical findings or the pathology seen on the MRI. (Rx 6, pg 87) Dr. Fetzner also noted that on exam he reported he could not actively raise his right arm above his head, however, he then did raise it to approximately 110 degrees of abduction. She outright expressed concern that the petitioner's symptoms were exaggerated. (Rx 6, pg 22)

The work conditioning notes also reflect "the client's refusal to perform resistive activities due to subjective complaints of pain without correlating clinical objective findings." (RX 6, pg 215) He required verbal cues and supervision to remain on task. The therapist went so far as to call this an "invalid" performance in work conditioning. The petitioner was given verbal warnings for non-compliance after receiving specific instructions in the proper conduct for participation. After continuing to demonstrate improper techniques, the therapist noted that "One would expect a client with a high level of low back pain to perform this activity with proper body mechanics to minimize the stress in the low back and to maximize the efficiency of the lift." (RX 6, pg. 216) It was at that point that an FCE with emphasis on validity was recommended. When the FCE was then performed, it was invalid due to submaximal effort from the petitioner. He in fact failed 18 out of 25 objective validity criteria (PX 24). Additionally, he had four out of five positive Waddell's signs for non-organic signs of low back pain. They specifically found that, "Mr. Loving is employable at this time." (PX 24).

This pattern of falsifying his presentation to his examining physicians was also pointed out in the records petitioner submitted related to the decision from the Social Security Administration. (PX 40). The report states,

"As can be seen from the records in this matter, the claimant has severe complaints with respect to his neck and back pain. The record shows that the claimant underwent surgery in September, 2006. All indications in the records show that although the claimant has continued to have severe complaints following the surgery, the objective findings have been minimal. During the physical examinations noted above subsequent to the surgery, it has been noted that the claimant has limitation of motion in the cervical and lumbar spine and the only signs supporting a diagnosis of radiculopathy have been some mild loss of sensation in the right thigh. The claimant has severe complaints which have been out of proportion to the objective evidence. The record is clear that the claimant does not have any limitations in the use of his arms or hands. The restrictions noted by Dr. McGinness are not supported by the record as a whole in this matter. As noted above, there are no treating notes of record to support the severe limitations noted by Dr. McGinness. As a result, the undersigned cannot afford the opinions of Dr. McGinness significant weight. The claimant's overall testimony in this matter was not fully credible. He has alleged very severe symptoms and limitations. He has stated that he has such severe back and neck pain that he cannot stand, walk or sit. However, it is noteworthy that he has not followed through with any epidural steroid injections and has apparently stopped trying any type of physical therapy. The functional capacity evaluation performed on the claimant on March 26, 2007 (Exhibit 16F) shows that claimant was attempting to portray himself much more limited than he actually was." (PX 40, p. 7 of 11).

The Social Security Administration found that while he would have some residual limitations, these would not prevent him from performing sedentary work. They note that with sedentary work there were 1,800 jobs available in the Chicago Metropolitan area for assembly, 1,200 jobs for hand packager, and 1,000 jobs for inspector. The report further indicates,

“The claimant is not persuasive. He said he cannot sit or stand for more than a few seconds and was up and down at the hearing. However, when it was noted he had to sit in the car for more than a few seconds when he goes to appointments and to get to the hearing, the claimant claimed that at every stoplight he opens the car door and stretches his legs out the door. This is rather hard to believe. It is noted that the claimant stated he has not driven since his back surgery in September, 2006. While it was pointed out that he was driving when he was involved in the motor vehicle accident in August, 2008 (Exhibit 11F), the claimant asserted that that was the only time he has driven since surgery. He claimed that his son was driving him to the doctor and got lost, so he had to take over the driving and then got into the motor vehicle accident. Other inconsistencies include the claimant testifying he cannot handle finances, he has done no cooking in the past two years and doing dishes, but information in Exhibits 4E and 8E suggest otherwise.” (PX 40, pg. 7 of 11)

The report further notes that while the claimant stated he had been using a cane for two years, an exam on November 13, 2007 indicated the petitioner did not have a cane and his gait was within normal limits.

The Arbitrator notes that a finding from the Social Security Disability Administration has no precedence. The Arbitrator does take note of the fact that inconsistencies were found, and that the trier of fact found the petitioner not credible with respect to his presentation and the testimony presented. This is consistent with the inconsistencies found in petitioner’s treatment at Midwest Orthopaedics at Rush and the functional capacity evaluation, among other records.

Later medical records also suggest that petitioner is not being forthright. The PT records from Saint Joseph’s/Candler Health System in Georgia include that petitioner washed, waxed and detailed his car over the weekend and then a week later he reported feeling well and “I feel like I could play football.” These comments were made in October 2015, the same month that Dr. Goldberg saw him and recommended cervical surgery. The Rush Oak Park Physical Therapy notes also repeatedly indicate significant self-limiting tendencies, and noted “observed movements and behaviors inconsistent with subjective reports” on October 28, 2019. Also on November 4, 2019, they again indicate the self-limiting tendencies and inconsistent observed movements and behaviors which were inconsistent with subjective reports.

All of these issues raise concerns regarding the petitioner’s presentation. Notwithstanding those concerns, the Arbitrator still finds that the petitioner suffered an injury to his low back on April 17, 2006 which necessitated a lumbar fusion. Dr. Goldberg who evaluated the petitioner on August 18, 2006 opined that the petitioner sustained a disc herniation and aggravated his degenerative disc disease with the work-related accident.

While Dr. Wehner could not substantiate any injury other than a sprain and Dr. Mather opined that a discectomy would have been more appropriate in light of the pathology on the MRI, the Arbitrator still agrees it was reasonable for the petitioner to follow the surgical recommendation of Dr. Goldberg. Dr. Goldberg was persuasive and credible in his testimony regarding his diagnosis of Petitioner's lumbar spine and the fusion surgery that was needed. Following the surgery, the petitioner had a favorable result to surgery. Despite the petitioner's testimony as to a "failed fusion", there is no evidence in the record to substantiate such a diagnosis. Instead, the records show he had an uncomplicated postoperative course and described successful resolution of his symptoms. Dr. Goldberg authorized the petitioner to return to work lifting 40 pounds occasionally from floor to waist, 25 pounds waist to shoulder, and overhead 20 pounds occasionally and placed the petitioner at MMI on March 7, 2007. (Rx. 6, pg 61) Regarding the cervical spine, Dr. Fetzer released to return to work full time and full duty on April 3, 2007 following the invalid FCE (Rx 6, pg 8)

Upon follow up questions by the arbitrator at trial, Petitioner testified that he felt a crackle and pain in the neck with the injury of April 17, 2006. This, however, is not supported by the medical records. Based on the Ambulance records and when the petitioner was seen at Resurrection Medical Center on April 17, 2006, he reported only low back pain. (PX 7). The history given was that he bent over to pick up a luggage bag and felt something pull in his back. A pain diagram also indicates pain only in the low back. The Chicago Fire Department ambulance records specifically note he had no neck or upper back pain. The petitioner described he felt something in his lower back go crunch after he bent over and lifted a piece of luggage (PX 7). Contrary to what the petitioner advised the Arbitrator, there was no injury to the neck or upper back reported at the time of the April 17, 2006 work accident. That said, based on the medical records and testimony by Dr. Goldberg, the Arbitrator finds that Petitioner did sustain a cervical injury and aggravation of his neck condition on the 3/10/06 accident date.

The Arbitrator notes that the petitioner also suffered an auto accident in August of 2008 which resulted in increased neck and back pain. He treated at Loyola ER, then with West Suburban Medical through early 2009.

In August 2010, Petitioner called Dr. McGinnis to request a cervical MRI and then went to see Dr. Goldberg, who he hadn't seen since his discharge from care in 2007. He reported that he had been constantly in pain for the last three weeks. It is unclear what caused this exacerbation. Dr. Goldberg recommended surgery but the petitioner did not want to proceed. Dr. Lami then performed an IME and opined that he did not need cervical surgery.

The basis for the surgery recommendation was concern for myelopathy. The petitioner's tests for myelopathy at his exams, however were inconsistent. Dr. Ganapathy on November 18, 2014 noted myofascial pain which was non-dermatomal and stated, "I am not convinced that he has myelopathy as today's exam was not in keeping with the exam finding from last visit." He referred the petitioner to Dr. Smucker for a possible diagnostic injection, but Dr. Smucker found his "symptoms of pain and paraesthesias were not consistent during the time of my discussion with him".

The neurologic exam showed no upper or lower extremity atrophy and balance and coordination were normal. Lower extremity neural tension signs were negative bilaterally. His lumbar range of motion was limited, but there was no focal mechanical reproducible pain. Cervical range of motion was also normal. Shoulder impingement was inconsistently positive on the left. Motor strength testing featured break away weakness through the proximal and distal bilateral upper and lower extremities. Dr. Smucker was concerned about the non-physiologic findings with diffuse inconsistent breakaway weakness on exam. The doctor did not see evidence of any cervical myelopathy, as such, he did not believe that the requested diagnostic cervical selective nerve root blocks would be valid in an individual with widespread inconsistencies on exam and in described symptoms.

Dr. Lami testified that the petitioner's condition of ill being in the cervical spine was not causally related to the work accident of April 17, 2006, or to any of the other work accidents. Dr. Mather testified that with respect to the cervical spine, the petitioner sustained only a cervical soft tissue strain or a temporary aggravation of Petitioner's right C4-C5 stenosis which had resolved itself at least by April when his symptoms resolved. Dr. Goldberg testified the petitioner injured both the cervical and lumbar spine at work, however, when asked about whether his current conditions were related to the work accident, Dr. Goldberg seemed to equivocate and could not affirmatively answer the question. He also was not aware of the automobile accident in 2008. Dr. Song also offered no opinion on whether the petitioner's condition of ill-being with respect to his cervical spine was causally related to the employment.

Overall, the Arbitrator finds that Petitioner sustained a cervical injury and right shoulder injury on 3/10/06 and a lumbar spine injury on 4/17/06. The petitioner also sustained more minor back injuries on 11/4/05 and 12/23/05. Regarding causation for Petitioner's current condition of ill being, the Arbitrator overall relies on the opinions and findings of both Dr. Goldberg in part and Dr. Mather, in part, in finding that: 1) Petitioner sustained work related lumbar spine and cervical spine injuries 2) Petitioner required lumbar fusion surgery and related care as provided by Midwest Orthopedics at Rush to his neck and back and 3) Petitioner was at MMI for his cervical spine in April 2007 and for the lumbar spine, March 2007 4) Petitioner required permanent restrictions and could not return to his prior job as a ramp agent for Respondent. The Arbitrator finds it reasonable that Dr. Wehner and Dr. Lami agree with the permanent restrictions of 25 pounds regarding the lumbar spine due to the fusion, but does not otherwise find their opinions to be persuasive. The Arbitrator does not find Dr. McGinness to be credible and is not persuaded by Dr. Song.

The Arbitrator relies on Dr. Goldberg's opinion when he gives causation for both the neck and back injuries as of the time he testified in 2016, however the Arbitrator does not agree that Petitioner's ongoing lumbar and cervical spine conditions as of 2016 are still related to the 2005 and 2006 work accidents. Unlike the IME physicians, Dr. Goldberg finds Petitioner did sustain a work-related cervical spine injury. However, there are no further treatment dates, opinions obtained or discussion with Dr. Goldberg regarding petitioner's conditions after his 2016 deposition. At this time, petitioner had still not had the 2022 second fusion, nor was Dr. Goldberg privy to the various IME opinions, deposition testimony and overall treatment records from 2016 to present. There are also no strong or persuasive opinions for causation of petitioner's current conditions after this deposition. The Arbitrator is also not persuaded

regarding Petitioner's current condition by Dr. Song who did not have all the records or a clear and complete picture of Petitioner's medical history. Dr. Song also deferred to Dr. Goldberg regarding work restrictions. Dr. Goldberg the treating surgeon, previously had provided restrictions of 40 lbs. floor to waist, frequent lift of 20 lbs floor to waist, frequent lift of 15 lbs waist to shoulder, occasional lift of 20 lbs. overhead and frequent lift of 10 lbs. overhead.

Regarding the lumbar surgery: while Dr. Mather's opinions are somewhat persuasive, the arbitrator more so relies on Dr. Goldberg's opinions which are convincing regarding the lumbar spine and the need for the fusion surgery he performed in 2006 and that was successful in helping petitioner's right leg complaints. The Arbitrator also finds it important that Dr. Goldberg testified that when Petitioner originally saw him regarding the lumbar spine, he has right leg symptoms improve after surgery, and it is not until a few years later where petitioner is getting bilateral leg pain and new pathology at other levels. Regarding the cervical, Petitioner had neck towards the right shoulder originally, over the course of time it appeared to progress into some early myelopathic findings. (Px41, pg54) It is clear per Dr. Goldberg that there was a change in petitioner's lumbar spine and cervical spine over the years, from the 2007 release from care with permanent restrictions and the 2010, 2013 and 2015 visits (last visit) with Dr. Goldberg.

It is noted that Dr. Goldberg last saw Petitioner in October 2015. Regarding causation for the back and neck and whether Petitioner's present condition of ill being is caused in whole or in part by any of the four work related accidents, the doctor testified the lumbar yes in whole part because "unfortunately he developed adjacent level problems." (Px41, pg. 54) Regarding the neck, he testified "all I can state is he did have an injury, he was treated by some of my partners, had some temporary improvement its not progressed." (Id.) The Arbitrator notes that the doctor found some adjacent level issues, however he also found that there was a stable lumbar fusion and he did not recommend further lumbar surgery. It important to note that the doctor did not change petitioner's work status or provide any additional opinions that changed the prior permanent restrictions he imposed in March 2007 for the lumbar spine.

In addition, regarding the neck, Dr. Goldberg did not find the condition to be worsening in 2015 but continued to recommend cervical surgery that petitioner declined and was also not approved. Dr. Goldberg as the treating surgeon was in the best position to opine as to Petitioner's conditions in 2006 and 2007, regarding the lumbar spine as well as cervical spine for finding a work related injury. He personally saw petitioner and examined him multiple times. He took numerous MRIs and reviewed many of them. He relied on his own medical records and those of his colleagues at Midwest Orthopedics. He was involved early on with petitioner's care and treatment and saw him from 2006 through 2015 (on and off). He testified that his opinions on the cervical spine was predicated on his review of Drs.' Palmer and Fetzer notes as well. Specifically, he testified that his colleagues thought petitioner had a shoulder condition and records reflect that petitioner injured his right shoulder and neck as well. The Arbitrator finds it important and persuasive that the doctor's objective findings matched petitioner's subjective complaints during his treatment of him, despite other treating physicians and IME doctors finding symptom magnification. There was clearly symptom magnification documented by numerous treating physicians per the extensive medical records in this case but it appears that with Dr. Goldberg, Petitioner was more credible with his pain complaints. All of the IME doctors

also documented symptom magnification and/or unexplained subjective complaints which goes towards credibility of Petitioner.

Regarding his history with petitioner, Dr. Goldberg testified that for the initial treatment starting in August 2006, he was primarily treating petitioner's back however he did previously review the cervical spine MRI in November 2006. (Px41, pg 35) The doctor opined that the prior 2006 MRI showed there were disk herniations at C3-4 and C4-5; at C3-4 it was central, at C4-5 it was central to the right; and there was a smaller herniation at C5-6 and C6-7. (Id.) It is therefore appears to the arbitrator that Petitioner sustained a right shoulder and neck injuries as described above by Dr. Goldberg, in the 3/10/06 injury. Importantly, Petitioner, per Dr. Goldberg had herniations on his cervical MRI as of November 2006.

It was reasonable for Dr. Goldberg to give permanent restrictions in this case Dr. Goldberg provided restrictions following work hardening of 40 lbs. floor to waist, frequent lift of 20 lbs floor to waist, frequent lift of 15 lbs waist to shoulder, occasional lift of 20 lbs. overhead and frequent lift of 10 lbs. overhead. Despite not agreeing with Dr. Goldberg in performing a fusion surgery, Dr. Mather agreed as a result of the first fusion surgery, the petitioner should have a 25 pound lifting restriction with bending no more than eight times per hour based on the lumbar fusion performed. (Rx 3, Pg. 13) This is reasonable to the Arbitrator. In accordance with petitioner's treating physicians at the time, Dr. Mather agreed the petitioner was at maximum medical improvement for the lumbar spine in March 7, 2007 and for the cervical spine on April 3, 2007. (Rx 3, Pg. 12)

Dr. Mather testified that with respect to the cervical spine, the petitioner sustained only a cervical soft tissue strain or a temporary aggravation of Petitioner's right C4-C5 stenosis which had resolved itself at least by April when his symptoms resolved. (Id.) The Arbitrator is persuaded by this opinion based on his testimony and the record as a whole. Dr. Mather, like the other IME doctors in this case, testified that he found the petitioner to have positive Waddell findings. (Rx 3, Pg. 9) These maneuvers are not supposed to provoke pain and are done to determine if there are any inconsistencies, symptom magnification or functional pain that cannot be medically explained. (Rx 3, Pg.10). Dr. Mather also pointed out that the petitioner would go to IMEs and show up with a cane, but then when he was seeing his regular treating doctors, he would not have the cane. He felt this was a clear example of the patient grossly magnifying symptoms. Dr. Mather further opined that petitioner was at maximum medical improvement for the lumbar spine as of March 7, 2007 consistent with his treating physicians who initially placed him at MMI. He does not believe petitioner required any further treatment after that date for the lumbar spine. The Arbitrator agrees. He testified that the fusion surgery performed by Dr. Song in 2022 was due to ongoing degenerative pathology and stenosis noted previously on the MRI done in 2010. The arbitrator finds this opinion to be persuasive. On cross examination, Dr. Mather agreed that petitioner would not be able to return back to work as a baggage handler after a two level fusion and the weightlifting requirements for a baggage handler was at least 50 pounds. (Rx3, pf 26)

The Arbitrator finds that Dr. McGinness is not entirely credible and is not more credentialed than the board-certified surgeons, both neuro and orthopedic who testified in this case. Petitioner testified that the doctor kept him off of work and he relied on her for his work status, appearing to disregard Dr. Goldberg's permanent restrictions. Further, Dr. McGinness was not aware that Petitioner had been released from Midwest Orthopedic surgeons and doctors with permanent restrictions. Despite being later informed, the doctor testified she was still more qualified to opine on restrictions for petitioner. This is not reasonable to the Arbitrator, that a primary care physician would possibly disregard work conditioning and/or FCE testing results and permanent restrictions imposed by the medical group Dr. McGinness apparently referred petitioner to because she is not a specialist or orthopedist.

The Arbitrator also finds it important to note that there were large gaps in care with Dr. Goldberg where petitioner treated with various other doctors and it appears petitioner never informed Dr. Goldberg or his other doctors of the MVC in August 2008 where he injured his neck and back, and also complained of chest pain. Dr. Mather is the sole doctor to have reviewed all of the treating records and was aware of the various medical opinions and additional treatment after the 2016 Dr. Goldberg deposition, as well as the 2008 MVC. While the Arbitrator finds causation for the injuries, that causation cuts off in 2007 when Petitioner is released from care. The lumbar fusion performed by Dr. Goldberg as well as all of Petitioner's care and treatment through April 2007 would also be causally related to the work injuries he sustained.

The Arbitrator agrees that petitioner's cervical spine and lumbar spine injuries to an extent, would be related to the work accidents. However, petitioner's current condition of ill-being for both injuries would cut off as of Dr. Goldberg's 2007 release from care. Regarding the myelopathy diagnosis, the Arbitrator notes Dr. Goldberg's findings and that the doctor testified it is a diagnosis that can wax and wane but the arbitrator is not persuaded this is work related due to numerous other doctors (treater and IME alike) not finding the same at any other examination over the years and because of the gaps in medical care among the numerous treating doctors . Therefore, the petitioner more than likely, at a minimum, aggravated both his neck and low back based on some of the generative findings shown on MRI scans and treating records, in these work accidents. In summary, his ongoing issues for many years after the 2007 release from care by Midwest Orthopedics at Rush, would not be related to his work accidents with Respondent.

The Arbitrator finds based off the extensive medical over 20 years, 8 depositions, the record as a whole that Petitioner sustained a neck injury and right shoulder injury in the 3/10/16 work accident and injured his low back in the 4/17/06 accident, in addition to injuring his lumbar spine in both 2005 work accidents as well. Despite his testimony at trial that he injured his neck on 4/17/06, the Arbitrator agrees with the IME doctors that the medical does not support that the cervical spine injury occurred on the 4/17/06 date. Regardless, like Dr. Mather opines, Petitioner sustained a cervical injury that would have resolved by the April 2007 release from care by his treating doctors.

Psychological

Petitioner introduced records of Dr. Gierl into evidence. (PX 14) The Arbitrator notes these are handwritten and difficult to decipher. Dr. Gierl issued a report dated February 18, 2019 to the Veterans Administration noting he had been seeing the petitioner since March 7, 2014 for severe depression. He noted that on or about August 16, 2017, the petitioner reported PTSD symptoms and reported trauma and abuse to the doctor from when he was in military training. The petitioner described suffering physical, verbal and emotional abuse to the doctor. He states this has been verified as he was discharged from the military after this abuse came to light. He reported this was still causing nightmares, flashbacks and severe emotional distress. It was his recommendation he receive his medication through the Veterans Administration due to PTSD symptoms which are the result of trauma and abuse experienced during military training. (PX 14).

In addition, when he was seen for treatment of the auto accident at West Suburban Medical Center on September 26, 2008, the Arbitrator notes he reported depression since the auto accident. (Px 28) The petitioner did not appear to testify to any ongoing psychological condition and the medical introduced supports an alternate cause of any psychological condition. Accordingly, the Arbitrator finds that there is insufficient evidence to support that any condition of ill-being with respect to petitioner's psychological condition is related to the work injuries.

Issue K, whether Petitioner is entitled to temporary total disability benefits, the Arbitrator finds as follows:

A claimant is temporarily totally disabled from the time an injury incapacitates him from work until such time as he is as far recovered or restored as the permanent character of his injury will permit. *Westin Hotel v. Indus. Comm'n*, 372 Ill.App.3d 527, 542 (1st Dist. 2007). In determining whether a claimant remains entitled to receiving TTD benefits, the primary consideration is whether the claimant's condition has stabilized and whether she is capable of a return to the workforce. *Interstate Scaffolding, Inc. v. Illinois Workers' Comp. Comm'n*, 236 Ill.2d 132, 148 (2010). Once an injured employee's physical condition stabilizes, she is no longer eligible for TTD benefits. *Archer Daniels Midland Co. v. Indus. Comm'n*, 138 Ill.2d 107, 118 (1990). To be entitled to TTD benefits, it is the claimant's burden to prove not only that he did not work but also that he was unable to work. *Holocker v. Illinois Workers' Compensation Comm'n*, 2017 IL App (3d) 16036WC, P35 (3rd Dist., 2017). The fundamental purpose of the Act is to provide injured workers with financial protection until they can return to the work force. *Id.* When determining whether an employee is entitled to TTD benefits, the test is whether the employee remains temporarily totally disable as a result of a work-related injury and whether the employee is capable of returning to the work force. *Id.* The touchstone for determining whether claimant is entitled to TTD is whether the claimant's conditions had stabilized to the extent that they are able to reenter the workforce. *Id.* at P40.

The Arbitrator finds based on the facts as discussed above, that the petitioner reached MMI for the lumbar spine on March 3, 2007 as was found by Dr. Goldberg his treating surgeon and MMI full duty for the cervical spine on April 3, 2007 per Dr. Fetzer.

The petitioner was released to return to work with permanent restrictions per Dr. Goldberg. As he was authorized off work from April 17, 2006 until he is placed at MMI, the petitioner is owed TTD benefits from April 17, 2006 to April 3, 2007, or 50 2/7 weeks at a TTD rate of \$723.85/week.

After April 17, 2006, work restrictions were imposed by Dr. Goldberg which precluded his return to work in his prior capacity as a ramp serviceman. Vocational rehabilitation was provided by the respondent through Vocamotive. Despite the personnel issues that eventually occurred with Vocamotive with Petitioner, the Arbitrator finds that Petitioner did not appear to actively cooperate in that process and terminated vocational services on December 21, 2007. The petitioner testified and the record confirms that he did not at any time look for alternate employment within his restrictions. While the petitioner testified that he was kept off work by Dr. McGinness, there are not medical records which support this and this is contrary to all of the other doctors involved in his case. It appears there was no opinion provided that the petitioner could not return to work or was permanently disabled until Dr. McGinness testified on December 2, 2016. Dr. McGinness addressed work restrictions at her deposition on December 2, 2016 and in only two work restriction notes which are dated May 2, 2006 and November 5, 2007 (PX 19, pg 242 and 243). The doctor testified that the petitioner's treating orthopedic physicians were instead responsible for addressing his work status. His treating orthopedists all returned him to work in some capacity. The Arbitrator did not find Dr. McGinness to be a credible or persuasive witness.

Accordingly, maintenance benefits are awarded from April 4, 2007 to December 21, 2007 when petitioner terminated vocational rehabilitation and quit any effort to look for alternate employment within his restrictions. Respondent is given a TTD credit for the \$71,350.62 in benefits paid prior to trial.

Issue L, the nature and extent of the injury, the Arbitrator finds as follows:

As Petitioner's accidents occurred before September 1, 2011, adherence to Section 8.1b(b) of the Act is not required for establishing permanent partial disability but it is helpful to the Arbitrator in analyzing the permanency of the injury Petitioner sustained. In determining PPD benefits, Section 8.1b(b) of the Act directs the Commission to consider: "(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." 820 ILCS 305/8.1b(b); *Con-Way Freight, Inc. v. Illinois Workers' Compensation Comm'n*, 2016 IL App (1st) 152576WC, ¶ 22, 67 N.E.3d 959. "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b). "None of the factors set forth in section 8.1b is to be the sole determinant of the claimant's disability." *Corn Belt Energy Corp. v. Illinois Workers' Compensation Comm'n*, 2016 IL App (3d) 150311WC, ¶ 49.

As the claimant's disability is not limited in nature that he is obviously unemployable, and as there is no medical evidence to support a claim of permanent total disability, the burden is upon the petitioner to establish the unavailability of employment to a person in his circumstances. *Valley Mould & Iron Co. v. Industrial Comm'n*, 84 Ill. 2d 538, 546-47 (1981).

An employee is totally and permanently disabled when he is unable to make some contribution to industry sufficient to justify payment of wages to him. *A.M.T.C. of Illinois v. Ind. Comm'n*, 77 Ill.2d 482, 487(1979). It is the petitioner's burden to establish that he falls into the 'odd lot' category either by showing that evidence of a diligent but unsuccessful attempt to find work, or by showing that because of his age, skills, training, experience and education that he cannot find regular employment. The Petitioner here has not presented sufficient evidence of either. He has not looked for any work and the restrictions are not so limiting to establish that there is no employment available to him. The Arbitrator was not persuaded by the opinions of Mr. Patsavas for reasons previously explained.

The petitioner's request for a permanent total disability award pursuant to Section 8(f) of the Act is not supported by the evidence. Overall, the long timeline of petitioner's injuries and treatment appear to show Petitioner sustained a serious and permanent lumbar spine injury that required lumbar spine fusion surgery. He also suffered right shoulder injury that was misdiagnosed and/or developed into a cervical spine injury. The Arbitrator finds that Petitioner should have attempted to work within the permanent restrictions his surgeon Dr. Goldberg provided, as he was found at MMI by his treating physicians by April 2007. Despite this, Petitioner admitted during testimony, he never attempted to find work. Dr. Mather, one of Respondent's IME, also agreed that Petitioner required lumbar surgery (disagreed with a fusion) and permanent restrictions and could not return to his old job. Dr. Lami and Dr. Wehner, also agreed with the permanent restrictions Dr. Goldberg gave in 2007. Dr. Song, petitioner's most recent neurosurgeon/treater never gave work restrictions and also testified that he would defer to Dr. Goldberg's restrictions. The Arbitrator finds Petitioner to have suffered a significant low back injury that permanently injured him to the point he could never return to work as a ramp agent for Respondent, as he was given permanent restrictions. This is and was a loss of trade injury as of 2007. However, the Arbitrator is not convinced Petitioner is permanently and totally disabled after review of the numerous medical evidentiary records over the last 20 years, eight depositions and other professional vocational opinions provided. See further analysis below regarding permanency.

The restrictions imposed by Dr. Goldberg were restrictions to lifting 40 pounds occasionally from floor to waist, 25 pounds waist to shoulder, and overhead 20 pounds occasionally. Even if the petitioner was limited to lifting 25 lbs as suggested by the invalid FCE, the IME doctors and Dr. Song, the restrictions were not so onerous as to make the petitioner not employable. Following petitioner's discharge with restrictions, the respondent provided vocational services through Vocamotive. He was not, however, cooperative with the process. Mr. Belmonte identified jobs for the petitioner within his restrictions which included truck dispatcher, aircraft dispatcher, assembler, newspaper circulation clerk, security guard supervisor, order picking, security, cashier, entry level customer service, mailroom clerk and other jobs. As a lead ramp agent, the petitioner was responsible for making sure the plane goes out on time and everything was on the plane that was supposed to be loaded. Accordingly, the petitioner was equipped to perform supervisory duties.

Rather than undertake a good faith effort to participate, the petitioner appeared to make excuses, stated he wanted to relocate to California, and proposed that he be a Senator or Hollywood script writer. He reported he couldn't complete his job search assignments as he had to have Christmas lights installed.

Petitioner refused to participate in any job search activities on days that he was not at Vocamotive. Rather than applying for job leads provided to him, he apparently left inappropriate commentary on his computer. This further demonstrates that Mr. Loving was not taking the job search seriously. The Arbitrator notes there was testimony regarding petitioner's pain levels and effect of pain medications on him at Vocamotive. Some of his testimony regarding these issues was mentioned in the treating records and some of petitioner's poor performance at vocational rehabilitation would be explained by his pain medications/ sleepiness but not all. Since 2007, it is clear from the record that the petitioner has not at any time undertaken a job search of any kind.

The Arbitrator finds the report Mr. Patsavas undertook in 2019 insufficient to prove petitioner is not employable. It appears that the report was not prepared in effort to find the petitioner alternate employment. Mr. Loving also did not express any desire to find employment to Mr. Patsavas. Nor was Mr. Patsavas able to identify any jobs he considered for Mr. Loving. Mr. Patsavas did not conduct an interest inventory to assess what areas of employment may be appropriate for the petitioner. He did not evaluate whether the petitioner was a candidate for a retraining program or any classes which would improve his employment prospects. No explanation was provided as to why the petitioner could not work in one of the employment sectors identified by Mr. Belmonte as within the petitioner's restrictions per his treating surgeon, Dr. Goldberg. In short, Mr. Patsavas, the vocational expert hired by the petitioner's attorney, did not do any testing or evaluation of the petitioner other than meeting briefly with the petitioner to review his work restrictions, employment history and transferable skills.

Although Mr. Patsavas knew the petitioner had a criminal record and that this could impact what types of jobs he could perform, he did not request information from the petitioner at his intake evaluation as to the extent of that criminal record. Mr. Patsavas should have done more to properly assess petitioner's prospective job options and make further efforts to determine whether petitioner was employable or to assist petitioner in finding employment himself. His limited or more abbreviated report undermines the persuasiveness of his report to the Arbitrator.

The Respondent paid maintenance benefits and offered pay for vocational rehabilitation, including a job search. The petitioner terminated those services, has never requested any other vocational assistance and has not shown any interest in finding work. Accordingly, the petitioner has not proven an entitlement to permanent total disability benefits under Section 8(f).

The Arbitrator instead turns to an assessment of the petitioner's permanent partial disability. 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 ramp serviceman at the time of the accident and that he is not able to return to work in his prior capacity as a result of said injury and permanent restrictiond. The Arbitrator notes that this was a low skilled position, but because it is no longer available to the petitioner, the Arbitrator gives significant weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 46 years old at the time of the accident. Because he is now 65 years old and at retirement age, 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 that the petitioner has permanent restrictions of 25 lbs lifting as a result of the work accident and injury to his lumbar spine. That said, such a restrictions likely would not have impeded Mr. Loving from many potential occupations should he have had the desire to return to work from 2007 to present. Based on the opinions of the vocational expert Joseph Belmonte in 2007, the petitioner could have returned to work with earnings between \$10 and \$14.50/hour. The Arbitrator therefore gives greater 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 no records of any treatment after the discharge from Dr. Song on March 7, 2023, were introduced into evidence. In addition, Petitioner testified that he had not had treatment since that time. At that time, the petitioner complained of neck pain but there are no recorded complaints for his low back. There is little documentation of current lumbar spine disability in the medical records, however Petitioner was still precluded from returning to work as of March 2007 due to his serious lumbar injury. Despite not finding petitioner's current conditions of ill-being for the lumbar spine and cervical spine related to his work injuries, the Arbitrator relies on Dr. Goldberg assigning permanent restrictions which prevented Petitioner from returning to work for Respondent as a ramp agent as of his release from care. These restrictions were not disputed by Dr. Mather. IME doctors Dr. Lami and Dr. Wehner, also agreed with the imposition of permanent restrictions due to the lumbar fusion surgery performed. The Arbitrator therefore gives more 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 55% loss of use of the person as a whole pursuant to §8(d)2 of the Act. Respondent shall pay Petitioner permanent partial disability benefits of \$651.46/week for 275 weeks, because the injuries sustained caused 55% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

For the reasons stated above, Petitioner is entitled to an award of benefits under The Illinois Workers' Compensation Act consistent with the findings herein.

It is so ordered:



Jacqueline C. Hickey
Arbitrator

3/3/25
Date

March 4, 2025

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	06WC021800
Case Name	Shelton L Loving v. United Airlines
Consolidated Cases	06WC021799 06WC021815 07WC002653
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	25IWCC0500
Number of Pages of Decision	58
Decision Issued By	Carolyn Doherty, Commissioner

Petitioner Attorney	Donald Gallagher
Respondent Attorney	Karen Coon

DATE FILED: 12/19/2025

/s/ Carolyn Doherty, Commissioner

Signature

06 WC 21800

Page 1

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)
☐ Modify	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Shelton L. Loving,
 Petitioner,

vs.

No: 06 WC 21800

United Airlines, 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 causal connection, temporary total disability, maintenance, 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.¹

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 4, 2025, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under Section 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.

¹ Petitioner's Petition for Review refers to 06 WC 21799, which was tried together with the claims in 06 WC 21800, 06 WC 21815, and 07 WC 2653, and the Arbitrator issued four decisions. The Statement of Exceptions of both parties address the issues in all four claims. Accordingly, the Commission is issuing four separate decisions in this matter.

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.

December 19, 2025

O: 12/10/25

CMD/kcb

045

/s/ Carolyn M. Doherty
Carolyn M. Doherty

/s/ Raychel A. Wesley
Raychel A. Wesley

/s/ Frank J. Soto
Frank J. Soto

ILLINOIS WORKERS' COMPENSATION COMMISSION
DECISION SIGNATURE PAGE

Case Number	06WC021800
Case Name	Shelton L Loving v. United Airlines
Consolidated Cases	06WC021799; 06WC021815; 07WC002653;
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	55
Decision Issued By	Jacqueline Hickey, Arbitrator

Petitioner Attorney	Donald Gallagher
Respondent Attorney	Karen Coon

DATE FILED: 3/4/2025

/s/Jacqueline Hickey, Arbitrator
Signature

THE INTEREST RATE FOR THE WEEK OF MARCH 4, 2025 4.14%

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

Shelton L. Loving

Employee/Petitioner

v.

United Airlines, Inc.

Employer/Respondent

Case # **06 WC 21800**

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 **Jacqueline Hickey**, Arbitrator of the Commission, in the city of **Chicago**, on **9/30/24**. 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 **12/23/05**, 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 **\$56,460.04**; the average weekly wage was **\$1,085.77**.

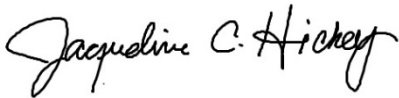
On the date of accident, Petitioner was 46 years of age, married with **4** dependent children.

ORDER

No permanent partial disability is awarded for this injury and this case. Permanency is awarded for Petitioner's 4/17/06 case only. Please see Decision in 07 WC 002653 and attached Rider to Decisions.

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 4, 2025

Shelton L. Loving,)
)
 Petitioner,)
) Case No. **06WC021799, 06WC021800**
 v.) (Cons.) **06WC021815 & 07WC002653**
)
United Airlines, Inc.,)
)
 Respondent.)

1

First Work Accident: 11/04/05

On November 4, 2005, the petitioner testified he was hooking up two containers for the luggage which weighed about 1,700 pounds. As he was going to clamp the container on the tug he was driving, he slipped on the ice, tried to catch himself and hurt his back (Tr. 24). The petitioner was seen at UIC Medical Clinic at O'Hare and was treated with muscle relaxers. The petitioner worked full duty until his second work accident and did not lose any time after this accident (Tr. 26-27).

Second Work Accident: 12/23/05

On December 23, 2005, the petitioner testified he was hooking up containers to a tug. He was hooking up two containers back-to-back and he injured his back, legs, and hips (Tr. 28). He once again was seen at UIC at O'Hare and then at Celar Chiropractic (Tr. 28). Petitioner testified he was also referred to and seen by Dr. McGinness, his primary care physician, by Celar. (Tr. 29). Again, the petitioner did not lose any time from work. (Id.)

Third Work Accident: 3/10/06

On March 10, 2006, the petitioner was handling luggage. As he was taking the luggage out of the containers to put on the belt, he felt something pop in his neck, arm and right shoulder (pp. 29-30). Petitioner sought treatment with Dr. McGinness, Celar Chiropractic, and Rush Oak Park Hospital (Tr. 31) but he continued working full duty (Tr. 31).

Fourth Work Accident: 4/17/06

On April 17, 2006, the petitioner was in the belly of a plane getting bags off the belt loader. Because he was working in an RJ jet, which was very tight, he was squatting to pick up luggage and heard something pop in his back (Tr. 33). He fell down and felt his neck pull because he was picking up the luggage and his back popped and went out and he fell (Tr. 33). He testified he could not move and the luggage started falling on him and he yelled for help. His coworkers stopped the belt and ran to get assistance (pp. 33-34). Petitioner was taken by ambulance to the hospital (Tr. 34). April 17, 2006 was the last day petitioner worked for Respondent, United Airlines (Tr. 35).

Petitioner's Testimony

After the ER, Petitioner was seen by his primary care physician Dr. McGinness who prescribed an MRI. (Tr. 35). After the MRI Mr. Loving was referred to Dr. Coe and Dr. Amin. (TR p 35). Petitioner was referred to Midwest Orthopedics at Rush and seen by Dr. Palmer a pain management doctor. (Tr. 36) Dr. Palmer eventually referred the petitioner to Dr. Goldberg for surgical consultation. (Id.) Petitioner also saw Dr. Nicholson from Midwest Orthopedics. (Tr.37) At Midwest Orthopaedics at Rush, Petitioner saw all of the following doctors: Dr. Nicholson, Dr. Goldberg, Dr. Palmer and Dr. April Fetzer (Tr. 36). Petitioner testified to the L4 through S1 fusion surgery performed by Dr. Goldberg but testified that it was a failed fusion and he got no relief from the surgery (Tr. 39). He subsequently followed up with Dr. Fetzer and got shots and pain management in his back, after the fusion. (Id.) He also received shots and physical therapy for his neck (Tr. 40).

Petitioner also testified that he relocated to Springfield in 2011 through 2014. (Tr. 40)

The petitioner began the vocational process with Joseph Belmonte at Vocamotive in September 2007 (Tr. 41). The petitioner had been released by Dr. Goldberg with lifting restrictions of 40 pounds from floor to waist, 25 pounds from waist to the middle of his chest and 10 pounds from his chest and up (Tr. 41-42). Petitioner testified he did not begin looking for jobs within those restrictions with Vocamotive as he was in a lot of pain and on a lot of heavy narcotics. (Tr. 42-43) He testified that he kept falling asleep with his head on the desk. He testified that he told Dr. McGinness he was having problems in class falling asleep due to the drugs and pain and that the doctor therefore took him out of school because of the narcotics (Tr. 44). The petitioner testified to the letter he received from Mr. Belmonte apologizing for the accusations regarding petitioner being called a liar and not getting hurt (Tr. 43-44) He testified that Vocamotive also had an employee who was less than professional and somewhat ill-will motivated with petitioner (Id.)

After stopping Vocamotive services, Petitioner testified that he treated with Dr. McGinness, in the basement of Oak Park Rush Physical Therapy Athletics in Countryside and did self-rehabilitation. (Tr. 52-53)

Petitioner testified in 2008 he was struck from behind in a car accident. The paramedics were called and an ambulance took him for medical treatment (Tr. 55). He was provided a pain shot and he began seeking treatment at West Suburban (Tr. 55). With reference to the auto accident in 2008, petitioner confirmed he was stopped at a stop sign and a lady ran into him going 35 to 40 miles per hour (Tr. 89). When he was seen at Loyola Hospital ER following the auto accident, he complained of pain to his neck, back, chest, and right shoulder (Tr. 90). He also treated for his neck and back with West Suburban Medical Center following the automobile accident (Tr. 90). He was unable to recall how much money he received in a monetary settlement from the auto accident (Tr. 91).

Petitioner testified that he initially saw Dr. Song in the hospital on November 15, 2022 at Hinsdale Hospital ER (Tr. 59). He testified that he went to Rush the day before and was given a shot of Toradol which did not improve his condition (Tr. 59). He felt he could not move his legs and was in excruciating pain. He reported he had to crawl to the front room to get to a phone to call paramedics, as he could not move (Tr. 60). Petitioner testified that he has not seen any doctor since Dr. Song performed the second lumbar surgery (Tr. 57). Before seeing Dr. Song petitioner was treating with Dr. Salvador in Springfield, Dr. Ross in Savannah, GA, and Rush Oak Park Hospital. (Tr. 61). Since the surgery, he testified that both legs are numb (Tr. 57).

The petitioner testified to prior education at Moody Bible Institute, National Technical Institute, and DeVry Technical Institute. In addition, he went to Malcom X College for three years. He previously worked as a forklift operator, and did manufacturing and palletizing. He also worked security for Arch and Bright Security at ORD and did temp work for Manpower. Lastly, he testified that he worked for the U.S. Postal Service (pp. 93-94). Mr. Loving was asked about his desire as expressed to Mr. Belmonte to move to California and become a script writer and becoming an alderman or congressman (Tr. 94). He stated he talked with Mr. Clint Eastwood a couple times and another black star, but they were not interested in his scripts (Tr. 95).

He also suggested that when working with Mr. Belmonte they showed he was getting As and Bs on the testing, but that he was asleep and they went into his computer and put the As and Bs in there for him (Tr. 96).

Mr. Loving testified that Dr. McGinness, his PCP and current physician, at the present still has petitioner temporarily and totally disabled, and completely off work. (Tr. 51-52) Presently, Petitioner testified that both of his legs go numb. (Tr. 57) Petitioner testified he has not looked for work within the restrictions given, as his body is no good (Tr. 64). The petitioner testified that currently he has ongoing pain and does not sleep at night. He is unable to clean and he has a maid from the State who comes to clean his house and cook his dinners (Tr. 69). He also received Meals on Wheels in Countryside, Illinois. (Tr. 69). Presently Petitioner stated he does not really feel like a man without being able to work and being infirmed. (Tr. 70) Mr. Loving is currently on Medicare and social security disability. (Tr. 73) Mr. Loving testified that he knows he cannot work and just underwent another back surgery in 2022. (Tr. 74) Petitioner stated he still has 10 rods and two brackets still in his lumbar spine. (Tr. 75) Petitioner has fallen to the ground twice after his second back surgery with Dr. Song. (Id.) Mr. Loving testified he has never, not been able to work until these four work related injuries occurred. (Tr. 104

On cross examination, the Petitioner testified he did not recall being seen on multiple dates in the years prior to the work accidents for low back pain. (Tr. 1-85) He did testify he previously suffered from migraines but did not recall who he had seen for them (Tr. 81). When presented with the medical records of prior low back pain complaints, he stated, "To me, it seems like there is consistency of going to the doctor for my back. I don't remember if it was" (Tr. 86). Petitioner was specifically asked about seven prior doctors' visits from March 1999 through August 2004, with/at St. Luke's, Dr. Leavitt, Dr. McGinness and Dr. Lenhardt for complaints relating to the low back, migraines and right upper arm. (Tr. 81-85).

Testimony of David Aranda- Respondent witness

The respondent introduced the surveillance video evidence with the testimony of David Aranda, the investigator. The petitioner was surveilled on March 5 and March 7, 2020. (RX 8a/8b) The petitioner is seen going on several errands. On March 7, 2020 the petitioner went to a church for an event. The video shows him walking freely and without pain. He is seen lifting and moving two traffic cones and lifting and carrying a piece of luggage. This is all done without any apparent limitation.

Medical Record Summary

On November 16, 1999 the petitioner was seen by Dr. J. Leavitt where he complained of both lower and upper back pain. Dr. Leavitt ordered an x-ray of the right hip and pelvis and suggested taking Motrin. As is noted by Dr. Leavitt in a visit with the petitioner on March 7, 2000, the petitioner never went to get the prescribed x-rays and he never took the suggested Motrin. Petitioner was still complaining of lower back pain at this time.

On August 23, 2002 petitioner presented to Anchor Medical Group complaining of chest pain, kidney pain, and right lower abdomen pain. The report is handwritten but petitioner was assessed in part with mechanical back pain. (Rx. 5)

On November 4, 2002 petitioner presented to Anchor Medical Group again complaining of back pain that appeared to be causing pain in his right upper arm. (RX 5, Pg. 8)

On April 6, 2004 Dr. Kurtzman authored a letter to Dr. McGinness for referring petitioner to him. Dr. Kurtzman recommended petitioner see a neurologist and obtain an MRI of the brain because of his history of migraine headaches that recently increased.

Petitioner went again to Oak Park Anchor Medical Group with complaints of back pain again on May 17, 2004. (RX 5, Pg. 13)

On June 28, 2004 petitioner complained of back pain and difficulty breathing during his visit at Anchor Medical Group. (RX 5, Pg. 14)

On July 12, 2004, petitioner was seen in follow up. (RX 5, Pg. 15-16) An x-ray of the dorsal spine was taken that showed apparent generalized increased sclerosis throughout the lower thoracic spine. A bone scan was recommended by the radiologist. On July 31, 2004 a bone scan showed no abnormalities.

On August 12, 2004 Dr. Lernhardt authored a letter to Dr. McGinnis regarding a recent evaluation of right posterior pleuric discomfort and back pain that petitioner stated was ongoing the prior 10 weeks. Dr. Lernhardt opined petitioner's back pain was very likely related to musculoskeletal discomfort and the mild pleuritic component was related to the same. He recommended petitioner continue analgesics and minimize heavy lifting.

On November 4, 2004 petitioner complained of right pelvic, hip, and back pain. (RX 5, Pg.8)

On April 15, 2005 petitioner complained severe headaches with dizziness during his visit at Anchor Medical Group. (RX 5, Pg. 21)

Petitioner was seen at UIC Medical Center at O'Hare November 4, 2005. (PX 20) He reported lifting heavy bags on his knees in the pit when he twisted the wrong way with a heavy bag. He reported feeling pain in his low back area.

The petitioner was seen on December 23, 2005 at UIC at O'Hare. (PX 20). He reported he had a lumbar sprain November 4 and was sent back to full duty on the date of accident but reported continued pain with lifting since that time and acute increase in low back pain and radiation into left thigh when lifting a heavy bag this afternoon. He reported no pain distal to the knee and no numbness, weakness or tingling. Neurological testing was normal. Petitioner was ordered to do light duty work and prescribed tramadol and naproxen.

The petitioner was seen again at UIC at O'Hare on December 29, 2005. He reported his pain was worse and he had trouble getting out of bed this morning. The impression was lumbar strain and he was referred to an ortho. (PX 20).

Petitioner was seen on January 10, 2006 at Rush Oak Park Physician's Group complaining of back pain, left abdominal pain and left ear pain. He reported that he injured himself at work on December 8, 2005 when he pulled something in his back. (RX 5, Pg. 28)

Petitioner then sought treatment at Celar Chiropractic with Dr. Celar beginning on January 11, 2006. Petitioner continued to be seen at that facility on a weekly basis for low back pain, left shoulder pain, and upper back pain. (PX 10)

On January 11, 2006 an x-ray of the lumbar spine was taken and showed: (1) spinal biomechanical alterations; (2) facet tropism; (3) facet arthrosis; and (4) degenerative disc disease at L5.

On February 22, 2006 Dr. Celar completed a work status form that indicated petitioner was to work full duty. Petitioner continued attending chiropractic sessions.

Petitioner was seen at Celar Chiropractic on March 14, 2006 for a new injury. On March 14, 2006, Dr. Celar opined petitioner had an acute rotator cuff/deltoid sprain/strain from the work injury and might need an MRI. He reported he was injured while lifting up and tossing a heavy bag. Petitioner reported pain in the right arm and upper back. PX 10.

On April 13, 2006 petitioner followed up at Rush Oak Park Physicians Group for pain in his right arm. (RX 5, Pg. 32)

On April 17, 2006, the petitioner was taken by Chicago Fire Department Ambulance to Resurrection Medical Center. The fire department ambulance records specifically note he had no neck or upper back pain. (Px 7)

The petitioner was seen at Resurrection Medical Center on April 17, 2006 for low back pain while lifting a suitcase. (PX 7). A pain diagram also indicates pain only in the low back. Petitioner stated he bent over to pick up a luggage bag and felt something pull in his back. He was ambulatory. Petitioner again reported he felt something in his lower back go crunch after he bent over and lifted a piece of luggage out of a small cargo area. (PX 7). At the time of petitioner's discharge, he reported his pain was much better. X-rays of the lumbar spine were normal with vertebral heights and intervertebral spaces maintained.

On April 18, 2006, the petitioner presented for evaluation of low back pain at Rush Oak Park Physicians Group after claiming he hurt his back at work on April 17, 2006. (RX 5, Pg. 34) He reported that while bending over to pick up some luggage, he felt a crackle in his right lower back.

An MRI of the right shoulder was performed on April 18, 2006. (RX 6, Pg 240) The study showed a possible Hill-Sachs deformity and associated marrow edema compatible with subacute injury. There was no conclusive evidence of a Bankart lesion. There were findings suggesting a strain of the distal aspect of the common tendon of the rotator cuff, however, it was noted a partial thickness tear could give a similar appearance

Petitioner was seen again by Dr. McGinness on April 26, 2006 for right lower back which radiated to the thigh with numbness to the right kneecap. (RX 5, Pg. 38)

On May 2, 2006, the Anchor Medical notes reflect that the injury was most likely a muscle sprain in the lower back. They refilled his hydrocodone and gave petitioner a prescription for Flexeril. An MRI was ordered.

Petitioner was seen on May 4, 2006 by Dr. Trish Palmer for evaluation of injuries to the left low back and right arm. (Rx 6, pg 46) Petitioner reported on March 10, 2006 he was lifting a heavy bag in his job as luggage handler. When he went to place it on the belt, he felt immediate pain. He complained of pain over the lateral anterior aspect of the right shoulder. Petitioner stated the low back pain began on April 17, 2006 while lifting a very heavy bag in a forward flexed position. Dr. Palmer diagnosed radicular back pain and right shoulder pain due to rotator cuff irritation or partial tear of the supraspinatus. As there was no frank tear, Dr. Palmer recommended a subacromial cortisone injection and physical therapy for the shoulder and the back. Dr. Palmer performed an injection into the subacromial space.

An MRI of the lumbar spine was performed on May 9, 2006 and demonstrated spondylitic and degenerative changes, a broad-based mild disc herniation at L4-L5, and a less pronounced herniation at L5-S1 to the right with associated right foraminal stenosis. (RX 6, pg 237)

When the petitioner returned to Dr. Palmer on May 15, 2006, he reported that the shoulder injections had completely relieved his pain for three days. (Rx 6, pg 44) His back symptoms were fairly consistent with the MRI results and Dr. Palmer recommended continued physical therapy. The petitioner was referred to Dr. Nicholson for further evaluation of the shoulder and was referred to Dr. April Fetzner for consideration of an epidural injection. Dr. Palmer continued monitoring the petitioner's Lyrica and Vicodin dosing, but noted she was limited as to what further she could offer the petitioner. The petitioner was seen in follow up by Dr. Palmer on June 12, 2006 with similar findings and recommendations. (Rx 6, pg 42)

The petitioner was next seen on June 19, 2006 by Dr. Palmer. (Rx 6, pg 40) He reported improvement in his back pain but was still complaining of a catching sensation with forward flexion in the shoulder. His back was improving with PT and he was referred to Dr. Nicholson for the shoulder. (Rx 6, pg 41)

A physical therapy progress note dated June 27, 2006 indicated that petitioner continued to have stiffness in his right upper extremity with continued decrease in range of motion. Overall though, petitioner felt his trunk range of motion and lumbar symptoms had improved. Active range of motion of the upper extremity was still limited which caused overhead activity deficits. On July 17, 2006, petitioner saw Dr. Palmer who opined petitioner might have a SLAP tear which did not show up on the MRI. (Rx 6, pg 38) Dr. Palmer referred petitioner to a shoulder specialist.

The petitioner was seen by shoulder specialist, Dr. Gregory Nicholson on August 1, 2006. (Rx 6, pg 86) Dr. Nicholson noted that as he started to examine the petitioner, he jumped out of the chair. The petitioner could not even tolerate even simple motion or isometrics. In reviewing the MRI, he noted there was a high signal within the bursa, however there did not appear to be a Hill Sachs deformity. The doctor noted the possibility of a small interior partial tear of the supraspinatus. He found the petitioner's pain to be out of proportion to his physical findings in the right shoulder. Dr. Nicholson noted the petitioner had a subacromial pathologic process including a small partial tear and subacromial bursitis. That being said, his pain was tremendously out of proportion to the physical findings. Dr. Nicholson opined that it would be dangerous to institute physical therapy or treatment until his back issues were sorted out. Dr. Nicholson was concerned about the petitioner's symptom magnification, as it was out of proportion to his physical findings for this type of pathology. (Rx 6, pg 87)

The petitioner was evaluated by Dr. April Fetzer on August 4, 2006. (Rx 6, pg 35) Petitioner reported that he initially injured himself on November 4, 2005 with right-sided axial low back pain and right thigh symptoms. He was treated by a United Airlines physician with a muscle relaxant and chiropractic treatment, however his symptoms never fully resolved. He continued working and reinjured himself on April 17, 2006. Dr. Fetzer diagnosed right L4 and L5 radiculopathy and recommended epidural steroid injections. Mr. Loving did not want to undergo same, and instead requested surgery. The petitioner was referred to Dr. Edward Goldberg for evaluation.

On August 14, 2006, Dr. Palmer noted a positive Spurling test on the right for reproduction of shoulder pain. (Rx 6, pg 33) This was noted to be a new finding. As this suggested that the shoulder pain may be originating in the neck, an MRI of the cervical spine was recommended. Id.

Dr. Goldberg evaluated the petitioner on August 18, 2006. (RX 6, pg 80) Dr. Goldberg opined that the petitioner sustained a disc herniation and aggravated his degenerative disc disease with the work-related accident. He recommended a laminectomy and discectomy at L4-L5 and posterolateral fusion at L4-L5 and L5-S1 with iliac bone crest and pedicle screw instrumentation.

Correspondence was issued by Dr. Nicholson on August 29, 2006 indicating that while petitioner may need physical therapy for his shoulder, he felt it would be counter-productive to have him get into the program and aggravate his low back condition. Dr. Nicholson noted that he had examined the patient and that his pain was out of proportion to his physical findings. (RX 6, pg 77) His complaints were noted to be "quite histrionic." The doctor further noted he was an extremely difficult gentleman to examine. Dr. Nicholson advised that he did not feel that there was a rotator cuff tear and suggested they instead address the lumbar situation.

On September 19, 2006 Dr. Goldberg performed the right L4-L5 hemilaminotomy and discectomy, and posterolateral spinal fusion at L4-L5 and L5-S1. The diagnosis was degenerative disk disease L4-L5 and L5-S1 with superimposed central herniated nucleus pulposus L4-L5. (RX 6, pg 117)

Following surgery, petitioner followed-up with Dr. Goldberg on October 4, 2006. (Rx 6, pg 75) Overall he was doing well. Petitioner's chief complaint was difficulty with sexual function. The doctor explained that it was extremely unlikely that this was caused by the spine surgery due to the fact that this was a posterior approach.

The petitioner was seen by Dr. Goldberg on October 23, 2006 at six weeks status post surgery. He was doing well and was neurologically intact. X-rays showed the instrumentation to be well positioned at L4-S1 with good fusion mass.

The MRI of the cervical spine was performed on November 10, 2006 and demonstrated C4-C5 right bulging disc, C5-C6 central broad-based bulging disc abutting the anterior border of the spinal canal producing mild to moderate spinal stenosis with mild to moderate narrowing of the intervertebral foramina, and C6-C7 central broad-based bulging disc with mild narrowing of the spinal canal. (RX 6, pg 234)

On November 13, 2006 petitioner met with Dr. Palmer to discuss the cervical MRI. (Rx 6, pg 26) As it was possible petitioner's shoulder pain was derived from disk problems in his neck, on December 4, 2006, Dr. Palmer suggested he see Dr. Fetzer for a cervical injection.

On December 6, 2006 Dr. Goldberg noted petitioner was doing quite nicely with respect to his low back. (Rx. 6, pg 67) He recommended six more weeks of therapy for the lumbar spine after which it was possible that light duty could be started. (Px 16)

The petitioner was seen by Dr. Fetzer on December 8, 2006. (Rx 6, pg 22) He had full active range of motion of the cervical spine in all planes and the cervical Spurling's maneuver was negative bilaterally. While he stated he could not actively raise his right arm above his head, on examination, he raised it to approximately 110 degrees of abduction. The doctor explained that Neer's, Hoffman's and supraspinatus testing were all positive. Shoulder internal and external rotation was both 5/5. She felt that the petitioner's symptoms may be somewhat exaggerated on exam. The differential diagnosis could include right C5 radiculopathy versus right rotator cuff pathology. A diagnostic right C5 selective nerve root injection was ordered.

The petitioner underwent a right C5 selective nerve root block on December 19, 2006. (Rx 6, pg 19) The petitioner was seen by Dr. Fetzer on January 16, 2007 after undergoing a right C5 selective nerve root block. (Rx. 6, pg 17) He denied any further radicular symptoms. As he had improved, Dr. Fetzer recommended they hold off on any additional epidural steroid injections and instead recommended work conditioning.

On January 17, 2007, four and one-half months status post-fusion L4 to S1, the petitioner's only complaint was pain over the left iliac crest donor site. (Rx. 6, pg 63) X-rays showed a very good fusion forming. His radicular pain and back pain had markedly improved. Dr. Goldberg recommended work conditioning for six weeks for the cervical and lumbar spine.

IME- Dr. Wehner

An IME was performed by Dr. Wehner on February 9, 2007. (Rx. 1, Dep Ex. 2) Dr. Wehner noted the history of treatment and provided a diagnosis of low back pain. She noted he had a fusion for some degenerative disc disease at L4-L5 and L5-S1. He was progressing slower than would be anticipated. She did not see anything in the cervical spine warranting surgery. He was not at maximum medical improvement and should continue with physical therapy prior to any work hardening. She cautioned against any other surgery given his fairly high pain complaints despite the fairly minor MRI findings and the overall response to surgery.

The petitioner was seen in follow up on February 13, 2007 by Dr. Fetzer. (Rx 6, pg 13) While the doctor had previously recommended a work conditioning program, Mr. Loving had not undergone any work conditioning. He instead reported that he had opted to do home exercises on his own. He reported a past history of migraines for which he would take Imitrex provided by his primary care physician Dr. McGinnis. Examination of the cervical spine was negative/normal. The doctor recommended a six-week course of work conditioning followed by a functional capacity evaluation and a second right C5 nerve root block. A right C5 selective nerve root block was performed on February 20, 2007. (Rx 6, pg 11)

On February 26, 2007 an initial baseline Physical Performance Test found petitioner demonstrated functional ability between the light and light to medium work demand levels. (Px 24) Work conditioning was prescribed.

Petitioner began work conditioning on February 27, 2007. A progress note dated March 7, 2007 reported petitioner had made “inappropriately slow progress in Work Conditioning due to the client’s refusal to perform resistive activities due to subjective complaints of pain without correlating clinical objective findings.” (RX 6, pg 215) Additionally, it was noted he required verbal cues and supervision to remain on task. The therapist asserted this was an “invalid” performance in work conditioning and noted petitioner had been given verbal warnings for non-compliance after receiving specific instructions in the proper conduct for participation. The petitioner demonstrated poor body mechanics and the therapist noted that “One would expect a client with a high level of low back pain to perform this activity with proper body mechanics to minimize the stress in the low back and to maximize the efficiency of the lift.” (RX 6, pg. 216) An FCE with emphasis on validity was recommended.

Dr. Goldberg saw the petitioner on March 7, 2007. (Rx. 6, pg 61) After additional work hardening, the doctor noted he could now lift 40 pounds occasionally from floor to waist, 25 pounds waist to shoulder, and overhead 20 pounds occasionally. Some invalidity was noted by the examiner during his evaluation. Dr. Goldberg authorized the petitioner to return to work within the work conditioning recommendations. Dr. Goldberg opined he was at MMI with respect to the lumbar spine and should see Dr. Fetzer regarding the cervical condition.

The petitioner was seen by Dr. Palmer on March 12, 2007. (Rx 6, Pg. 59) Petitioner reported that he had three injections to the neck with Dr. Fetzer. Due to an increase in pain from the right lateral neck to the superior shoulder into the forearm and fingers, Dr. Palmer referred him back to Dr. Goldberg for evaluation of the neck and shoulder.

The petitioner was seen at Accelerated Rehabilitation Center for a functional capacity evaluation on March 26, 2007 ordered by Dr. Fetzer. (RX 6, Pg. 207) A physical demand level could not be determined due to petitioner failing eighteen out of twenty-five objective validity criteria. The results were found to be invalid due to the submaximal effort given by petitioner. Notably, he also scored positive on four out of five Waddell's signs for low back pain. It was felt that he was capable of functioning at a higher category of work than he demonstrated in the testing.

The petitioner was seen on April 3, 2007 again by Dr. Fetzer after undergoing the functional capacity evaluation. (RX 6, pg 8) Dr. Fetzer noted that it was found to be an invalid study secondary to sub-maximal effort with 4/5 Waddell's nonorganic signs being positive on this evaluation. On physical examination, Dr. Fetzer noted, "Mr. Loving exhibits some Waddell signs today including overreaction simulation and he does not participate in our exam." (RX6, pg 8) The doctor noted that based on his failure of all reported treatment in combination with his multiple non-organic signs and the invalid functional capacity evaluation, the doctor believed he was at maximum medical improvement for his symptoms at this time. He was released to return to work full time and full duty. (Rx 6, pg 8)

The petitioner was seen at Rush Oak Park Outpatient Physical Therapy for a lumbar, cervical and spine evaluation on April 5, 2007. It was noted that his back pain began in 2004 when he hurt himself at work while lifting luggage. His neck pain began in 2007 and was of insidious onset. The petitioner reported he was depressed and unable to perform activities. He was on medication for depression and had significant difficulty performing almost any activity. It was recommended they do physical therapy three times a week for eight weeks.

Petitioner was seen by Dr. Palmer on April 11, 2007. (Rx 6, pg 57) The doctor noted he had not gone back to work, although he had been advised to do so. He rated his pain at 9/10, but on physical examination the petitioner was in no acute distress. He had no psychomotor agitation and neurological examination revealed give-way weakness. Dr. Palmer reviewed the notes of Dr. Fetzer and Dr. Goldberg and noted that he had multiple non-organic signs and an invalid FCE. **He was at MMI for the cervical spine and lumbar spine. Dr. Palmer recommended he return to work with restrictions per Dr. Fetzer for his neck and per Dr. Goldberg for his back.**

Dr. Fetzer evaluated the petitioner on April 13, 2007. (RX 6, pg. 127) On exam, he exhibited some waddell signs today including overreaction simulation and he did not participate in the exam. He would not actively range his arms above 70 degrees. Motor testing showed give-way throughout the bilateral upper extremities. She noted that given the failure of all reported treatment attempts in combination with his multiple nonorganic signs that are present and the invalid functional capacity evaluation, she placed the petitioner at MMI and released him to return to work at full time, full duty. (RX 6, pg 127)

On May 15, 2007, the petitioner presented to Rush Oak Park Physicians Group with complaints of low back pain and shoulder pain. (RX 5, Pg. 42) . He was noted to be currently taking Atarax and Vicodin. The petitioner returned to the Rush Oak Park on June 21, 2007 with continued complaints of back pain with radiation down his right leg. (RX 5, Pg.44)

On July 9, 2007, Dr. Sandeep Amin on referral from Dr. McGuinness, discussed various options including medical management versus surgical re-evaluation or repeat epidural injections. The petitioner was not interested in considering surgery, a stimulator implant, or an epidural injection. He was started on Topamax.

The petitioner was seen for back pain at Rush Oak Park Physicians Group on August 28, 2007. (RX 5, Pg. 48) The petitioner was next seen at Rush Oak Park on December 20, 2007 for complaints of back pain and left first finger pain. (RX 5, Pg. 48)

On February 21, 2008, petitioner underwent MRI of lumbar spine with and without contrast. The study showed spondylotic changes of with degenerative disks at L4-L5 and L5-L1. Also noted was the posterior fusion with fixation devices in place extending from L4-L1 and central protrusion of the disc at L5-L1. The was a moderate degree of stenosis at L2-L3 and L3-L4, mild stenosis at L4-L5

The petitioner returned to Rush Oak Park on May 16, 2008 complaining that his back pain started worsening in the past 3-4 days despite his medication. (RX 5, Pg.54) The petitioner was referred for steroid injections. At additional visits on July 1, 2008 and August 14, 2008, the petitioner complained of back and neck pain.

Motor Vehicle Collision

The petitioner was involved in an auto accident where he was rear ended on August 19, 2008. Following the automobile accident, the petitioner was seen at Loyola Hospital ER. (RX 7) The petitioner presented on August 19, 2008 as a restrained driver who was rear-ended injuring his neck, back, chest and left jaw. (Rx. 7, Pg. 175) He reported he was thrown forward, hitting his chest on the steering wheel. He was restrained, but the seat belt did not lock and he hit the steering wheel. In addition to pain in the chest, the petitioner also complained of worsening low back pain, neck pain and right shoulder pain. He also had complaints of pain in the hips. A CT scan of the cervical spine showed no evidence of acute fracture or subluxation. Imaging of the shoulder/hip/spine was negative for acute fracture or dislocation X-rays of the lumbosacral spine showed a posterior spinal fusion L4 to S1 with trace retrolisthesis L5-S1. X-rays of the cervical spine showed slight right convex curvature, which may be related to muscle spasm or patient positioning. There was also straightening of the cervical spine likely related to muscle spasm or cervical collar. CT scans of the lumbar and cervical spine were suggested if the petitioner remained symptomatic. The petitioner was admitted to general medicine for a workup of chest pain, evaluation of back mass and pain control.

The hospital discharge summary reflects that the petitioner is a 49-year-old male with primary history of chronic low back pain, status post laminectomy, who presented to the emergency department with chest pain following a motor vehicle accident. (RX 7, Pg.150) He was restrained, but the seat belt did not lock and he hit the steering wheel. The air bag did not deploy. The petitioner complained of non-radiating numbness and a burning sensation in the left side of the chest. This was relieved with oxygen in the field and morphine was provided in the emergency department. The petitioner also complained of worsening low back pain, neck pain and right shoulder pain. He denied any focal weakness or loss of motion. Imaging of the shoulder/hip/spine was negative for acute fracture or dislocation. A CT of the neck incidentally noted a soft tissue nodule. The petitioner was discharged with Flexeril and Vicodin for musculoskeletal pain. He was referred to physical therapy which was scheduled to begin on August 22, 2008.

Dr. McGinnis completed a cervical spine residual functional capacity questionnaire, headache residual functional capacity questionnaire and lumbar spine functional capacity questionnaire on August 24, 2008. (PX 19) The cervical spine functional capacity questionnaire indicated the petitioner had cervical radiculopathy with chronic pain and paraesthesias. The headache, residual functioning capacity questionnaire indicated he had migraines, cervical radiculopathy and lumbar radiculopathy for a period of six years. He would get headaches lasting three days. The doctor felt he was unable to work because of these and again noted he was incapable of even a low stress job. The lumbar assessment similarly indicates that it has been present for six years and that the petitioner is unable to work. (PX 19).

Following the auto accident, the petitioner was seen at West Suburban Medical Center on August 28, 2008. (PX 28) He reported pain in his head, chest, hips and back. He reported he was sitting at a red light when he was rear-ended by a driver going 35 to 40 miles per hour. He was in Loyola Medical Center for two days and was still having significant low back pain and shooting pain down the right leg, as well as into the right neck and shoulder pain. This was constant with numbness and tingling into the hands and fingers. He was on Fentanyl and Darvocet and his pain was noted to be more intense since the auto accident. It was also noted the petitioner had a history of migraine headaches and was requesting an Imitrex refill. He was diagnosed with upper and lower back muscle spasms following a motor vehicle accident and musculoskeletal chest pain. Physical therapy was ordered, as well as Valium and Norco. He was directed to continue Fentanyl, Darvocet and Norco. He had continued pain on September 9, 2008.

Petitioner was next seen for a follow up at Rush Oak Park on August 29, 2008. (RX 5, Pg. 60) He complained of back pain, right shoulder pain, neck pain, and migraine headaches. Additionally on August 29, 2008 Dr. McGinness completed a Lumbar Spine Residual Functional Capacity Questionnaire. This indicated petitioner back pain was ongoing for six years and he was diagnosed with lumbar radiculopathy.

On September 8, 2008 petitioner was assessed by Dr. Lenny Cohen, a neurologist of Rush Oak Park. (PX 19) Petitioner reported a history of chronic back pain in the lumbar and cervical spine. Dr. Cohen recommended an EMG of the upper and lower extremities, trigger point injections, stopping temazepam, cyclobenzaprine, diazepam, propoxyphene, fentanyl, and limiting Vicodin. A prescription for Amrex was recommended.

A CT of the neck with contrast was performed September 24, 2008 for a left neck nodule, which had been identified on the prior cervical CT done following the auto accident on August 19, 2008. Resolution was limited below C4 and there was concern for a disc herniation in the lower cervical spine. Further evaluation was advised. There was no evidence of acute fracture or subluxation.

When he was seen in follow-up at West Suburban Medical Center on September 26, 2008, he reported ongoing neck, shoulder and back pain. (PX 28) He also reported depression since the auto accident. It was noted he had been seeing a therapist and psychiatrist and had been started on Cymbalta. He reported passive suicidal ideation and thoughts of ending his life on occasion. The records of this date also indicate the petitioner was no longer using a cane. was status post MVA with depression and the patient acknowledged a "long road ahead" to recovery. (PX 28)

He again followed up at West Suburban Medical Center on October 3, 2008 for his motor vehicle accident and resulting neck and back pain. (PX 28) It was noted that he was moving slowly, with his gait slightly forward at waist. He continued to follow up for neck and back pain related to his motor vehicle accident, including cervical, thoracic and lumbar somatic dysfunction, for which he underwent manipulation through at least February 26, 2009. In March of 2009, he was referred for functional capacity testing. (PX 28)

On October 23, 2008 Dr. Goldberg prescribed physical therapy for lumbar range of motion and strengthening for three times a week for six weeks. Dr. Goldberg had assessed status post lumbar fusion at L4-5 and L5-S1.

The petitioner continued to follow up regularly at West Suburban Medical Center status post motor vehicle accident through March 2009. (PX 28)

Second IME- Dr. Wehner

The respondent obtained an independent medical evaluation from Dr. Julie Wehner on January 7, 2009. (Rx 1, Dep Exhibit 3) At the IME evaluation, the petitioner reported his pain level at 9/10. His pain complaints and abnormal posturing were not explained by the radiographic findings or the surgery that was performed. Dr. Wehner opined that the petitioner had reached maximum medical improvement for any work injury and could return to work with a 25-pound lifting restriction. She also agreed that he should be weaned off narcotic pain medications due to the high predilection for addiction.

Petitioner followed-up at Rush Oak Park on January 19, 2009, February 17, 2009 and March 24, 2009 but the Arbitrator notes the reports are not entirely legible. Petitioner also followed up at Rush Oak Park on August 3, 2009 and October 6, 2009 with complaints of neck and back pain.

On January 7, 2010 petitioner received a Partially Favorable decision from the Social Security Administration for disability benefits. (PX 40)

On August 26, 2010 the petitioner called Dr. McGinness' office and stated that he needed an order for an MRI.

On September 2, 2010 an MRI of lumbar spine suggested the mild diffuse disc protrusions at the L5-S1 and L4-L5 were stable. There was spinal stenosis at L3-L4, milder at L2-L3 with no significant change since earlier examination. An MRI of cervical spine showed a disc protrusion with spinal stenosis and C3-C4, C5-C6, and C6-C7. There was relative spinal stenosis at C4-C5 and a tiny benign cyst within the central spine canal at the T4 level.

The petitioner was seen by Dr. Edward Goldberg on September 8, 2010 after a significant gap in treatment with the doctor, for complaints involving his neck and right arm. (Rx. 6, pg 55) The petitioner complained of central neck pain radiating down the top of the right shoulder and the lateral aspect of his upper arm into his forearm as well as the third and fourth digits. He reported that he had been constantly in pain for the last three weeks. Dr. Goldberg noted he had some prior treatment relating to a C4-C5 disc herniation in the past and had been treated with epidural steroid injections. The doctor reviewed the MRI of September 2, 2010 and felt he had multi-level cervical spondylosis causing radiculopathy and cord stenosis. As he exhibited a clinical picture of myeloradiculopathy, Dr. Goldberg recommended an anterior cervical discectomy and fusion at C3-C4 and C4-C5. Dr. Goldberg noted that they discussed the natural course and history of his myelopathy.

IME-Dr. Lami

On January 5, 2011 petitioner attended an IME with Dr. Lami to address the proposed cervical surgery. (RX 2, Dep Ex. 2) After a review of petitioner's medical history, Dr. Lami opined petitioner had subjective neck pain and right anterior shoulder pain with degenerative changes seen on the MRI. Dr. Lami opined that the cervical issues were not related to the work accident and opined that he did not need cervical surgery. Petitioner only needed a home exercise program. Regarding the cervical spine, Dr. Lami opined petitioner needed no work restrictions. Regarding the lumbar spine, Dr. Lami noted the invalid FCE and opined that a lifting restriction of 25-30 pounds would be reasonable. Petitioner was at MMI.

On February 28, 2011, petitioner met with Dr. Riley for a tender lymph node. Petitioner was assessed with lymphadenopathy and Dr. Riley noted petitioner did not complete his antibiotics as prescribed. Of note, petitioner mentioned back pain and stated his pain was 10 out of 10 but Dr. Riley opined he did not show evidence of this.

On October 19, 2011 Dr. McGinness prescribed petitioner Norco. This was again prescribed along with Tagamet on February 28, 2012. Another prescription of Norco was made on May 2, 2012. More medication refill requests were made on August 1, 2012; November 15, 2012; January 15, 2013; and February 18, 2013.

The petitioner saw Dr. McGinnis on March 14, 2013 complaining of back pain, chronic neck pain and depression. He now complained of facial and dental pain and an ache in his left forearm. He also had back pain and cramping in his left leg. He complained of depression which they noted they had treated him for in 2008 with Cymbalta. The doctor prescribed Fentanyl patches, Viagra and Cymbalta. Petitioner was living in Atlanta but was in town this week for an IME.

Second IME- Dr. Lami

On March 15, 2013, petitioner attended another IME, with Dr. Lami who opined petitioner's current symptoms were unrelated and out of proportion to the report injury on April 17, 2006. (RX 2, Dep Ex. 3) Dr. Lami opined petitioner was at MMI for the sprain he sustained on April 17, 2006. Dr. Lami also opined any complex regional pain syndrome was not related to his work injury and neither would be the proposed neck surgery. Dr. Lami could not support that petitioner was totally disabled because of the invalid FCE and psychosocial factors at play. He opined a lifting restriction of 25-30 pounds again would be reasonable. No further treatment was recommended.

On March 18, 2013, Dr. Goldberg authored a letter to petitioner's attorney, Mr. Gallagher. (RX 6, pg 53) Petitioner complained of posterior neck pain that radiated into the right shoulder, cramping in all four extremities, low back pain, and bilateral lower extremity paraesthesias. Dr. Goldberg suggested a possible assessment of cervical myelopathy and recommended another cervical MRI. Additionally, he recommended another lumbar MRI to determine if there was an adjacent level problem.

On May 22, 2013, Dr. McGinness prescribed Norco and Tagamet again. Norco was again prescribed on July 10, 2013. The petitioner requested medication refills on: August 15, 2013; August 28, 2013; September 27, 2013; November 8, 2013; December 2, 2013; January 9, 2014; February 3, 2014; and February 26, 2014.

Third IME- Dr. Lami

Dr. Lami issued a report on August 15, 2013. (RX 2, Dep Ex. 4) He opined he could not support surgery for myelopathy to be related to any of the work accidents. That would be a chronic compression of the spinal cord and no sign of same was found by Dr. Goldberg in 2010. A cervical MRI would be reasonable if Dr. Goldberg truly found myelopathic symptoms at this time. The requested lumbar MRI was not reasonable as petitioner showed a solid lumbar fusion without any neurologic deficit and only subjective pain. Additionally, Dr. Lami opined petitioner's spinal fusion was unrelated to the work accidents and his work restrictions were due to that. His work restrictions were not causally related to any of the work accidents.

Dr. Goldberg authored a March 7, 2014 letter responding to the petitioner's attorney's request for a summary of treatment. (Rx 6, pg 49) Dr. Goldberg opined petitioner's work accidents aggravated his degenerative disease of the lumbar spine and that the lumbar spine surgery and therapy were appropriate to relieve petitioner of the effects of his work accident. Dr. Goldberg did not comment on petitioner's right shoulder complaints and deferred to Dr. Palmer's and Dr. Nicholson's opinions.

On March 7, 2014 the petitioner returned to Dr. McGinnis for assessment of back pain, cervical radiculopathy, depression, migraines, gastroesophageal reflux disease, palpitations, erectile dysfunction, prostatitis and fatigue.

On July 3, 2014 petitioner presented to SIU Center for Family Medicine and met with Dr. Khattak. An x-ray of the lumbar spine was stable from previous imaging. After examination, Dr. Khattak diagnosed petitioner with chronic lower back pain that was likely secondary to arthritis. Petitioner refused physical therapy. Dr. Khattak advised petitioner to treat with exercise, stretches, heating pads, and Meloxicam. (Px. 11)

On August 4, 2014 petitioner was initially evaluated for physical therapy at Koke Mill. His diagnoses included lumbago, back pain, and neck pain. Therapy was planned for 1-3 times a week for twelve weeks. Petitioner attended physical therapy which included aqua therapy. Petitioner underwent occupational therapy at Memorial Rehabilitation Services at Koke Mill from August 6, 2014 through November 3, 2014. (PX 3).

Petitioner saw Dr. Khattak on September 4, 2014 and complained of low back pain and neck pain. Examination showed tenderness to palpation over the C4-5 and lower lumbar area. Petitioner had full range of motion and full strength. He ambulated with a cane. Dr. Khattak ordered MRIs of the cervical and lumbar spine and provided an orthopedic referral. (Px. 11)

On September 19, 2014, petitioner presented to Memorial Medical Center for an MRI of his cervical and lumbar spine. The cervical spine MRI revealed multilevel degenerative changes with mild central canal stenosis at C5-C6 and C6-C7 and multilevel moderate to severe neural foraminal encroachment. The lumbar spine MRI revealed multilevel degenerative most severe at L2-L3 and L3-L4 with severe central canal stenosis. There was also multilevel moderate to severe neural foraminal encroachment. (Px 11)

Petitioner presented to Dr. Venkat Ganapathy on September 24, 2014 with complaints of neck and back pain. (PX 12) The assessment was cervical myelopathy at C6-C7, posterolateral disc herniation at the right C4-C5 disc space, multi-level degenerative disc disease at the cervical spine and central stenosis, lateral recess and foraminal stenosis at L2-L3 and L3-L4 as well as multi-level degenerative disc disease and facet hypertrophy in the lumbar spine. The recommendations were an anterior cervical decompression and fusion and a subsequent posterior lumbar decompression and fusion. Petitioner was directed to obtain a lumbar spine CT due to a question of pars fractures at L2-L3 and L3-L4 and an EMG of the upper extremities for possible carpal tunnel syndrome on the left.

An EMG performed by Dr. Trudeau found right C5 and C7 radiculopathy which was moderately severe, but which was characterized as an older or chronic finding. There were also moderately severe bilateral median neuropathies at the wrist, moderately severe on the left and mild on the right. There was no current evidence of cervical radiculopathy, brachioplexopathy, or mononeuritis multiplex. (PX 21)

The CT of the lumbar spine performed on September 26, 2014 showed the prior fusion from L4-S1. (Px. 11) It was noted that unless there were prior CTs to demonstrate stable position, the short fixation screws which were threaded into the posterior aspect of each pedicular screw were displaced. (Dr. Goldberg later testified the loose screws were not causing any symptoms.)

On November 8, 2014, petitioner underwent an MRI of the cervical spine, which revealed: (1) minimal change since the earlier examination; (2) spinal stenosis was stable at C3-C4, C5-C6, and C6-C7; (3) left neural foraminal stenosis stable at C5-C6 and milder neural foraminal narrowing on the right at C5-C6 and bilaterally at C4-C5 as well as narrowing related to uncovertebral joint degenerative change; (4) osseous and disc degenerative changes; and (5) straightening of the cervical spine.

The petitioner was seen in follow up by Dr. Ganapathy on November 18, 2014. (PX 12) The doctor noted the petitioner had a difficult problem with long term opioid use, multiple sources of pain with axial as well as radicular pain. He also had myofascial pain which was non-dermatomal and pressure point pain. X-rays of the cervical spine showed mild degenerative disc disease from C4-C5 to C6-C7 with no change in alignment to suggest instability. The doctor noted he may still have radiculopathy, but it was difficult to assess in this setting as there were multiple other pain generators. The doctor also bolded the statement that, “I am not convinced that he has myelopathy as today’s exam was not in keeping with the exam finding from last visit.” Dr. Ganapathy felt they needed to understand which of the discs were causing the problems. He therefore recommended a C5 root block injection and a bilateral C7 selective root block injection, performed at separate times, to determine which of these was the offending level.

The petitioner was seen by Dr. Paul S. Smucker on November 21, 2014 on referral from Dr. Ganapathy to perform the root block injection. (PX 3, pg 4) The doctor noted that his “symptoms of pain and paresthesias were not consistent during the time of my discussion with him”. The neurologic exam showed no upper or lower extremity atrophy and balance and coordination were normal. Lower extremity neural tension signs were negative bilaterally. His lumbar range of motion was limited, but there was no focal mechanical reproducible pain. Cervical range of motion was normal. Shoulder impingement was inconsistently positive on the left. Motor strength testing featured break away weakness through the proximal and distal bilateral upper and lower extremities. Straight leg raising was negative bilaterally, as was Tinel’s at the carpal and cubital tunnels. The doctor reviewed the cervical radiographs which showed multi-level mild spondylosis but well preserved intervertebral disc space heights throughout the cervical spine. The cervical MRI from September 19, 2014 showed mild degenerative disc disease at multiple levels. There was moderate to severe neuroforaminal narrowing on the right at C4-5 and bilaterally at C5-C6. There was no severe significant canal stenosis at any level. Lumbar X-rays showed post-operative changes with hardware fusion at L4-L5 and L5-S1. The lumbar MRI of July 3, 2014 showed multi-level degenerative disc disease with facet arthropathy. These combined to create severe canal stenosis at L2-L3 and L3-L4. There was bilateral neuroforaminal narrowing at L2-L3 and L3-L4 as well.

Dr. Smucker noted the petitioner had non-physiologic findings with diffuse inconsistent breakaway weakness on exam. There was diffuse muscular tenderness consistent with myofascial pain syndrome. There was mild to moderate cervical degenerative disc disease with mild central stenosis at C5-C6 and C6-C7. The petitioner was status post L4-S1 fusion with multi-level neuroforaminal stenosis. There was a possible element of neurogenic claudication, although this was difficult to discern through the diffuse complaints he had to offer.

The doctor did not see evidence on his overall presentation including physical exam of cervical myelopathy. Dr. Smucker did not believe that the requested diagnostic cervical selective nerve root blocks would be valid in this individual given the widespread inconsistency of exam and described symptoms. Included with the records of Dr. Smucker is a note in which the petitioner called the office on December 8, 2014 to discuss the November 21, 2014 visit with Dr. Smucker. (PX 3, pg 8) He was frustrated that Dr. Smucker changed the procedure plan suggested by Dr. Ganapathy. The petitioner was advised that the dictation by Dr. Smucker would not be changed, as it was the doctor's medical opinion after the evaluation. The petitioner also requested no records were to be released without his prior approval. A right C5 selective nerve root block was performed on January 22, 2015 and a left C7 selective nerve root block was performed January 23, 2015. A final injection/nerve root block at the right C7 was performed February 11, 2015.

Dr. McGinness saw the petitioner on June 19, 2015. Petitioner stated that he had been seen by a neurosurgeon and was told surgery would not get rid of his pain, therefore he was not planning to undergo surgery.

The petitioner returned to Dr. Goldberg on September 9, 2015, with ongoing cervical and lumbar complaints. Dr. Goldberg recommended MRIs of the cervical and lumbar spine, as well as a functional capacity evaluation. As the petitioner continued to be myelopathic, Dr. Goldberg continued to recommend cervical surgery.

The MRI of the cervical spine, performed on September 11, 2015, re-demonstrated degenerative changes causing mild spinal canal stenosis at C3-C4, C4-C5, and C5-C6, with mild to moderate stenosis at C6-C7. There was severe right foraminal stenosis at C4-C5, which was more pronounced than the prior study. The lumbar MRI was read as showing moderate canal stenosis with massive hypertrophy causing lateral recess and neural foraminal stenosis at L2-L3 and L3-L4. Following review of the MRIs on October 2, 2015, Dr. Goldberg felt that the petitioner was now having an adjacent level breakdown due to the prior lumbar fusion. He therefore recommended decompression at L2 through L4 with laminectomy and/or possible fusion to address the low back pain. In addition, Dr. Goldberg continued to recommend the cervical fusion from C3 through C7. Mr. Loving, however, did not want to consider surgical treatment at this time, and instead the doctor recommended pain management. The petitioner advised Dr. Goldberg that he would be spending the winter in Savannah, Georgia, with his brother. The doctor provided him with a referral to take to Georgia to obtain pain management physician there as well. The recommendation included epidural steroid injections and chronic pain management.

The medical records document physical therapy performed at Saint Joseph's/Candler Health System in Savannah, Georgia from October 6, 2015 through November 19, 2015. (PX 18) The notes of November 2, 2015 indicate the petitioner washed, waxed and detailed his car this weekend. On October 21, 2015, the petitioner reported feeling well and "I feel like I could play football." At the time of discharge, the petitioner reported a significant amount of improvement and was excited that he was feeling better in time for the holidays. He made excellent rehab progress meeting all short and long term goals with the exception of hip extension range of motion.

Petitioner returned for 12 sessions of aquatic/physical therapy at St. Joseph's/Candler in Savannah from March 17, 2016 to April 28, 2016. (PX 18)

Dr. McGinness treated petitioner on September 21, 2016 for continued all over pain. He reported new pain and popping in the right shoulder for two weeks. At the time of the appointment, petitioner ambulated without a cane, but requested a form for a disability card for transportation. Dr. McGinness updated petitioner's diagnosis to include acute right shoulder pain.

Petitioner followed-up with Dr. McGinness on November 3, 2016 with complaints of worsening neck and back pain since August. Petitioner reported pain down the arm to the hand and down the leg and around the groin. Physical therapy was not helping his pain. Dr. McGinness provided petitioner with a prescription of Oxycodone and Lidoderm patches and referred petitioner to the pain clinic for treatment.

Petitioner was seen by Dr. Matthew Jaycox on January 19, 2017 for pain in the low right back and pain in the upper and lower extremities. He was assessed with cervical radiculopathy, degenerative disc disease, myelopathy and facet arthropathy in the cervical spine. He was to be scheduled for cervical epidural steroid injections at C7 through T1. If no relief, they would refer him for surgery.

On January 26, 2017, Dr. Dennis Gumbrecht treated petitioner at the Rush University Medical Center Department of Anesthesia Pain Service. Petitioner reported pain in the cervical spine, specifically midline pain that radiated into the bilateral upper extremities to the fingers. A cervical epidural steroid injection was performed.

Petitioner was seen by Dr. McGinness on January 26, 2017 and reported continued neck and back pain and stated that his right leg buckled several times a week. A left trigger finger diagnosis was also noted. Dr. McGinness refilled petitioner's pain medications.

Dr. Gumbrecht performed a cervical epidural steroid injection on March 9, 2017. A second cervical epidural steroid injection was performed on May 11, 2017.

Petitioner presented to Dr. McGinness on January 16, 2018 and reported pain in his back, neck and right knee.

Petitioner presented to Dr. McGinness on May 8, 2018 and reported continued neck and back pain and that he did not feel the lumbar surgery improved his function enough so that he would contemplate neck surgery. Petitioner reported he had as much lumbar pain as he had prior to surgery.

On October 18, 2018, petitioner returned to Dr. McGinness for back and neck pain and reported he was taking long lasting hydrocodone only when his pain is at a 10/10. Mood was noted as okay on an anti-depressant. Petitioner reported he was going to the gym. According to this note the history of a fall was on June 21, 2018. The assessment was lumbar radiculopathy, depression and cervical radiculopathy. The plan was a refill of hydrocodone.

Petitioner started a new course of physical therapy on January 24, 2019 at NovaCare on referral by Dr. McGinness with a diagnosis of lumbar radiculopathy and cervical radiculopathy. Petitioner reported the pain started in 2006 when he felt pain in his low back and neck when carrying and pushing many bags and containers at work which weighed over 100 pounds. Petitioner attended 11 sessions through March 4, 2019.

The petitioner was seen again by Dr. Jaycox on March 19, 2019 for pain in the right shoulder up into his head and back pain with shooting pain down his right leg and migraines. It was noted the petitioner had returned after an 18 month absence. He was living in Savannah, Georgia and had since returned to Illinois with a return of his neck and arm pain with radiation at the right upper extremity as well as occasional low back pain into the right leg.

The petitioner underwent cervical epidural steroid injections on March 21, 2019 and April 25, 2019 at C7-T1. The petitioner was seen on May 30, 2019 in follow up and reported feeling approximately 75% better with increased activity levels. It was noted he gets out of the house to walk and exercise three to four times per week.

Petitioner was seen at Rush Oak Park Physical Therapy for a spine evaluation on October 9, 2019. It was recommended he continue physical therapy twice a week for six to eight weeks. The physical therapy progress note from October 28, 2019 indicated significant self-limiting tendencies, and noted "observed movements and behaviors inconsistent with subjective reports." The notes of November 4, 2019 again indicate the self-limiting tendencies and inconsistent observed movements and behaviors which were inconsistent with subjective reports. He also performed all activities in a slow and deliberate manner. By November 6, 2019, he had improved neck symptoms and wished to focus on the low back pain.

The petitioner was seen by Dr. Jaycox on December 18, 2019 for a follow up of upper back and neck pain. His pain had been 7/10 and worse on the right side with radiation into the arm. He also described weakness in the grip on the right side. The petitioner underwent cervical epidural steroid injection on December 31, 2019.

The petitioner presented on March 9, 2020 to the Emergency Department at Rush Oak Park Hospital. He stated he had low back pain which was uncontrollable with Norco. He was given an injection of Toradol. He was given a prescription for physical therapy on discharge.

The petitioner was seen by Dr. Jaycox on May 28, 2020 for follow up after cervical epidural injections performed in December 2019. He felt about 50% better, but had not increased his activity levels. He reported that he gets out to exercise two to three times per week. The pain in the right arm and hands was unchanged and the remaining pain was now in the neck. It was recommended that they perform bilateral cervical facet injections from C3 through C7.

On June 20, 2020, the petitioner underwent bilateral cervical facet joint injections at C2-C3, C3-C4, C4-C5 and C5-C6.

Respondent Records Review- Dr. Mather

An orthopedic surgeon, Dr. Steven Mather, issued a records review report on August 5, 2021. (Rx 3, Dep Exh 2) The petitioner was a status post L4-L5-S1 fusion with unrelated lumbar spinal stenosis at L2-L3 and L3-L4. Dr. Mather found the lumbar stenosis was not work related. Dr. Mather found the petitioner sustained disc herniations at L4-L5 and L5-S1, but the appropriate surgery would have been a simple discectomy, and it is unclear why the patient underwent a fusion as this did not meet the standard criteria for such a procedure. There was no evidence of instability, advanced, degenerative disc disease or any condition that would require a fusion.

Dr. Mather also found the cervical spine showed typical degenerative changes/osteophytes which were also unrelated to any work injury. The C3-C4 disc herniation was first noted on the September 5, 2017 MRI. While the petitioner may have sustained an aggravation of the right C4-C5 osteophyte/stenosis, this would've resolved by April 3, 2007 when his exam had returned to normal and he was released to return to work by Dr. Fetzer. Further, Dr. Fetzer had noted he had multiple positive Waddell findings at the time of his discharge from care, and he had no signs of any ongoing neurologic compression as his neurologic exam had completely returned to normal. Dr. Mather noted there were demonstrated inconsistencies and nonorganic pain findings when presenting to his treating physician, Dr. Fetzer and Dr. Nicholson. This indicated many of his symptoms were simply subjective in nature and not supported by clinical physical examination. Patients with multiple positive Wadell signs almost always have psychogenic sources of pain rather than objective organic sources of pain, and he felt this case was no exception. He also noted the patient provided maximum effort and exaggerating his complaints. (Rx 3, Dep Exh 2)

Petitioner presented to U Chicago Medicine Advent Health Hinsdale November 8, 2022 for progressive worsening of his low back pain with increased lower back pain becoming progressively worse over the last few days. Dr. Song in neurosurgery was consulted. An MRI showed severe central stenosis at L2-L3 and L3-L4 which was thought to be causing his complaints. The petitioner was admitted and Dr. Song performed L2-L4 PSF surgery. (PX 2, p. 10). On November 15, 2022, x-rays of the lumbar spine showed the hardware in the lower lumbar spine to be in proper position. At the time of the November 22, 2022 discharge, post-operative back pain had improved but was still present.

On December 6, 2022, petitioner presented to Dr. Song for his first post-operative visit. The numbness, tingling and weakness in his anterior thighs and ankle were unchanged. Petitioner was overall happy and reported his chronic low back pain had essentially resolved. Petitioner was discharged on December 7, 2022. (PX 2, p. 4). (PX 3)

At the next follow up on December 20, 2022. He reported his strength was improving in his bilateral lower extremities. Petitioner reported numbness in his right thigh and complained of a strong burning sensation in his calves and shins bilaterally. Dr. Song recommended he continue physical therapy and opined his neuropathic complaints may take time to improve.

Petitioner presented for his third post-operative visit on February 7, 2023. Petitioner opined his leg symptoms were 90% resolved and the right leg symptoms were 63% resolved. A diagnosis was made of spinal stenosis of the lumbar region.

On February 14, 2023, petitioner returned to Dr. Song to review his legal case and the request sent by his attorney. Dr. Song could not make comment until it passed through the Adventist legal team. Dr. Song opined petitioner had adjacent segment disease related to prior lumbar fusion which was “apparently” causally related to his work injury in 2006 and 2014. Petitioner also complained of neck pain and severe right arm pain that radiated down the arm to the hand and was complicated by petitioner’s carpal tunnel surgery. X-rays of the cervical spine were ordered for a diagnosis of cervical radiculopathy.

Petitioner underwent an MRI of the cervical spine on February 24, 2023 at UChicago Medicine. The study showed hypertrophic degenerative changes with moderate spinal stenoses at C3-4, C4-5, C5-6 and C6-7 levels and moderate to severe foraminal narrowing on the left at C3-4, bilaterally at C4-5, C5-6 and C6-7 levels and on the left at the C7-T11 level.

Petitioner returned to Dr. Song to discuss imaging results on March 7, 2023. He continued to complain of neck pain with numbness, tingling and weakness into the right deltoid and into his arm. The numbness in his fingers had resolved after his bilateral carpal tunnel surgery. Dr. Song was uncertain whether petitioner would have any relief with surgery but if petitioner wished to proceed, Dr. Song would consider a C4-5 and C5-6 ACDF. Dr. Song noted it was hard to determine if his findings on his cervical spine were normal degenerative changes or related to his work injury that happened 17 years ago. An assessment was made of spinal stenosis of the lumbar region and cervical radiculopathy and petitioner was instructed to return to the office as needed.

IME- Dr. Mather

Dr. Mather performed an independent medical evaluation on March 28, 2024 (RX 3, Dep Exh 3) Dr. Mather opined that the recent fusion surgery was due to normal degenerative changes and that as it had been 16 years since the previous surgery therefore, in his opinion, the need for same was unrelated to that original fusion done L4-L5-S1.” (Rx 3, dep exh 3) The petitioner also had positive Waddell’s signs. Upon examination, the petitioner had no tenderness to lumbar spine, but with any simulated axial rotation, he would wince and yell out loudly and nearly collapsed to the floor. However, he had was found to have no real pain with actual axial compression of the spine. The doctor also found him to have diffuse non-dermatomal numbness in the right lower extremity.

Deposition Testimony

Testimony of Dr. Goldberg- treating surgeon

Dr. Edward Goldberg testified on **April 11, 2016** regarding the 2006 discectomy and fusion. (Px 41, pg 11) The doctor testified after review of the MRI he felt Petitioner had some disk degeneration of both L4-5, L5-S1 with an annular tear at both levels. He also felt that he had a central herniation at L4-5. (Px41, pg. 10) On 9/19/06 Dr. Goldberg performed the following: a discectomy at L4-5 for the herniation and then an instrumented fusion at L4-5 and L5-S1 with pedicle screw instrumentation and iliac crest bone graft. (Px41, pg 13-14) As of 8/18/06, the doctor had petitioner off of work and following surgery as well through 3/7/07 when he was released with permanent restrictions. (Px41, pg 11 & 29) As of 12/6/06, Petitioner was enrolled in physical therapy and was reporting some low back pain and stiffness to Dr. Goldberg, but denied any radicular or leg pain. (Px41, pg 19) The doctor found him to be neurologically intact, and the fusion to be healing nicely at both this visit and the January 2007 visit, following x-rays performed. (Id at 24)

Regarding the history reported to him, Dr. Goldberg testified petitioner initially injured his low back on 11/4/05 when he lifted and developed acute right sided low back pain and then pain into the anterior thigh on right side. Then petitioner suffered a reinjury on 4/17/06 again “after lifting and twisting”. (Px41, pg9) The only information Dr. Goldberg had as to how the petitioner was injured working on a ramp was that he was lifting. (PX 41, pg 16) At no time from August 18, 2006 to January 7, 2007 did the petitioner mention any other than his back and at no time did the petitioner have any complaints about his cervical pain. (PX 41, pg 24-25) When asked if it was possible to have cervical pain that was masked by shoulder pain, the doctor said it was unlikely as they were very independent body parts. (PX 41, pg 25-26)

On the 3/7/07 last visit following the fusion, Dr. Goldberg wrote that Petitioner testified to finishing work conditioning and since then had increasing neck pain and reported some low back pain. He denied radicular pain, he had good lumbar motion but limited painful range of motion in his cervical spine. (Px41, pg 28) Regarding work capabilities, Petitioner was now capable of lifting 40 pounds occasionally from floor to waist, overhead 20 pounds, frequent basis lift 20 pounds floor to waist and 10 pounds overhead; when reviewing the work conditioning note it indicated petitioner was required to lift 70 pounds for his original work position. (Px41, pg 28) At this point in time, 3/7/07, Dr. Goldberg testified he was at MMI for the lumbar spine and could go back to work within the work restrictions as well as follow up with Dr. Fetzer for the cervical spine she was treating him for. (Id. at 29)

Dr. Goldberg testified the petitioner injured both the cervical and lumbar spine at work. (PX 41, pg 52-53) He was aware of only the November 4, 2005 and April 17, 2006 accidents. (PX 41, pg 58) When asked about whether his current conditions were related to the work accident, Dr. Goldberg seemed to equivocate and stated only that he had an injury was seen by his partners, had some temporary improvement and it had not progressed. (PX 41, pg 54) **Dr. Goldberg placed the petitioner at maximum medical improvement and released him to return to work with restrictions consistent with the work hardening reports on March 7, 2007. (PX 41, pg 62)**

He did not see him again until September 8, 2010 when he saw him for cervical complaints. Petitioner reported neck pain radiating to the top of the right shoulder and that the pain was constant for past 3 weeks. He reviewed an MRI and given the findings on his exam, discussed surgery. Specifically, the doctor found he had disk herniations at C3-4 and C4-5 and smaller ones at C5-6 and C6-7, and that the C3-4 and C4-5 herniations were causing some impingement on the spinal cord. (PX 41, pg 32-34) Dr. Goldberg discussed possibility of cervical spine surgery due to the change in symptoms and herniations on MRI but the petitioner did not wish to proceed with surgery. (PX 41, pg 34 and 52)

Regarding his history with petitioner, Dr. Goldberg testified that for the initial treatment starting in August 2006, he was primarily treating petitioner's back however he did previously review the cervical spine MRI in November 2006. (Px41, pg 35) The doctor opined that the prior MRI showed there were disk herniations at C3-4 and C4-5; at C3-4 it was central, at C4-5 it was central to the right; and there was a smaller herniation at C5-6 and C6-7. (Id.) Regarding prior cervical treatment in 2006, the doctor testified that Dr. Fetzer had done an epidural which provided good relief and that second epidural was not done since there was good relief. (Id.) From March 2007 through September 2010, Dr. Goldberg was not aware whether petitioner was working and he did not comment on petitioner's ability to work. (Px41, pg 36).

As of the 3/18/13 visit, that was the last examination of petitioner where he reported posterior neck pain, cramping in all four extremities from neck into right shoulder, low back pain and bilateral lower extremity paresthesia's; he had been seeing Dr. McGinness and taking hydrocodone, Cymbalta for depression and using Fentanyl patch; not been working; reported unsteadiness with ambulation; he had limited lumbar range in motion, cervical range was 50 percent normal; x-rays of lumbar spine showed healed fusion but a locking nut at L4 appeared to disengage from screw but incidental finding; cervical x-ray showed disk narrowing particularly at C5-6." (Px41, pg 37-39) Dr. Goldberg testified that he was concerned petitioner had some cervical cord involvement called myelopathy, recommended new MRI of lumbar spine to assess whether was any adjacent, meaning next level pathology, because when the doctor treated petitioner for the lumbar spine in 2006-2007, his radicular pain had resolved and now petitioner was having bilateral lower extremity new complaints. (Px41, pg, 39) As of the 3/18/13 visit, Petitioner had not been working. (Px41, pg.41)

Dr. Goldberg testified that in his March 2014 report (requested by Petitioner's lawyers), he noted that Dr. Palmer reflected in her notes, neck, right shoulder and back pain and that as of April 2006 Dr. Palmer gave work restrictions. (Px41, pg 42-43) He understood that Dr. Palmer was treating petitioner's cervical and right shoulder complaints prior to his involvement with petitioner in August 2006. (Id.) He testified that in his report where he wrote "I do believe that his lumbar condition is due to the work accident as well as the cervical condition based upon my review of these records", refers to Dr. Palmer and Dr. Fetzer's records from his office. (Px41, pg43-44). Specifically, he testified that Dr. Palmer thought it was a shoulder injury from March 2006, refers patient to Dr. Nicholson for injection with no improvement then refers to Dr. Fetzer who does a C5 selective nerve root block which improves neck pain such that the doctor recommended work conditioning. (Id.) Dr. Goldberg testified that he formulated the opinion that

both the lumbar and cervical conditions were related to work based on the record review mentioned above. (Id.)

On the December 2014 visit, the doctor found 5 out of 5 strength in upper and lower extremities but unsteady gait which could be due to spinal cord compression, which petitioner was using a cane; petitioner had abnormal Hoffman's signs; and he recommended cervical surgery again. (Px41, pg 45-46). The doctor opines at this visit that the cervical and lumbar conditions are due to the work accident and encouraged treatment and discussed signs and symptoms of myelopathy, or spinal cord compression. (Id. at 46) At the September 2015 visit, Petitioner presented with lumbar and cervical complaints for which the doctor recommended a MRI. (Id. at 47) Dr. Goldberg testified that there was significant stenosis at C4-5, C5-6 and C6-7; lumbar MRI showed no ongoing compression from L4 to S1 where original surgery was but "there was some moderate spinal stenosis at L2-3 and L3-4...in other words, adjacent level problems." (Px41, pg.48). Surgery was once again recommended but never scheduled. (Id.)

The last visit was on October 2, 2015 where cervical surgery was recommended but not approved, and petitioner was referred to pain management and he was not working, on disability. (Px41, pg. 50) Dr. Goldberg testified that he reviewed the new cervical and lumbar MRIs as of September 2015 and he felt there was significant stenosis at C4-5 and C5-6 and C6-7; he felt the lumbar spine showed no going compression L5-S1 where the original surgery was but did note at L2-3 and L3-4 there was some moderate spinal stenosis centrally and in the lateral recesses, in other words adjacent level problems. (Px41, pg 48) The doctor testified when he saw petitioner last he did not wish to proceed with cervical surgery. (Px41, pg52)

Dr. Goldberg testified that regarding the lumbar spine petitioner had two injuries in November 2005 and he continued to work then exacerbation in April 2006. (Px41, pg. 52-53) Specifically, petitioner had low back right leg radicular type symptoms that the doctor felt was due to the work accident and then regarding the cervical spine, his opinions were predicated upon notes from Drs. Palmer and Fetzer. (Id.) He testified that the records do reflect that petitioner did injure his shoulder and neck and that his treatment for back and neck since November 2005 was reasonable, necessary and related to the work accidents. (Id.) Further, Dr. Goldberg testified the subjective complaints consistent with objective findings as well (Id.) However, the doctor stated that "it's not until a few years later where he's getting bilateral leg pain now and there's new pathology at other levels"; regarding cervical complaints, "he had neck towards right shoulder originally, over the course of time it appeared to progress into some early myelopathic findings." (Px41, pg 54) He thought petitioner's symptoms were what MRIs showed. (Id.)

Regarding causation for the back and neck and whether Petitioner's present condition of ill being is caused in whole or in part by any of the four work related accidents, the doctor testified the lumbar yes in whole part because "unfortunately he developed adjacent level problems." (Px41, pg. 54) Regarding the neck, he testified "all I can state is he did have an injury, he was treated by some of my partners, had some temporary improvement its not progressed." (Id.)

On cross examination, Dr. Goldberg testified he did not review any medical records from prior to the work accidents and he did not have any information regarding the 3/10/06 or 12/23/05 work accidents. (Px41, pg. 57-58) He opined the lumbar spine injury appeared to be caused initially on 11/4/05 and an exacerbation on 4/17/06. (Id.) Regarding the 3/10/06 accident, all Dr. Goldberg had was Dr. Palmer's notes which included that patient works as luggage handler and he has pain in the right anterior aspect of his right shoulder from accident on 3/10/06. (Px41, pg. 58) Regarding Dr. Nicholson, Dr. Goldberg doesn't know why he did not review his records but testified he does know that Dr. Nicholson did not feel petitioner's complaints were related to the shoulder. (Id. at 59). Dr. Goldberg acknowledged that Dr. Nicholson found pain complaints to be out of proportion to physical findings regarding the shoulder. (Id. at 60). Dr. Goldberg had not seen the FCE results at the time he released petitioner with restrictions as the FCE was after; but he did note that work conditioning showed some concerns about invalidity. (Px41, pg. 62). He then saw petitioner three years later and then again on 9/8/10. (Id.)

In the 6 year period between March 7, 2007 and March 18, 2013, the petitioner was seen by the doctor, only on September 8, 2010. (PX 41, pg 32,36,37) The doctor testified that he did not have any information regarding his symptoms or treatment during those periods, other than petitioner reporting he saw Dr McGinness who was prescribing Norco and Darvocet. (PX 41, pg 65 & 67) Dr. Goldberg also did not have any information regarding the automobile accident which occurred in 2008 and testified petitioner did not report the auto accident to him when he saw him in September 2010. (PX 41, pg 66) The doctor agreed an automobile accident could cause or aggravate his cervical and lumbar conditions. (Id.) The doctor testified that the cervical MRI from 2006 showed abutting the cord at C3-4 and C4-5, resulting in stenosis. (Id.)

The doctor acknowledged he saw petitioner on 3/18/13 at the request of his attorney and he was not aware of any treatment petitioner had from September 2010 through March 2013. (Px41, pg. 67). Dr. Goldberg did not review any 2008 records regarding the automobile accident and could not say to what extent that accident or injury aggravated petitioner's cervical or lumbar conditions. (Px41, pg 70) The doctor did not review records from Dr. Smucker, did review some records from Dr. Ganapathy, but was not aware the doctors noted that petitioner did not have findings consistent with cervical myelopathy in November 2014; however this did not alter his opinions because when Dr. Goldberg examined petitioner, he did "find some hyperreflexia, some Hoffman's, consistent with some myelopathy but myelopathy as we stated can wax and wane." (Px41, pg 71) He further testified he did not think the dislodged locking nut had any bearing on petitioner's clinical symptoms and are in the soft tissue nowhere near spinal canal/nerves; and that he had good decompression of the levels of the fusion. (Id. at 72) .

Testimony of Dr. Lami- Respondent IME

The deposition of Dr. Lami, the respondent's IME examiner, was completed on **January 18, 2017**. (RX 2) Dr. Lami is a board-certified orthopedic spine surgeon. (Rx 2, pg 5) Dr. Lami testified that the petitioner's condition of ill being in the cervical spine was not causally related to the work accident of April 17, 2006, or to any of the other work accidents. (Rx 2, Pg 9-10)

Dr. Lami explained that he personally reviewed the MRI findings from November 9, 2006, which failed to show myelopathy, traumatic findings or other significant pathology, but did show: some bulging of the disc with no compression at C4-5; at C5-6 a central disc protrusion which was degenerative in nature, C6-7 protruding disc without any significant compression of the cord. (Rx. 2, Pg. 8-9) In addition, on examination, the cervical spine exam was negative for any significant abnormalities or signs of injury. Based on the doctor's exam of March 15, 2013, he was unable to support any need for cervical surgery related to the April 17, 2016 Work accident. (Rx. 2 Pg. 14)

The petitioner described to Dr. Lami that at the time of the April 17, 2006 accident he felt a crack in his lower back. The notes from the emergency room showed no cervical spine issues or did the records of the initial providers. It wasn't until later in the medical records, where there was a suggestion of right shoulder pain which developed overtime into cervical spine type issues. (Rx 2 Pg. 10) In addition, doctor opined the MRI from 2006 showed no significant pathology only degenerative changes. (Rx 2, Pg 10) Regarding work restrictions, Dr. Lami opined that given the two level lumbar fusion, he recommended maximum lifting from 25 to 30 pounds. (Rx2, pg 11) Dr. Lami also agreed with the treating physicians that he was at MMI on 4/3/07. (Id.) The doctor opined that the need for any cervical surgery would not be related to the 4/17/06 work accident because he did not feel petitioner suffered a cervical spine injury on 4/17/06. (Rx2, pg14) The doctor did not find evidence of myelopathy on the MRIs or on examination of petitioner but did agree with Dr. Goldberg that it can be a progressive condition. (Rx2, pg 15) On cross examination, the doctor acknowledged that a neck injury can have pain in the arm and that sometimes cervical injuries causing pain in the arm can be misdiagnosed as a shoulder injury, "if it is evaluated by an appropriate doctor, its not likely". (Rx2, pg 23) When asked if the shoulder symptoms could have masked the neck injury in the case of Mr. Loving, Dr. Lami testified that it could not. (Rx 2, Pg. 32-34) If the petitioner had a neck injury which resulted in myelopathy; this would be traumatic and would be obvious at the time of the injury. This did not occur in Mr. Loving's case. On redirect, Dr. Lami was asked about Dr. Fetzer's December 2006 report where petitioner stated he was moving luggage at his job, moving forward with arms extended and he felt a pop in his right shoulder. (Rx2, pg 35) The doctor opined this is not something that would cause an injury in your neck. (Id.)

Testimony of Dr. Wehner- Respondent IME

Dr. Julie Wehner is a board-certified orthopedic spine surgeon who testified on **February 17, 2017**. who performed an IME on February 9, 2007 and January 7, 2009. (RX 1) On exam, Dr. Wehner found was no clonus or positive Hoffman's or Babinski signs to support a diagnosis of cervical myelopathy. (Rx 1, Pg. 10) The doctor opined that after review of the medical records and her first examination of petitioner, she gave a diagnosis of low back pain and that he was status post-fusion for degenerative disk disease at L4-5 and L5-S1 (Rx1, pg 8) Regarding the cervical spine, the doctor did not see anything on the MRI that warranted surgery and that the MRI findings did not match clinical findings for level of pain petitioner was demonstrating. (Id.) Dr. Wehner opined Petitioner did not need cervical surgery because petitioner has degenerative findings at C4-5, C5-6 and C6-7, they were not causing cord or nerve root impingement and because "the level of his pain complaints on clinical exam did not correlate with this mild degree of finding." (Rx1, pg. 9) The doctor did not find that petitioner had myelopathy but that he should complete post operative therapy. (Rx1, pg.10)

The doctor testified that the two-level lumbar fusion performed by Dr. Goldberg in 2006 was not appropriate and that the surgery performed was unlikely to provide a good outcome for petitioner, for the MRI findings that were present. (Rx 1, Pg. 12, 30) She indicated that the patient had symptom magnification and pain complaints which were out of proportion to the diagnostic findings at the 2009 exam. (Rx 1, pg 14-15) As such, she felt that he did not have a good prognosis and surgery was unlikely to provide a good outcome. (Rx 1, Pg. 9,10-12) In addition, Dr. Wehner testified that the petitioner exhibited signs of symptom magnification. (Id.) Further the doctor reviewed the 2008 lumbar spine MRI and diagnosed petitioner with chronic pain syndrome following the 2009 IME. (Rx1, pg.15) Specifically, she explained petitioner has ongoing pain that's usually longer than six months duration and that pain complaints were much higher than one would expect after this type of surgery, petitioner was two years out from surgery, high doses of pain medications that are not medically appropriate at that point, normal neurological exam, symptom magnification behaviors and a MRI that did not show any problems with actual surgery performed, (Id.) Regarding the narcotic usage, the doctor testified that is was not medically appropriate and that petitioner was taking Doxepin- anti depressant, Abilify, and Cymbalta which were different mood stabilizing drugs. (Rx1, pg.16) Then petitioner was on Hydrocodone- narcotic, Fexofenadine- narcotic, Fentanyl – very strong narcotic pain medication, Celebrex- anti-inflammatory, then he had patches; petitioner also was on Topmax probably for headaches (Id.) Dr. Wehner opined that it is strongly discouraged that people use this type of doses of narcotics and mixing all different classes of medications. (Id.)

Dr. Wehner as of the last IME recommended Petitioner go back to work with no lifting more than 25 pounds and that he did not need any further medical treatment for his back and that he should be weaned off his narcotic pain medications. (Rx1, pg. 17) The doctor did not believe that the petitioner had any condition of ill-being with respect to the cervical or lumbar spine that was related to the work accident other than a lumbar strain. (Rx 1, Pg. 18,19) Further the doctor found petitioner did not need further treatment for the neck. She testified that his pain levels did not correlate to the radiographic findings. (Rx 1, Pg. 19) She noted there were no acute findings on the first lumbar MRI and that Petitioner had pre-existing degenerative changes of the lumbar spine (Rx. 1 Pg. 18) Despite having a invalid FCE, Dr. Wehner acknowledged petitioner still required the 25 pound permanent restriction because he underwent surgical intervention, and based on the type of surgery done and his age, some people might need restrictions to get back to work in some capacity. (Rx1, pg. 20)

The petitioner had a cervical injection which was a diagnostic tool to ascertain if pain complaints were stemming from the cervical spine or shoulder. (Rx. 1, Pg 33, 37) Dr. Wehner testified that as he did not improve with the injection, this would signify that there was not a problem stemming from the cervical spine. (Rx 1, Pg. 37) As of the date of the deposition, the doctor had not seen petitioner since January 2009. (Id.)

Testimony of Dr. McGinnis- Treating physician

The deposition of Dr. Catherine McGinnis was completed on **December 2, 2016**. (PX 42) Dr. McGinnis testified that she is board certified in family medicine not orthopedic medicine and does not perform any surgeries. (PX 42, Pg 6) Further, she testified she referred petitioner to various other doctors for his back and shoulder/neck. (Px42, pg. 86)

It is Dr. McGinnis' opinion that the petitioner's neck and back pain was causally related to the injuries sustained at work. (Px 42, pg 83) The doctor testified that Petitioner saw her office for low back pain after a work injury on 4/17/06 and petitioner stated he was loading luggage on the plane when he felt a crackle in his right lower back. (Px 42, pg 15) Her assessment at that time was muscle sprain and she refilled his pain medications. (Id.) However, when cross-examined, the doctor testified she had no information regarding any accidental injuries other than the injury to his arm throwing luggage which he reported at the visit on April 13, 2006. (Px 42, pg 99) She specifically denied having any information regarding the accident on November 4, 2005 or the injury on December 23, 2005. (pg. 100)

Dr. McGinness testified that at the 12/20/07 visit Petitioner had severe low back pain and back muscle spasms and needed an x-ray for his finger. (Px42 pg. 26) She treated him for erectile dysfunction and "wrote a letter for work that he was not able to do his job. (Id.) Specifically, the letter she wrote was for "back pain relating to the herniated disc, not being able to participate in his retraining classes at this time because his narcotic medication put him to sleep and because his back pain requires him to get up and walk around frequently." (Px42 pg. 27) Dr. McGinness testified she wrote this letter "based upon his complaints". (Id.)

The Arbitrator notes that the doctor appears to have mentioned neck pain for the first time in her records, in her testimony, following receipt of a letter from pain doctor, Dr. Amin, around March 2008. (Px42, pg 29) When asked about keeping Petitioner off of work, she testified that both the specialists and herself kept petitioner off of work during this period of time prior to March, 10, 2008. (Px42 pg. 30) The doctor testified that Petitioner "now developed pain in the neck radiating down the left arm and right arm" as of 7/1/08 visit she had with him. (Px42, pg. 33)

On the 6/5/09 visit, Dr. McGinness notes that Petitioner would no longer be employed by United and that he understood United would not take back an employee with duty restrictions and that he would never be able to return to unrestricted duty. (Px42, pg 42). Dr. McGinness testified to numerous refill phone call notes for pain medications for the back, migraines, depression and stomach issues from August 2012 through March 2014, where petitioner was not seen in the office (Px42, pg 56) There was only one visit during this time, in March 2013, that the doctor appears to have seen/examined Petitioner. (Id.) The Arbitrator notes that this corresponds with the time period that Petitioner testified to be living out of state, as documented by Dr. McGinness as well.

Dr. McGinness opined that Petitioner's problems to his neck and back are the direct result of his work injuries and that his treatment received was reasonable and necessary. (Px42, pg82) She testified that his subjective complaints were always consistent with her objective findings, specifically with his neurologic exam, physical exam and MRI clearly show targets. (Px42, pg. 83)

When asked why she opined that Petitioner's present condition of ill being as it relates to both the back and neck (as of the deposition date of 12/2/16) was caused in part or by any of the four work related incidents, Dr. McGinness testified: "This --this is a man who'd been seeing us for decades and prior to his injuries he was not what you would call a frequent flier, he was in--- he did have occasional musculoskeletal complaints as a results of hard, physical labor prior to these injuries but you would not see him for months at a time, he was never drug seeking, he would occasionally need a statement for work, and then he had the injuries and he had pain ever since." (Px42, pg. 83-84)

When asked about work restrictions, the doctor testified she believed he was never able to return to work after April 2006, and that she thinks they tried to send him back with restrictions but Petitioner was not able to. (Px42 pg. 84) Dr. McGinness, also opined that Petitioner was permanently and totally disabled and the basis for the opinion was "He has limited strength. He can't get his arms above his head. Baggage handlers have to be able to lift a suitcase that if it doesn't have a heavy tag on it, it weighs 100 pounds and stack it into awkward positions; they may be in a squat, they may be on their knees. The nature of his job is not something you can do with weakness in both hand and both legs due to nerve compression." (Px42, pg84-85)

On cross examination, the doctor acknowledged she did not have all the Midwest Orthopedic records and that she was not aware or did not see that Dr. Fetzer released petitioner to return to work full time and full duty on 4/3/07 given the results of the FCE, positive Waddell's findings, and multiple nonorganic signs. (Px42 pg 87) The doctor also testified that she didn't know Dr. Palmer also reviewed the records and on 4/11/07 released petitioner to return to work in accordance with recommendations from Dr. Fetzer and Dr. Goldberg. (Id.) The doctor was also not aware that Dr. Goldberg, the orthopedic surgeon he was referred to for his back, placed him at MMI and released him to return to work lifting 40 pounds occasionally on 3/7/07. (Px 42, pg88)

Dr. McGinness testified she disagreed with Petitioner's orthopedic treating doctors, Dr. Fetzer, Dr. Palmer, Dr. Goldberg and Dr. Nicholson, who believed Petitioner could return to work full duty or with a 40pound lifting restriction in 2007. (Px42, pg88) She stated she disagreed because of the nature of his job and that he cannot do it with nerve compression. (Px42, pg89) Dr. McGinness opined that even if the orthopedic doctors released him to work with the 40 pound restriction, Petitioner could not return to work in some capacity. (Px42, pg 89) She opined she was in a better position than the orthopedic doctors to make that determination because she looks at Petitioner's total body and level of function and Petitioner could not work.(Id.) On cross exam, the doctor further admitted she was not aware of the inconsistencies in the work conditioning reports by the physical therapists, or in the examinations by Dr. Nicholson and Dr. Fetzer. (Px42 90) Despite not knowing about the above or the invalid FCE, Dr. McGinness testified that her opinions regarding work ability and restrictions remain the same because "given the nature of his job and abnormal MRIs and abnormal nerve conduction studies it is my belief that this man is never able to return to work." (Px42, pg 90)

Dr. McGinness opined that the right shoulder complaints were related to the neck after “looking at how it was evolving over time. But the nerve- but his MRI of his neck demonstrates things that certainly cause shoulder pain.” (Px 42, 90) The doctor discussed in her direct testimony that she “certainly did enough letters” regarding his work status; however, when it was pointed out on cross examination that there are only two letters authorizing petitioner off work at any time, she suggested that off-work notes were instead being written by his orthopedic physicians. (Px. 42 pg 91) The doctor testified migraines preexisted the work accident. (Px42, 97)

The doctor testified that she continued to refill her patient’s medication with phone calls while the petitioner was living in Georgia and she did not see any records from Georgia during this period. After 2009, the petitioner saw Dr. McGinnis for annual medical visits on October 6, 2009, August 17, 2010, June 16, 2011, July 25, 2012, March 14, 2013, March 7, 2014, and September 11, 2015. While he did at some appointments complain of neck and back pain, he was seen for medication refills, swollen glands, abdominal pain and gastrointestinal issues.

Dr. McGinnis testified that prior to the work accidents, she had seen him for back pain on November 4, 2002. (PX 42, pg 101) She saw him May 17, 2004 for neck , muscle spasms and back pain (PX 42, pg 103), and upper back pain June 28, 2004 (PX 42, pg 104), back and hip pain on November 25, 2004 PX 42, pg 104).

Dr. McGinness also admitted on cross examination that she was not aware of Petitioner’s automobile accident in August 2008. She also did not review the medical records from the ER for this automobile accident. (Px42, pg 104-105).

Testimony of Dr. Song- treating surgeon

Dr. Song is a board-certified neurosurgeon. (Px. 45, pg 6) The doctor initially saw the petitioner as an inpatient at Hinsdale Hospital on **November 15, 2022**. He performed a laminectomy from L2 to L4 with fusion. (Px 45, pg. 9) **When asked about whether the prior low back surgery, had any effect on his need for a low back surgery in 2022, the doctor stated, “I don’t have a strong opinion on that. As I said, I could opine on what could have caused the patient’s most recent problems. But whether or not the previous fusion was involved, I can only say possibly.”** (Px 45, pg 13) **When asked to specify his opinion as to what caused his most recent problems, the doctor stated, “well, the differential, as we said, could have been the previous surgery. It could have been any other injury he had in the intervening 15 years or just normal degenerative changes.”** (Px. 45, pg 13) Dr. Song testified he was unaware of the auto accident in 2008. (Px 45, pg 13-14, 24)

On cross examination, Dr. Song did confirm that an automobile accident could be a competent cause of an injury to the low back. (Px. 45, pg 24). The doctor was asked about his report of February 14, 2023, which stated that his lumbar fusion was “apparently causally related” to the adjacent segment disease from his prior lumbar fusion (Px 45, pg. 18), however when asked about that statement on cross examination, the doctor stated that information “must have been from a direct interview with the patient.” (Px 45, pg. 27)

The doctor described adjacent segment disease as “this is a condition where people...had a prior fusion...so over time the remaining segments that were not operated on theoretically can develop more – you know, have to do more work to get the same range of motion. So if they do more work, theoretically, they can wear out quicker.” (Px45, pg.17) Dr. Song testified that he performed a laminectomy from L2 to L4 associated with a posterior lumbar fusion and that he last saw Petitioner on March 7, 2023. (Px45, pg. 19-20) The doctor did not address petitioner’s ability to work in his notes and testified he would defer to Dr. Goldberg or whoever originally gave petitioner the work-related restrictions. (Px45, pg.20)

On cross examination, Dr. Song testified he did not think he had any information specifically written in his notes about what petitioner alleges occurred at work in 2005 or 2006. (Px45, pg. 23) He had not reviewed any prior medical records and testified his opinions regarding a work-related injury or whether it caused any condition of ill being with the neck and back were based on what the petitioner told him about the causal relationship and not from any independent information. (Px 45, pg. 23-24) The doctor had no independent knowledge of the alleged work related injuries or the petitioner’s medical treatment prior to coming under his care. (Px 45, Pg 23-24) Dr. Song did not have any opinion as to whether there was any injury to the cervical spine as a result of any work related accident in 2005 or 2006. (Px 45, pg. 24.)

Dr. Song testified that did not review any medical records regarding an automobile accident Petitioner had in 2008 and that an automobile accident could be a competent cause of injury to the lower back. (Px45, pg 24) In reviewing the medical records from the petitioner’s admissions to the hospital in November 2022, the doctor testified the diagnosis would be low back pain and findings would have been lumbar stenosis and a lumbar degenerative spondylosis. (Px 45, pg. 25) The doctor explained that stenosis is narrowing of the spinal canal or neural foramen can be a degenerative condition but could also be narrowed for any reason. Degenerative spondylosis is arthritis. (Px 45, pg. 26) Following the surgery, the petitioner did well and the doctor’s note of December 6, 2022 stated the petitioner was happy and his chronic low back pain had essentially resolved. (Px 45, pg. 26) On February 7, 2023, the petitioner reported that his left leg symptoms were 80 to 90% resolved and his right leg symptoms were 63% resolved page (px45, pg. 26–27). **Dr. Song testified that he had not issued any work restrictions and would defer to the 25 lb. restriction issued by Dr. Goldberg in 2007.**

Dr. Song was asked about the statement made that the prior lumbar fusion was “apparently causally related” to his work injury in 2006 and also 2014. The doctor explained he did not review any records so the opinion of “ “apparently causally related” must have been from a direct interview with petitioner. (Px45, pg. 27) The doctor also testified regarding petitioner having right arm symptoms and possible right C5-C6 radiculopathy that was complicated by bilateral carpal tunnel surgery he also had. (Px45, pg28)

Dr. Song testified that if the prior lumbar fusion was related to a work accident or injury, and the doctor diagnosed petitioner with adjacent segment disease and that led to the most recent surgery, then the surgery does appear to be causally related to a work injury. (Px45, pg. 30). Even if the prior fusion was not related to a work injury, the doctor testified that “the current issue or most recent issues are still related at least partially to the prior lumbar fusion.” (Id.)

Dr. Song testified that he did not review any of the medical since the prior fusion, did not review Dr. Goldberg's records or prior operative report and has not issued any work restrictions at any time. (Px45, pg.31) The doctor was asked "so, hypothetically, if Dr. Goldberg has stated that the reason why he did the fusion in the first place was a work-related injury, my hypothetical is correct, then. Your causal connection opinion is correct where you say it's causally related because I'm fixing an adjacent segment disease that was caused by a work-related fusion. The doctor answered "I think... As I said before, I believe it is a factor. But, again, is it a major factor? I'm not sure if that's significant. It is a factor, but with so much time in between, it's hard to say how big of a role that played." (Px 45, pg. 32-33)

Testimony of Dr. Mather- Respondent IME

Dr. Steven Mather is a board-certified orthopedic surgeon who testified on **September 5, 2024**. (Rx 3, Pg. 5) Dr. Mather opined that based on the diagnostic films he reviewed, the petitioner had a right L4-L5 and L5-S1 disc herniations. For this condition, if conservative treatment failed, the standard recommended by the American Board of Orthopedic Surgery would be to perform a discectomy. (Rx 3, Pg. 8) He testified fusions are only used to stabilize something or if the patient had an unusual history of chronic back pain for many years which continued and then ruptured the disc. (Rx 3, Pg. 8) **Dr. Mather testified that with respect to the cervical spine, the petitioner sustained only a cervical soft tissue strain or a temporary aggravation of Petitioner's right C4-C5 stenosis which had resolved itself at least by April when his symptoms resolved.** (Id.) The MRI showed only normal degenerative changes of the cervical spine. (Rx 3, Pg. 7-8)

Dr. Mather testified that he found the petitioner to have positive Waddell findings. (Rx 3, Pg. 9) These maneuvers are not supposed to provoke pain and are done to determine if there are any inconsistencies, symptom magnification or functional pain that cannot be medically explained. (Rx 3, Pg.10). Dr. Mather testified that many of the work restrictions were imposed purely based on what the patient said they could do, however, this would be suspect when a patient has a positive Waddell findings as the patient is magnifying their symptoms. (Rx 3, Pg. 13) Dr. Mather also pointed out that the petitioner would go to IMEs and show up with a cane, but then when he was seeing his regular treating doctors, he would not have the cane. He felt this was a clear example of the patient grossly magnifying symptoms. **Despite this, Dr. Mather agreed as a result of the first fusion surgery, the petitioner should have a 25 pound lifting restriction with bending no more than eight times per hour based on the lumbar fusion performed.** (Rx 3, Pg. 13) **In accordance with petitioner's treating physicians at the time, Dr. Mather agreed the petitioner was at maximum medical improvement for the lumbar spine in March 7, 2007 and for the cervical spine on April 3, 2007.** (Rx 3, Pg. 12) The doctor also testified that cervical was non occupational because his own treating physicians placed him at MMI back in 2007 as he didn't really have any significant clinical findings. (Rx3, pg18)

Dr. Mather testified the fusion performed by Dr. Song in 2022 was not related to the work accident and was instead just normal age appropriate or age-related degeneration. (Rx 3, Pg. 19) **In support of this, he pointed out that three years after the original fusion, the patient was already showing stenosis two levels away which strongly indicates it was present to some degree prior to the fusion and progressed in a typical fashion for type of**

degeneration. (Rx 3, Pg. 19) Dr. Mather did agree that as a result of the initial lumbar fusion in 2007, the petitioner required permanent 25 pound lifting restrictions with bending and twisting only eight times per hour. This restriction would preclude his returning to work as a ramp serviceman.

Dr. Steven Mather testified with respect to the cervical spine, the petitioner suffered only a cervical strain or aggravation of the pre-existing stenosis at C4-C5. The petitioner was at maximum medical improvement by April 3, 2007. He did not agree that cervical surgery would be appropriate as there were no indications of myelopathy or any neurological impingement stemming from the cervical pathology at C4-C5. Specifically, he found that even though petitioner has a C3-4 herniation, Petitioner does not have myelopathy or C4 radiculopathy because Petitioner did not have certain positive findings and that the herniations cause tingling as opposed to real pain. (Rx3, pg. 11)

The petitioner was at maximum medical improvement for the lumbar spine as of March 7, 2007 consistent with his treating physicians who initially placed him at MMI. He does not believe petitioner required any further treatment after that date for the lumbar spine. He testified that the fusion surgery performed by Dr. Song in 2022 was due to ongoing degenerative pathology and stenosis noted previously on the MRI done in 2010.

On cross examination, Dr. Mather agreed that petitioner would not be able to return back to work as a baggage handler after a two level fusion and the weightlifting requirements for a baggage handler was at least 50 pounds. (Rx3, pf 26)

David Patsavas- Vocational Rehabilitation counselor

The deposition of David Patsavas, the petitioner's vocational expert, was taken on September 9, 2022. (PX 43) Mr. Patsavas testified he prepared a report in 2019 with medical records reviewed, the petitioner's employment history and his opinion is that there is no stable labor market for Mr. Loving. (Px 43, pg 20-22) He testified that Petitioner could not return as a baggage handler nor could he have returned to any kind of employment as of the time of his assessment, because of petitioner's "lack of transferrable skills, required medication levels, and physical limitations. (Px43, pg21-22). Mr. Patsavas did not perform a labor market survey or do any vocational testing, nor did he perform any computer testing. (Px 43, pg 24-25). When asked what functional restrictions he used in determining there was no stable labor market for Mr. Loving, he appeared to have difficulty answering the question. (Px 43, pg 28-29). He indicated that one of Mr. Loving's physicians indicated he was permanently and totally disabled; he incorrectly suggested another indicated that he should have sedentary restrictions, while he suggested the invalid FCE found he should have a 25-pound restriction. When asked which of these restrictions he used, he could not clearly answer the question and appeared to use various restrictions of light category restrictions and also sedentary restrictions (Px 43, pg 29). He testified that Mr. Loving has not, at any time, looked for alternate employment or provided job search logs. (Px 43, pg 28). In meeting with the petitioner, Mr. Loving also did not express any desire to find employment. (Px 43, pg 28).

Mr. Patsavas' report indicated that the petitioner had a police record. When questioned, Mr. Patsavas did not have any further information regarding that issue. He testified that having a

criminal record could impact types of jobs the petitioner might be able to perform but he did not ask the petitioner to ascertain the impact on any vocational prospects. (Px 43, pg 26-27). When asked what jobs he considered for the petitioner, Mr. Patsavas answered, "none." (Px 43, pg 30).

Testimony of Joe Belmonte- Vocational Rehabilitation counselor

Joseph Belmonte was retained by Respondent to provide vocational services to the petitioner in 2007 following his discharge from care by the physicians at Midwest Orthopedics at Rush. (RX 4.) Mr. Belmonte testified on **November 11, 2022**. Dr. Goldberg the treating surgeon had provided restrictions of 40 lbs. floor to waist, frequent lift of 20 lbs floor to waist, frequent lift of 15 lbs waist to shoulder, occasional lift of 20 lbs. overhead and frequent lift of 10 lbs. overhead. (Rx 4, pg. 51) Mr. Belmonte testified that the petitioner was eligible for employment in a stable labor market at that time within his restrictions. (RX4, Pg. 35) The anticipated likely wage range was \$10 to \$14.50/hour (Rx. 4, Pg. 16)

Following the initial interview and in accordance with the petitioner's restrictions and employment history, a number of different positions were identified which it was felt the petitioner could likely perform. (PX 44, Pg. 15) These included truck dispatcher, aircraft dispatcher, assembler, newspaper circulation clerk and security guard supervisor. (Rx. 4, Pg. 15-16) After administering various tests to identify the petitioner's strengths and weaknesses, additional potential employment opportunities were identified which were a match with the petitioner's abilities. These included charge account clerk, shipping order clerk, route delivery clerk, nutritional aide, electronics utility worker, security gate guard, stock control clerk, information clerk, expeditor, service order expeditor. (RX 4, Pg 23-24)

In addition, Mr. Belmonte testified regarding concerns which were raised as to the petitioner's compliance, interest and motivation in finding work. Mr. Belmonte issued correspondence to Mr. Loving on December 21, 2007 addressing the lack of compliance in the vocational process. (Rx 4, Pg. 29) The concerns centered around three issues. The first involved issues of cooperation, timeliness, attendance, absences and early departures. In addition, there were inappropriate verbal and written comments in response to guidance given to him in good faith by the Vocamotive staff. Finally, there was inappropriate identification of job targets such as Hollywood script writer, congressman or alderman coupled with no apparent effort to identify meaningful job targets consistent with his work history and educational level. (Rx 4, pg 30) Mr. Belmonte requested that Mr. Loving verify whether he was actually willing to cooperate with the job search process and provide an answer by December 26, 2007. (Rx 4, Dep Exh 3)

Mr. Belmonte testified he told the petitioner that "it was my professional opinion that he was not motivated to participate in the service, getting a job was not a priority and that he wasn't cooperating and that I felt that he should be discharged from the service." (Rx 4, Pg. 30) They were willing to give him another chance, however, he Mr. Belmonte laid out that he needed to be realistic in understanding job targets. Mr. Belmonte informed petitioner that he was clearly employable in jobs such as order picking, security, cashier, entry level customer service, mailroom clerk and other jobs. (Rx 4, pg 31)

Mr. Belmonte admitted that during his work with the petitioner, a report was issued prematurely commenting on petitioner's honesty and Mr. Belmonte issued an apology to the petitioner and his attorney on December 21, 2007. (Rx 4 pg 33) They included raw notes which should have been edited down and reviewed by Mr. Belmonte, though through administrative error that did not happen in this case. (Rx 4 pg 33-34)

The records introduced regarding the vocational placement indicate multiple issues raised by Mr. Loving in connection with his efforts. They include that "Mr. Loving stated that he had decided that he wanted to relocate to California and become a Script Writer" (Rx 4, Dep Exh 2) At one point Mr. Loving indicated that he left his last employer as the business was closed. He was questioned on this as United Airlines had not closed, to which he responded, "You told me to answer the questions; I didn't know you wanted the truth." The petitioner is noted not to have completed job search leads or applied to the jobs he was directed to apply for. (Rx 4, Dep exh 2).

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim *O'Dette v. Industrial Comm'n*, 79 Ill. 2d 249, 253 (1980) including that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 63 (1989) It is well established that the Act is a humane law of remedial nature and is to be liberally construed to effect the purpose of the Act - that the burdens of caring for the casualties of industry should be borne by industry and not by the individuals whose misfortunes arise out of the industry, nor by the public. *Shell Oil v. Industrial Comm'n*, 2 Ill.2nd 590, 603 (1954).

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). 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 demeanor of the witness and any external inconsistencies with his/her testimony. Where a claimant's testimony is inconsistent with his/her 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). The Arbitrator, as the trier of fact in this case, has the responsibility to observe the witnesses testify, judge their credibility, and determine how much weight to afford their testimony and the other evidence presented. *Walker v. Chicago Housing Authority*, 2015 IL App (1st) 133788, ¶ 47.

In the case at hand, the Arbitrator observed Petitioner during the hearing and finds him to be only a partially credible witness and his overall testimony is not entirely reliable or credible. He was also a poor historian. The Arbitrator notes Petitioner denied prior low back injuries despite evidence of multiple prior doctor visits for the back pain. Petitioner clearly had some prior back complaints however his work accident on 4/17/06 created a significant change and worsening of Petitioner's lumbar spine. The Arbitrator also finds it important that Petitioner's own treating physicians, including multiple physicians at various medical institutions throughout the years, note

petitioner to have subjective complaints that do not match objective findings or noted symptom magnification.

The Arbitrator further notes that Petitioner is seen on 2020 surveillance video in evidence (Rx8 a, b), volunteering or working with his church, carrying items of unknown weights including clothing, a suitcase and construction cones. The petitioner testified these items and his conduct on surveillance are nonetheless within Dr. Goldberg's permanent restrictions from 2007. The Arbitrator tends to agree that the items are likely within the weight restrictions for carrying/lifting, but notes that this also shows Petitioner is somewhat more active than he testified and likely capable of working within those same restrictions despite testifying that he never attempted to find work within said restrictions. The Arbitrator does not find it reasonable based on the facts of the case and medical evidence, that Petitioner never attempted to find work within the permanent restrictions he was given by Dr. Goldberg in 2007.

Petitioner is and was likely able to do more than be completely off work following his examinations and release from care by Dr. Goldberg and Dr. Fetzer in March and April 2007. However, Petitioner testified that he relied on his PCP, Dr. McGinness, not his orthopedic surgeon and specialists, that he is completely off of work and unable to work. The Arbitrator does not afford the findings and opinions of Dr. McGinness much weight as they are not supported by the record as a whole in this matter. The Arbitrator also notes that despite testifying that he was under doctor's care and/or relying on Dr. McGinness regarding his ability to work from the first date of accident through present, the Arbitrator notes there are also numerous gaps in treatment with Dr. McGinness as elaborated on below: October 2009- August 2010, September 2010- October 2011, October 2011- March 2013 (other than prescription refills with Dr. McGinness), October 2015- March 2016, April 2016-September 2016, May 2017-January 2018, only three visits total in 2018 with Dr. McGinness, May 2019- October 2019 and June 2020 through November 2022. The Arbitrator does note that Petitioner did move a handful of times during this time period which could possibly explain some gaps in care but not all.

Further, the Arbitrator notes Petitioner claims lumbar spine, cervical spine and right shoulder injuries as it relates to his work injuries. The Arbitrator finds petitioner to be credible enough regarding the work accidents and injuries initially sustained, however the Arbitrator has not been convinced that Petitioner's ongoing and current cervical spine, lumbar spine and or right shoulder/arm complaints and progressively worsened conditions, are causally related to the original accidents at work. Despite petitioner's testimony, the Arbitrator finds it to be significant regarding causation, that there was an intervening 2008 rear end motor vehicle collision that occurred, injuring petitioner's low back and neck among other injuries, as well as a large 15 year gap from Dr. Goldberg's issuance of permanent restrictions and Petitioner's necessitating a second lumbar fusion surgery with Dr. Song. It is clear from the medical evidence that petitioner's cervical spine and lumbar spine were injured in the motor vehicle collision requiring medical care. The Arbitrator finds it important that Petitioner's own PCP Dr. McGinness also determined petitioner was injured to the extent following this collision, to be completely taken off a work within a week after that collision.

Regarding the medical witnesses and experts in this case, the Arbitrator finds that overall, the treating physicians, Section 12 examiners and vocational rehabilitation counselors, except for Dr. McGinness, are credible witnesses, however, only finds the opinions of Dr. Goldberg and Drs. Palmer and Fetzer regarding the lumbar spine and cervical spine, Dr. Mather regarding the lumbar spine in part, as well as Mr. Belmonte regarding work capabilities, to be persuasive in making her findings and award as further explained below. The Arbitrator is not persuaded by the opinions of Dr. McGinness, Dr. Song, Dr. Wehner, Dr. Lami and Mr. Patsavas. See below for further discussion.

Issue F, whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds as follows:

To obtain compensation under the Act, a claimant must prove that some act or phase of his employment was a causative factor in his ensuing injuries. It is not necessary to prove that the employment was the sole causative factor or even that it was the principal causative factor, but only that it was a causative factor. *Tolbert v. Ill. Workers' Comp. Comm'n*, 2014 IL App (4th) 130523WC, ¶ 1, 11 N.E.3d 453. "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 Com.*, 93 Ill. 2d 59, 63 442 N.E.2d 908 (1982). Proof of the state of health of an employee prior to and down to the time of the injury, and the change immediately following the injury and continuing thereafter, is competent as tending to establish that the impaired condition was due to the injury. *Kress Corp. v. Industrial Commission*, 190 Ill. App. 3rd 72, 82 (1989).

Therefore, based on a chain of events analysis the evidence shows a causal relationship between the 3/10/06 incident at work and the cervical spine and right shoulder injuries only. Further, based on a chain of events analysis the evidence shows a causal relationship between the 4/17/06 incident at work and the lumbar spine injury that necessitated a fusion surgery and permanent restrictions. The Arbitrator further notes that Petitioner sustained minor lumbar spine injuries at work for Respondent on 11/4/05 and 12/23/05 as well. Petitioner was working full duty without restrictions for Respondent until his first work accident on 11/4/05. Following the 4th accident of 4/17/06, his lumbar spine condition significantly worsened requiring him to seek medical care, be taken off work etc. Regarding the cervical spine, there are clearly some degenerative changes noted on the MRI as well as on the lumbar MRI, however, Petitioner appears to have injured his cervical spine or aggravated it at a minimum, per the Midwest Orthopedic doctors, following the 3/10/06 work accident. Overall, the Arbitrator concludes Petitioner sustained work-related injuries to the lumbar spine and cervical spine but does not find petitioner's current condition of ill-being for both injuries to be causally related. Petitioner reached MMI for all work-related injuries on 4/3/07, per Drs. Goldberg, Fetzer and later Mather.

For the case at hand, Petitioner clearly had prior back pain and some visits with doctors or chiropractors before his four work accidents occurred. The Arbitrator acknowledges that the 2006 lumbar and cervical MRI findings after his work accidents also show some degenerative findings as well but it is still clear to the Arbitrator that the last two work accidents at a minimum, aggravated and worsened Petitioner's cervical and lumbar spine to the point that he required extensive medical treatment for the lumbar spine and needed to be taken off work by his doctors. Even though petitioner was not entirely credible on this issue at trial, medical evidence supports there was some prior back medical history for Petitioner. However, Petitioner was nonetheless working full duty without restrictions for Respondent at the time of first work accident of 11/4/05, and there is no evidence to the contrary. Petitioner also returned to work three times for Respondent before his final work accident on 4/17/06.

The Arbitrator notes that there are questions regarding how the first three accidents occurred. In each case, the accident as testified to by the petitioner does not entirely correlate with the medical history in the contemporaneous medical records.

The petitioner testified that on November 4, 2005, he was hooking up containers for the luggage which weighed about 1,700 pounds. As he was going to clamp the container on the tug he was driving, he slipped on the ice, tried to catch himself and hurt his back (Tr. 24). The medical records from that date at UIC Medical Center at O'Hare indicated instead that he reported lifting heavy bags on his knees in the pit when he twisted the wrong way with a heavy bag. (PX 20)

For the December 23, 2005 accident, the petitioner testified he was hooking up containers to a tug when he injured his back, legs, and hips (Tr. 28). The medical records from December 23, 2005 at UIC at O'Hare instead reflect the petitioner reported continued pain with lifting since the prior injury and acute increase in low back pain and radiation into left thigh when lifting a heavy bag this afternoon. (PX 20).

On March 10, 2006, the petitioner testified that as he was taking luggage out of the containers, he felt something pop in his neck, arm and right shoulder (pp. 29-30). The medical records reflect the petitioner was seen at Celar Chiropractic on March 14, 2006 reporting a new injury while lifting up and tossing a heavy bag. He reported pain in his right shoulder at that time and a shoulder MRI was ordered shortly thereafter.

The foregoing accident issues notwithstanding, the petitioner did not lose any time from work and sought more minimal treatment until the fourth alleged accident in April. On April 17, 2006, the petitioner was in the belly of a plane lifting luggage when he felt a crackle in his low back. He collapsed and was taken by Chicago Fire Department Ambulance to Resurrection Medical Center. The arbitrator finds that the first two accidents of November 4, 2005 and December 23, 2005 involved lumbar strains and the March 10, 2006 accident involved a right shoulder strain and aggravation of cervical spine injury. The injuries from these accidents were superseded by the April 17, 2006 accident.

In reviewing the medical records, they are replete with concerns about symptom magnification and the petitioner falsifying his presentation to his examining physicians. From the first visit with Dr. Nicholson on August 1, 2006, there were concerns about the petitioner's symptom magnification, as his presentation was out of proportion to his physical findings or the pathology seen on the MRI. (Rx 6, pg 87) Dr. Fetzner also noted that on exam he reported he could not actively raise his right arm above his head, however, he then did raise it to approximately 110 degrees of abduction. She outright expressed concern that the petitioner's symptoms were exaggerated. (Rx 6, pg 22)

The work conditioning notes also reflect "the client's refusal to perform resistive activities due to subjective complaints of pain without correlating clinical objective findings." (RX 6, pg 215) He required verbal cues and supervision to remain on task. The therapist went so far as to call this an "invalid" performance in work conditioning. The petitioner was given verbal warnings for non-compliance after receiving specific instructions in the proper conduct for participation. After continuing to demonstrate improper techniques, the therapist noted that "One would expect a client with a high level of low back pain to perform this activity with proper body mechanics to minimize the stress in the low back and to maximize the efficiency of the lift." (RX 6, pg. 216) It was at that point that an FCE with emphasis on validity was recommended. When the FCE was then performed, it was invalid due to submaximal effort from the petitioner. He in fact failed 18 out of 25 objective validity criteria (PX 24). Additionally, he had four out of five positive Waddell's signs for non-organic signs of low back pain. They specifically found that, "Mr. Loving is employable at this time." (PX 24).

This pattern of falsifying his presentation to his examining physicians was also pointed out in the records petitioner submitted related to the decision from the Social Security Administration. (PX 40). The report states,

"As can be seen from the records in this matter, the claimant has severe complaints with respect to his neck and back pain. The record shows that the claimant underwent surgery in September, 2006. All indications in the records show that although the claimant has continued to have severe complaints following the surgery, the objective findings have been minimal. During the physical examinations noted above subsequent to the surgery, it has been noted that the claimant has limitation of motion in the cervical and lumbar spine and the only signs supporting a diagnosis of radiculopathy have been some mild loss of sensation in the right thigh. The claimant has severe complaints which have been out of proportion to the objective evidence. The record is clear that the claimant does not have any limitations in the use of his arms or hands. The restrictions noted by Dr. McGinness are not supported by the record as a whole in this matter. As noted above, there are no treating notes of record to support the severe limitations noted by Dr. McGinness. As a result, the undersigned cannot afford the opinions of Dr. McGinness significant weight. The claimant's overall testimony in this matter was not fully credible. He has alleged very severe symptoms and limitations. He has stated that he has such severe back and neck pain that he cannot stand, walk or sit. However, it is noteworthy that he has not followed through with any epidural steroid injections and has apparently stopped trying any type of physical therapy. The functional capacity evaluation performed on the claimant on March 26, 2007 (Exhibit 16F) shows that claimant was attempting to portray himself much more limited than he actually was." (PX 40, p. 7 of 11).

The Social Security Administration found that while he would have some residual limitations, these would not prevent him from performing sedentary work. They note that with sedentary work there were 1,800 jobs available in the Chicago Metropolitan area for assembly, 1,200 jobs for hand packager, and 1,000 jobs for inspector. The report further indicates,

“The claimant is not persuasive. He said he cannot sit or stand for more than a few seconds and was up and down at the hearing. However, when it was noted he had to sit in the car for more than a few seconds when he goes to appointments and to get to the hearing, the claimant claimed that at every stoplight he opens the car door and stretches his legs out the door. This is rather hard to believe. It is noted that the claimant stated he has not driven since his back surgery in September, 2006. While it was pointed out that he was driving when he was involved in the motor vehicle accident in August, 2008 (Exhibit 11F), the claimant asserted that that was the only time he has driven since surgery. He claimed that his son was driving him to the doctor and got lost, so he had to take over the driving and then got into the motor vehicle accident. Other inconsistencies include the claimant testifying he cannot handle finances, he has done no cooking in the past two years and doing dishes, but information in Exhibits 4E and 8E suggest otherwise.” (PX 40, pg. 7 of 11)

The report further notes that while the claimant stated he had been using a cane for two years, an exam on November 13, 2007 indicated the petitioner did not have a cane and his gait was within normal limits.

The Arbitrator notes that a finding from the Social Security Disability Administration has no precedence. The Arbitrator does take note of the fact that inconsistencies were found, and that the trier of fact found the petitioner not credible with respect to his presentation and the testimony presented. This is consistent with the inconsistencies found in petitioner’s treatment at Midwest Orthopaedics at Rush and the functional capacity evaluation, among other records.

Later medical records also suggest that petitioner is not being forthright. The PT records from Saint Joseph’s/Candler Health System in Georgia include that petitioner washed, waxed and detailed his car over the weekend and then a week later he reported feeling well and “I feel like I could play football.” These comments were made in October 2015, the same month that Dr. Goldberg saw him and recommended cervical surgery. The Rush Oak Park Physical Therapy notes also repeatedly indicate significant self-limiting tendencies, and noted “observed movements and behaviors inconsistent with subjective reports” on October 28, 2019. Also on November 4, 2019, they again indicate the self-limiting tendencies and inconsistent observed movements and behaviors which were inconsistent with subjective reports.

All of these issues raise concerns regarding the petitioner’s presentation. Notwithstanding those concerns, the Arbitrator still finds that the petitioner suffered an injury to his low back on April 17, 2006 which necessitated a lumbar fusion. Dr. Goldberg who evaluated the petitioner on August 18, 2006 opined that the petitioner sustained a disc herniation and aggravated his degenerative disc disease with the work-related accident.

While Dr. Wehner could not substantiate any injury other than a sprain and Dr. Mather opined that a discectomy would have been more appropriate in light of the pathology on the MRI, the Arbitrator still agrees it was reasonable for the petitioner to follow the surgical recommendation of Dr. Goldberg. Dr. Goldberg was persuasive and credible in his testimony regarding his diagnosis of Petitioner's lumbar spine and the fusion surgery that was needed. Following the surgery, the petitioner had a favorable result to surgery. Despite the petitioner's testimony as to a "failed fusion", there is no evidence in the record to substantiate such a diagnosis. Instead, the records show he had an uncomplicated postoperative course and described successful resolution of his symptoms. Dr. Goldberg authorized the petitioner to return to work lifting 40 pounds occasionally from floor to waist, 25 pounds waist to shoulder, and overhead 20 pounds occasionally and placed the petitioner at MMI on March 7, 2007. (Rx. 6, pg 61) Regarding the cervical spine, Dr. Fetzer released to return to work full time and full duty on April 3, 2007 following the invalid FCE (Rx 6, pg 8)

Upon follow up questions by the arbitrator at trial, Petitioner testified that he felt a crackle and pain in the neck with the injury of April 17, 2006. This, however, is not supported by the medical records. Based on the Ambulance records and when the petitioner was seen at Resurrection Medical Center on April 17, 2006, he reported only low back pain. (PX 7). The history given was that he bent over to pick up a luggage bag and felt something pull in his back. A pain diagram also indicates pain only in the low back. The Chicago Fire Department ambulance records specifically note he had no neck or upper back pain. The petitioner described he felt something in his lower back go crunch after he bent over and lifted a piece of luggage (PX 7). Contrary to what the petitioner advised the Arbitrator, there was no injury to the neck or upper back reported at the time of the April 17, 2006 work accident. That said, based on the medical records and testimony by Dr. Goldberg, the Arbitrator finds that Petitioner did sustain a cervical injury and aggravation of his neck condition on the 3/10/06 accident date.

The Arbitrator notes that the petitioner also suffered an auto accident in August of 2008 which resulted in increased neck and back pain. He treated at Loyola ER, then with West Suburban Medical through early 2009.

In August 2010, Petitioner called Dr. McGinnis to request a cervical MRI and then went to see Dr. Goldberg, who he hadn't seen since his discharge from care in 2007. He reported that he had been constantly in pain for the last three weeks. It is unclear what caused this exacerbation. Dr. Goldberg recommended surgery but the petitioner did not want to proceed. Dr. Lami then performed an IME and opined that he did not need cervical surgery.

The basis for the surgery recommendation was concern for myelopathy. The petitioner's tests for myelopathy at his exams, however were inconsistent. Dr. Ganapathy on November 18, 2014 noted myofascial pain which was non-dermatomal and stated, "I am not convinced that he has myelopathy as today's exam was not in keeping with the exam finding from last visit." He referred the petitioner to Dr. Smucker for a possible diagnostic injection, but Dr. Smucker found his "symptoms of pain and paraesthesias were not consistent during the time of my discussion with him".

The neurologic exam showed no upper or lower extremity atrophy and balance and coordination were normal. Lower extremity neural tension signs were negative bilaterally. His lumbar range of motion was limited, but there was no focal mechanical reproducible pain. Cervical range of motion was also normal. Shoulder impingement was inconsistently positive on the left. Motor strength testing featured break away weakness through the proximal and distal bilateral upper and lower extremities. Dr. Smucker was concerned about the non-physiologic findings with diffuse inconsistent breakaway weakness on exam. The doctor did not see evidence of any cervical myelopathy, as such, he did not believe that the requested diagnostic cervical selective nerve root blocks would be valid in an individual with widespread inconsistencies on exam and in described symptoms.

Dr. Lami testified that the petitioner's condition of ill being in the cervical spine was not causally related to the work accident of April 17, 2006, or to any of the other work accidents. Dr. Mather testified that with respect to the cervical spine, the petitioner sustained only a cervical soft tissue strain or a temporary aggravation of Petitioner's right C4-C5 stenosis which had resolved itself at least by April when his symptoms resolved. Dr. Goldberg testified the petitioner injured both the cervical and lumbar spine at work, however, when asked about whether his current conditions were related to the work accident, Dr. Goldberg seemed to equivocate and could not affirmatively answer the question. He also was not aware of the automobile accident in 2008. Dr. Song also offered no opinion on whether the petitioner's condition of ill-being with respect to his cervical spine was causally related to the employment.

Overall, the Arbitrator finds that Petitioner sustained a cervical injury and right shoulder injury on 3/10/06 and a lumbar spine injury on 4/17/06. The petitioner also sustained more minor back injuries on 11/4/05 and 12/23/05. Regarding causation for Petitioner's current condition of ill being, the Arbitrator overall relies on the opinions and findings of both Dr. Goldberg in part and Dr. Mather, in part, in finding that: 1) Petitioner sustained work related lumbar spine and cervical spine injuries 2) Petitioner required lumbar fusion surgery and related care as provided by Midwest Orthopedics at Rush to his neck and back and 3) Petitioner was at MMI for his cervical spine in April 2007 and for the lumbar spine, March 2007 4) Petitioner required permanent restrictions and could not return to his prior job as a ramp agent for Respondent. The Arbitrator finds it reasonable that Dr. Wehner and Dr. Lami agree with the permanent restrictions of 25 pounds regarding the lumbar spine due to the fusion, but does not otherwise find their opinions to be persuasive. The Arbitrator does not find Dr. McGinness to be credible and is not persuaded by Dr. Song.

The Arbitrator relies on Dr. Goldberg's opinion when he gives causation for both the neck and back injuries as of the time he testified in 2016, however the Arbitrator does not agree that Petitioner's ongoing lumbar and cervical spine conditions as of 2016 are still related to the 2005 and 2006 work accidents. Unlike the IME physicians, Dr. Goldberg finds Petitioner did sustain a work-related cervical spine injury. However, there are no further treatment dates, opinions obtained or discussion with Dr. Goldberg regarding petitioner's conditions after his 2016 deposition. At this time, petitioner had still not had the 2022 second fusion, nor was Dr. Goldberg privy to the various IME opinions, deposition testimony and overall treatment records from 2016 to present. There are also no strong or persuasive opinions for causation of petitioner's current conditions after this deposition. The Arbitrator is also not persuaded

regarding Petitioner's current condition by Dr. Song who did not have all the records or a clear and complete picture of Petitioner's medical history. Dr. Song also deferred to Dr. Goldberg regarding work restrictions. Dr. Goldberg the treating surgeon, previously had provided restrictions of 40 lbs. floor to waist, frequent lift of 20 lbs floor to waist, frequent lift of 15 lbs waist to shoulder, occasional lift of 20 lbs. overhead and frequent lift of 10 lbs. overhead.

Regarding the lumbar surgery: while Dr. Mather's opinions are somewhat persuasive, the arbitrator more so relies on Dr. Goldberg's opinions which are convincing regarding the lumbar spine and the need for the fusion surgery he performed in 2006 and that was successful in helping petitioner's right leg complaints. The Arbitrator also finds it important that Dr. Goldberg testified that when Petitioner originally saw him regarding the lumbar spine, he has right leg symptoms improve after surgery, and it is not until a few years later where petitioner is getting bilateral leg pain and new pathology at other levels. Regarding the cervical, Petitioner had neck towards the right shoulder originally, over the course of time it appeared to progress into some early myelopathic findings. (Px41, pg54) It is clear per Dr. Goldberg that there was a change in petitioner's lumbar spine and cervical spine over the years, from the 2007 release from care with permanent restrictions and the 2010, 2013 and 2015 visits (last visit) with Dr. Goldberg.

It is noted that Dr. Goldberg last saw Petitioner in October 2015. Regarding causation for the back and neck and whether Petitioner's present condition of ill being is caused in whole or in part by any of the four work related accidents, the doctor testified the lumbar yes in whole part because "unfortunately he developed adjacent level problems." (Px41, pg. 54) Regarding the neck, he testified "all I can state is he did have an injury, he was treated by some of my partners, had some temporary improvement its not progressed." (Id.) The Arbitrator notes that the doctor found some adjacent level issues, however he also found that there was a stable lumbar fusion and he did not recommend further lumbar surgery. It important to note that the doctor did not change petitioner's work status or provide any additional opinions that changed the prior permanent restrictions he imposed in March 2007 for the lumbar spine.

In addition, regarding the neck, Dr. Goldberg did not find the condition to be worsening in 2015 but continued to recommend cervical surgery that petitioner declined and was also not approved. Dr. Goldberg as the treating surgeon was in the best position to opine as to Petitioner's conditions in 2006 and 2007, regarding the lumbar spine as well as cervical spine for finding a work related injury. He personally saw petitioner and examined him multiple times. He took numerous MRIs and reviewed many of them. He relied on his own medical records and those of his colleagues at Midwest Orthopedics. He was involved early on with petitioner's care and treatment and saw him from 2006 through 2015 (on and off). He testified that his opinions on the cervical spine was predicated on his review of Drs.' Palmer and Fetzer notes as well. Specifically, he testified that his colleagues thought petitioner had a shoulder condition and records reflect that petitioner injured his right shoulder and neck as well. The Arbitrator finds it important and persuasive that the doctor's objective findings matched petitioner's subjective complaints during his treatment of him, despite other treating physicians and IME doctors finding symptom magnification. There was clearly symptom magnification documented by numerous treating physicians per the extensive medical records in this case but it appears that with Dr. Goldberg, Petitioner was more credible with his pain complaints. All of the IME doctors

also documented symptom magnification and/or unexplained subjective complaints which goes towards credibility of Petitioner.

Regarding his history with petitioner, Dr. Goldberg testified that for the initial treatment starting in August 2006, he was primarily treating petitioner's back however he did previously review the cervical spine MRI in November 2006. (Px41, pg 35) The doctor opined that the prior 2006 MRI showed there were disk herniations at C3-4 and C4-5; at C3-4 it was central, at C4-5 it was central to the right; and there was a smaller herniation at C5-6 and C6-7. (Id.) It is therefore appears to the arbitrator that Petitioner sustained a right shoulder and neck injuries as described above by Dr. Goldberg, in the 3/10/06 injury. Importantly, Petitioner, per Dr. Goldberg had herniations on his cervical MRI as of November 2006.

It was reasonable for Dr. Goldberg to give permanent restrictions in this case Dr. Goldberg provided restrictions following work hardening of 40 lbs. floor to waist, frequent lift of 20 lbs floor to waist, frequent lift of 15 lbs waist to shoulder, occasional lift of 20 lbs. overhead and frequent lift of 10 lbs. overhead. Despite not agreeing with Dr. Goldberg in performing a fusion surgery, Dr. Mather agreed as a result of the first fusion surgery, the petitioner should have a 25 pound lifting restriction with bending no more than eight times per hour based on the lumbar fusion performed. (Rx 3, Pg. 13) This is reasonable to the Arbitrator. In accordance with petitioner's treating physicians at the time, Dr. Mather agreed the petitioner was at maximum medical improvement for the lumbar spine in March 7, 2007 and for the cervical spine on April 3, 2007. (Rx 3, Pg. 12)

Dr. Mather testified that with respect to the cervical spine, the petitioner sustained only a cervical soft tissue strain or a temporary aggravation of Petitioner's right C4-C5 stenosis which had resolved itself at least by April when his symptoms resolved. (Id.) The Arbitrator is persuaded by this opinion based on his testimony and the record as a whole. Dr. Mather, like the other IME doctors in this case, testified that he found the petitioner to have positive Waddell findings. (Rx 3, Pg. 9) These maneuvers are not supposed to provoke pain and are done to determine if there are any inconsistencies, symptom magnification or functional pain that cannot be medically explained. (Rx 3, Pg.10). Dr. Mather also pointed out that the petitioner would go to IMEs and show up with a cane, but then when he was seeing his regular treating doctors, he would not have the cane. He felt this was a clear example of the patient grossly magnifying symptoms. Dr. Mather further opined that petitioner was at maximum medical improvement for the lumbar spine as of March 7, 2007 consistent with his treating physicians who initially placed him at MMI. He does not believe petitioner required any further treatment after that date for the lumbar spine. The Arbitrator agrees. He testified that the fusion surgery performed by Dr. Song in 2022 was due to ongoing degenerative pathology and stenosis noted previously on the MRI done in 2010. The arbitrator finds this opinion to be persuasive. On cross examination, Dr. Mather agreed that petitioner would not be able to return back to work as a baggage handler after a two level fusion and the weightlifting requirements for a baggage handler was at least 50 pounds. (Rx3, pf 26)

The Arbitrator finds that Dr. McGinness is not entirely credible and is not more credentialed than the board-certified surgeons, both neuro and orthopedic who testified in this case. Petitioner testified that the doctor kept him off of work and he relied on her for his work status, appearing to disregard Dr. Goldberg's permanent restrictions. Further, Dr. McGinness was not aware that Petitioner had been released from Midwest Orthopedic surgeons and doctors with permanent restrictions. Despite being later informed, the doctor testified she was still more qualified to opine on restrictions for petitioner. This is not reasonable to the Arbitrator, that a primary care physician would possibly disregard work conditioning and/or FCE testing results and permanent restrictions imposed by the medical group Dr. McGinness apparently referred petitioner to because she is not a specialist or orthopedist.

The Arbitrator also finds it important to note that there were large gaps in care with Dr. Goldberg where petitioner treated with various other doctors and it appears petitioner never informed Dr. Goldberg or his other doctors of the MVC in August 2008 where he injured his neck and back, and also complained of chest pain. Dr. Mather is the sole doctor to have reviewed all of the treating records and was aware of the various medical opinions and additional treatment after the 2016 Dr. Goldberg deposition, as well as the 2008 MVC. While the Arbitrator finds causation for the injuries, that causation cuts off in 2007 when Petitioner is released from care. The lumbar fusion performed by Dr. Goldberg as well as all of Petitioner's care and treatment through April 2007 would also be causally related to the work injuries he sustained.

The Arbitrator agrees that petitioner's cervical spine and lumbar spine injuries to an extent, would be related to the work accidents. However, petitioner's current condition of ill-being for both injuries would cut off as of Dr. Goldberg's 2007 release from care. Regarding the myelopathy diagnosis, the Arbitrator notes Dr. Goldberg's findings and that the doctor testified it is a diagnosis that can wax and wane but the arbitrator is not persuaded this is work related due to numerous other doctors (treater and IME alike) not finding the same at any other examination over the years and because of the gaps in medical care among the numerous treating doctors . Therefore, the petitioner more than likely, at a minimum, aggravated both his neck and low back based on some of the generative findings shown on MRI scans and treating records, in these work accidents. In summary, his ongoing issues for many years after the 2007 release from care by Midwest Orthopedics at Rush, would not be related to his work accidents with Respondent.

The Arbitrator finds based off the extensive medical over 20 years, 8 depositions, the record as a whole that Petitioner sustained a neck injury and right shoulder injury in the 3/10/16 work accident and injured his low back in the 4/17/06 accident, in addition to injuring his lumbar spine in both 2005 work accidents as well. Despite his testimony at trial that he injured his neck on 4/17/06, the Arbitrator agrees with the IME doctors that the medical does not support that the cervical spine injury occurred on the 4/17/06 date. Regardless, like Dr. Mather opines, Petitioner sustained a cervical injury that would have resolved by the April 2007 release from care by his treating doctors.

Psychological

Petitioner introduced records of Dr. Gierl into evidence. (PX 14) The Arbitrator notes these are handwritten and difficult to decipher. Dr. Gierl issued a report dated February 18, 2019 to the Veterans Administration noting he had been seeing the petitioner since March 7, 2014 for severe depression. He noted that on or about August 16, 2017, the petitioner reported PTSD symptoms and reported trauma and abuse to the doctor from when he was in military training. The petitioner described suffering physical, verbal and emotional abuse to the doctor. He states this has been verified as he was discharged from the military after this abuse came to light. He reported this was still causing nightmares, flashbacks and severe emotional distress. It was his recommendation he receive his medication through the Veterans Administration due to PTSD symptoms which are the result of trauma and abuse experienced during military training. (PX 14).

In addition, when he was seen for treatment of the auto accident at West Suburban Medical Center on September 26, 2008, the Arbitrator notes he reported depression since the auto accident. (Px 28) The petitioner did not appear to testify to any ongoing psychological condition and the medical introduced supports an alternate cause of any psychological condition. Accordingly, the Arbitrator finds that there is insufficient evidence to support that any condition of ill-being with respect to petitioner's psychological condition is related to the work injuries.

Issue K, whether Petitioner is entitled to temporary total disability benefits, the Arbitrator finds as follows:

A claimant is temporarily totally disabled from the time an injury incapacitates him from work until such time as he is as far recovered or restored as the permanent character of his injury will permit. *Westin Hotel v. Indus. Comm'n*, 372 Ill.App.3d 527, 542 (1st Dist. 2007). In determining whether a claimant remains entitled to receiving TTD benefits, the primary consideration is whether the claimant's condition has stabilized and whether she is capable of a return to the workforce. *Interstate Scaffolding, Inc. v. Illinois Workers' Comp. Comm'n*, 236 Ill.2d 132, 148 (2010). Once an injured employee's physical condition stabilizes, she is no longer eligible for TTD benefits. *Archer Daniels Midland Co. v. Indus. Comm'n*, 138 Ill.2d 107, 118 (1990). To be entitled to TTD benefits, it is the claimant's burden to prove not only that he did not work but also that he was unable to work. *Holocker v. Illinois Workers' Compensation Comm'n*, 2017 IL App (3d) 16036WC, P35 (3rd Dist., 2017). The fundamental purpose of the Act is to provide injured workers with financial protection until they can return to the work force. *Id.* When determining whether an employee is entitled to TTD benefits, the test is whether the employee remains temporarily totally disable as a result of a work-related injury and whether the employee is capable of returning to the work force. *Id.* The touchstone for determining whether claimant is entitled to TTD is whether the claimant's conditions had stabilized to the extent that they are able to reenter the workforce. *Id.* at P40.

The Arbitrator finds based on the facts as discussed above, that the petitioner reached MMI for the lumbar spine on March 3, 2007 as was found by Dr. Goldberg his treating surgeon and MMI full duty for the cervical spine on April 3, 2007 per Dr. Fetzer.

The petitioner was released to return to work with permanent restrictions per Dr. Goldberg. As he was authorized off work from April 17, 2006 until he is placed at MMI, the petitioner is owed TTD benefits from April 17, 2006 to April 3, 2007, or 50 2/7 weeks at a TTD rate of \$723.85/week.

After April 17, 2006, work restrictions were imposed by Dr. Goldberg which precluded his return to work in his prior capacity as a ramp serviceman. Vocational rehabilitation was provided by the respondent through Vocamotive. Despite the personnel issues that eventually occurred with Vocamotive with Petitioner, the Arbitrator finds that Petitioner did not appear to actively cooperate in that process and terminated vocational services on December 21, 2007. The petitioner testified and the record confirms that he did not at any time look for alternate employment within his restrictions. While the petitioner testified that he was kept off work by Dr. McGinness, there are not medical records which support this and this is contrary to all of the other doctors involved in his case. It appears there was no opinion provided that the petitioner could not return to work or was permanently disabled until Dr. McGinness testified on December 2, 2016. Dr. McGinness addressed work restrictions at her deposition on December 2, 2016 and in only two work restriction notes which are dated May 2, 2006 and November 5, 2007 (PX 19, pg 242 and 243). The doctor testified that the petitioner's treating orthopedic physicians were instead responsible for addressing his work status. His treating orthopedists all returned him to work in some capacity. The Arbitrator did not find Dr. McGinness to be a credible or persuasive witness.

Accordingly, maintenance benefits are awarded from April 4, 2007 to December 21, 2007 when petitioner terminated vocational rehabilitation and quit any effort to look for alternate employment within his restrictions. Respondent is given a TTD credit for the \$71,350.62 in benefits paid prior to trial.

Issue L, the nature and extent of the injury, the Arbitrator finds as follows:

As Petitioner's accidents occurred before September 1, 2011, adherence to Section 8.1b(b) of the Act is not required for establishing permanent partial disability but it is helpful to the Arbitrator in analyzing the permanency of the injury Petitioner sustained. In determining PPD benefits, Section 8.1b(b) of the Act directs the Commission to consider: "(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." 820 ILCS 305/8.1b(b); *Con-Way Freight, Inc. v. Illinois Workers' Compensation Comm'n*, 2016 IL App (1st) 152576WC, ¶ 22, 67 N.E.3d 959. "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b). "None of the factors set forth in section 8.1b is to be the sole determinant of the claimant's disability." *Corn Belt Energy Corp. v. Illinois Workers' Compensation Comm'n*, 2016 IL App (3d) 150311WC, ¶ 49.

As the claimant's disability is not limited in nature that he is obviously unemployable, and as there is no medical evidence to support a claim of permanent total disability, the burden is upon the petitioner to establish the unavailability of employment to a person in his circumstances. *Valley Mould & Iron Co. v. Industrial Comm'n*, 84 Ill. 2d 538, 546-47 (1981).

An employee is totally and permanently disabled when he is unable to make some contribution to industry sufficient to justify payment of wages to him. *A.M.T.C. of Illinois v. Ind. Comm'n*, 77 Ill.2d 482, 487(1979). It is the petitioner's burden to establish that he falls into the 'odd lot' category either by showing that evidence of a diligent but unsuccessful attempt to find work, or by showing that because of his age, skills, training, experience and education that he cannot find regular employment. The Petitioner here has not presented sufficient evidence of either. He has not looked for any work and the restrictions are not so limiting to establish that there is no employment available to him. The Arbitrator was not persuaded by the opinions of Mr. Patsavas for reasons previously explained.

The petitioner's request for a permanent total disability award pursuant to Section 8(f) of the Act is not supported by the evidence. Overall, the long timeline of petitioner's injuries and treatment appear to show Petitioner sustained a serious and permanent lumbar spine injury that required lumbar spine fusion surgery. He also suffered right shoulder injury that was misdiagnosed and/or developed into a cervical spine injury. The Arbitrator finds that Petitioner should have attempted to work within the permanent restrictions his surgeon Dr. Goldberg provided, as he was found at MMI by his treating physicians by April 2007. Despite this, Petitioner admitted during testimony, he never attempted to find work. Dr. Mather, one of Respondent's IME, also agreed that Petitioner required lumbar surgery (disagreed with a fusion) and permanent restrictions and could not return to his old job. Dr. Lami and Dr. Wehner, also agreed with the permanent restrictions Dr. Goldberg gave in 2007. Dr. Song, petitioner's most recent neurosurgeon/treater never gave work restrictions and also testified that he would defer to Dr. Goldberg's restrictions. The Arbitrator finds Petitioner to have suffered a significant low back injury that permanently injured him to the point he could never return to work as a ramp agent for Respondent, as he was given permanent restrictions. This is and was a loss of trade injury as of 2007. However, the Arbitrator is not convinced Petitioner is permanently and totally disabled after review of the numerous medical evidentiary records over the last 20 years, eight depositions and other professional vocational opinions provided. See further analysis below regarding permanency.

The restrictions imposed by Dr. Goldberg were restrictions to lifting 40 pounds occasionally from floor to waist, 25 pounds waist to shoulder, and overhead 20 pounds occasionally. Even if the petitioner was limited to lifting 25 lbs as suggested by the invalid FCE, the IME doctors and Dr. Song, the restrictions were not so onerous as to make the petitioner not employable. Following petitioner's discharge with restrictions, the respondent provided vocational services through Vocamotive. He was not, however, cooperative with the process. Mr. Belmonte identified jobs for the petitioner within his restrictions which included truck dispatcher, aircraft dispatcher, assembler, newspaper circulation clerk, security guard supervisor, order picking, security, cashier, entry level customer service, mailroom clerk and other jobs. As a lead ramp agent, the petitioner was responsible for making sure the plane goes out on time and everything was on the plane that was supposed to be loaded. Accordingly, the petitioner was equipped to perform supervisory duties.

Rather than undertake a good faith effort to participate, the petitioner appeared to make excuses, stated he wanted to relocate to California, and proposed that he be a Senator or Hollywood script writer. He reported he couldn't complete his job search assignments as he had to have Christmas lights installed.

Petitioner refused to participate in any job search activities on days that he was not at Vocamotive. Rather than applying for job leads provided to him, he apparently left inappropriate commentary on his computer. This further demonstrates that Mr. Loving was not taking the job search seriously. The Arbitrator notes there was testimony regarding petitioner's pain levels and effect of pain medications on him at Vocamotive. Some of his testimony regarding these issues was mentioned in the treating records and some of petitioner's poor performance at vocational rehabilitation would be explained by his pain medications/ sleepiness but not all. Since 2007, it is clear from the record that the petitioner has not at any time undertaken a job search of any kind.

The Arbitrator finds the report Mr. Patsavas undertook in 2019 insufficient to prove petitioner is not employable. It appears that the report was not prepared in effort to find the petitioner alternate employment. Mr. Loving also did not express any desire to find employment to Mr. Patsavas. Nor was Mr. Patsavas able to identify any jobs he considered for Mr. Loving. Mr. Patsavas did not conduct an interest inventory to assess what areas of employment may be appropriate for the petitioner. He did not evaluate whether the petitioner was a candidate for a retraining program or any classes which would improve his employment prospects. No explanation was provided as to why the petitioner could not work in one of the employment sectors identified by Mr. Belmonte as within the petitioner's restrictions per his treating surgeon, Dr. Goldberg. In short, Mr. Patsavas, the vocational expert hired by the petitioner's attorney, did not do any testing or evaluation of the petitioner other than meeting briefly with the petitioner to review his work restrictions, employment history and transferable skills.

Although Mr. Patsavas knew the petitioner had a criminal record and that this could impact what types of jobs he could perform, he did not request information from the petitioner at his intake evaluation as to the extent of that criminal record. Mr. Patsavas should have done more to properly assess petitioner's prospective job options and make further efforts to determine whether petitioner was employable or to assist petitioner in finding employment himself. His limited or more abbreviated report undermines the persuasiveness of his report to the Arbitrator.

The Respondent paid maintenance benefits and offered pay for vocational rehabilitation, including a job search. The petitioner terminated those services, has never requested any other vocational assistance and has not shown any interest in finding work. Accordingly, the petitioner has not proven an entitlement to permanent total disability benefits under Section 8(f).

The Arbitrator instead turns to an assessment of the petitioner's permanent partial disability. 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 ramp serviceman at the time of the accident and that he is not able to return to work in his prior capacity as a result of said injury and permanent restrictiond. The Arbitrator notes that this was a low skilled position, but because it is no longer available to the petitioner, the Arbitrator gives significant weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 46 years old at the time of the accident. Because he is now 65 years old and at retirement age, 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 that the petitioner has permanent restrictions of 25 lbs lifting as a result of the work accident and injury to his lumbar spine. That said, such a restrictions likely would not have impeded Mr. Loving from many potential occupations should he have had the desire to return to work from 2007 to present. Based on the opinions of the vocational expert Joseph Belmonte in 2007, the petitioner could have returned to work with earnings between \$10 and \$14.50/hour. The Arbitrator therefore gives greater 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 no records of any treatment after the discharge from Dr. Song on March 7, 2023, were introduced into evidence. In addition, Petitioner testified that he had not had treatment since that time. At that time, the petitioner complained of neck pain but there are no recorded complaints for his low back. There is little documentation of current lumbar spine disability in the medical records, however Petitioner was still precluded from returning to work as of March 2007 due to his serious lumbar injury. Despite not finding petitioner's current conditions of ill-being for the lumbar spine and cervical spine related to his work injuries, the Arbitrator relies on Dr. Goldberg assigning permanent restrictions which prevented Petitioner from returning to work for Respondent as a ramp agent as of his release from care. These restrictions were not disputed by Dr. Mather. IME doctors Dr. Lami and Dr. Wehner, also agreed with the imposition of permanent restrictions due to the lumbar fusion surgery performed. The Arbitrator therefore gives more 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 55% loss of use of the person as a whole pursuant to §8(d)2 of the Act. Respondent shall pay Petitioner permanent partial disability benefits of \$651.46/week for 275 weeks, because the injuries sustained caused 55% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

For the reasons stated above, Petitioner is entitled to an award of benefits under The Illinois Workers' Compensation Act consistent with the findings herein.

It is so ordered:



Jacqueline C. Hickey
Arbitrator

3/3/25
Date

March 4, 2025

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	06WC021815
Case Name	Shelton L Loving v. United Airlines
Consolidated Cases	06WC021799 06WC021800 07WC002653
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	25IWCC0501
Number of Pages of Decision	58
Decision Issued By	Carolyn Doherty, Commissioner

Petitioner Attorney	Donald Gallagher
Respondent Attorney	Karen Coon

DATE FILED: 12/19/2025

/s/ Carolyn Doherty, Commissioner

Signature

06 WC 21815

Page 1

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)
☐ Modify	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Shelton L. Loving,
 Petitioner,

vs.

No: 06 WC 21815

United Airlines, 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 causal connection, temporary total disability, maintenance, 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.¹

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 4, 2025, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under Section 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.

¹ Petitioner's Petition for Review refers to 06 WC 21799, which was tried together with the claims in 06 WC 21800, 06 WC 21815, and 07 WC 2653, and the Arbitrator issued four decisions. The Statement of Exceptions of both parties address the issues in all four claims. Accordingly, the Commission is issuing four separate decisions in this matter.

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.

December 19, 2025

O: 12/10/25

CMD/kcb

045

/s/ Carolyn M. Doherty
Carolyn M. Doherty

/s/ Raychel A. Wesley
Raychel A. Wesley

/s/ Frank J. Soto
Frank J. Soto

ILLINOIS WORKERS' COMPENSATION COMMISSION
DECISION SIGNATURE PAGE

Case Number	06WC021815
Case Name	Shelton L Loving v. United Airlines
Consolidated Cases	06WC021799; 06WC021800; 07WC002653;
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	55
Decision Issued By	Jacqueline Hickey, Arbitrator

Petitioner Attorney	Donald Gallagher
Respondent Attorney	Karen Coon

DATE FILED: 3/4/2025

/s/Jacqueline Hickey, Arbitrator
Signature

THE INTEREST RATE FOR THE WEEK OF MARCH 4, 2025 4.14%

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

Shelton L. Loving

Employee/Petitioner

v.

United Airlines, Inc.

Employer/Respondent

Case # **06 WC 21815**

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 **Jacqueline Hickey**, Arbitrator of the Commission, in the city of **Chicago**, on **9/30/24**. 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 **3/10/06**, 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 **\$56,460.04**; the average weekly wage was **\$1,085.77**.

On the date of accident, Petitioner was 46 years of age, married with **4** dependent children.

ORDER

No permanent partial disability is awarded for this injury and this case. Permanency is awarded for Petitioner's 4/17/06 case only. Please see Decision in 07 WC 002653 and attached Rider to Decisions.

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 4, 2025

First Work Accident: 11/04/05

On November 4, 2005, the petitioner testified he was hooking up two containers for the luggage which weighed about 1,700 pounds. As he was going to clamp the container on the tug he was driving, he slipped on the ice, tried to catch himself and hurt his back (Tr. 24). The petitioner was seen at UIC Medical Clinic at O'Hare and was treated with muscle relaxers. The petitioner worked full duty until his second work accident and did not lose any time after this accident (Tr. 26-27).

Second Work Accident: 12/23/05

On December 23, 2005, the petitioner testified he was hooking up containers to a tug. He was hooking up two containers back-to-back and he injured his back, legs, and hips (Tr. 28). He once again was seen at UIC at O'Hare and then at Celar Chiropractic (Tr. 28). Petitioner testified he was also referred to and seen by Dr. McGinness, his primary care physician, by Celar. (Tr. 29). Again, the petitioner did not lose any time from work. (Id.)

Third Work Accident: 3/10/06

On March 10, 2006, the petitioner was handling luggage. As he was taking the luggage out of the containers to put on the belt, he felt something pop in his neck, arm and right shoulder (pp. 29-30). Petitioner sought treatment with Dr. McGinness, Celar Chiropractic, and Rush Oak Park Hospital (Tr. 31) but he continued working full duty (Tr. 31).

Fourth Work Accident: 4/17/06

On April 17, 2006, the petitioner was in the belly of a plane getting bags off the belt loader. Because he was working in an RJ jet, which was very tight, he was squatting to pick up luggage and heard something pop in his back (Tr. 33). He fell down and felt his neck pull because he was picking up the luggage and his back popped and went out and he fell (Tr. 33). He testified he could not move and the luggage started falling on him and he yelled for help. His coworkers stopped the belt and ran to get assistance (pp. 33-34). Petitioner was taken by ambulance to the hospital (Tr. 34). April 17, 2006 was the last day petitioner worked for Respondent, United Airlines (Tr. 35).

Petitioner's Testimony

After the ER, Petitioner was seen by his primary care physician Dr. McGinness who prescribed an MRI. (Tr. 35). After the MRI Mr. Loving was referred to Dr. Coe and Dr. Amin. (TR p 35). Petitioner was referred to Midwest Orthopedics at Rush and seen by Dr. Palmer a pain management doctor. (Tr. 36) Dr. Palmer eventually referred the petitioner to Dr. Goldberg for surgical consultation. (Id.) Petitioner also saw Dr. Nicholson from Midwest Orthopedics. (Tr.37) At Midwest Orthopaedics at Rush, Petitioner saw all of the following doctors: Dr. Nicholson, Dr. Goldberg, Dr. Palmer and Dr. April Fetzer (Tr. 36). Petitioner testified to the L4 through S1 fusion surgery performed by Dr. Goldberg but testified that it was a failed fusion and he got no relief from the surgery (Tr. 39). He subsequently followed up with Dr. Fetzer and got shots and pain management in his back, after the fusion. (Id.) He also received shots and physical therapy for his neck (Tr. 40).

Petitioner also testified that he relocated to Springfield in 2011 through 2014. (Tr. 40)

The petitioner began the vocational process with Joseph Belmonte at Vocamotive in September 2007 (Tr. 41). The petitioner had been released by Dr. Goldberg with lifting restrictions of 40 pounds from floor to waist, 25 pounds from waist to the middle of his chest and 10 pounds from his chest and up (Tr. 41-42). Petitioner testified he did not begin looking for jobs within those restrictions with Vocamotive as he was in a lot of pain and on a lot of heavy narcotics. (Tr. 42-43) He testified that he kept falling asleep with his head on the desk. He testified that he told Dr. McGinness he was having problems in class falling asleep due to the drugs and pain and that the doctor therefore took him out of school because of the narcotics (Tr. 44). The petitioner testified to the letter he received from Mr. Belmonte apologizing for the accusations regarding petitioner being called a liar and not getting hurt (Tr. 43-44) He testified that Vocamotive also had an employee who was less than professional and somewhat ill-will motivated with petitioner (Id.)

After stopping Vocamotive services, Petitioner testified that he treated with Dr. McGinness, in the basement of Oak Park Rush Physical Therapy Athletics in Countryside and did self-rehabilitation. (Tr. 52-53)

Petitioner testified in 2008 he was struck from behind in a car accident. The paramedics were called and an ambulance took him for medical treatment (Tr. 55). He was provided a pain shot and he began seeking treatment at West Suburban (Tr. 55). With reference to the auto accident in 2008, petitioner confirmed he was stopped at a stop sign and a lady ran into him going 35 to 40 miles per hour (Tr. 89). When he was seen at Loyola Hospital ER following the auto accident, he complained of pain to his neck, back, chest, and right shoulder (Tr. 90). He also treated for his neck and back with West Suburban Medical Center following the automobile accident (Tr. 90). He was unable to recall how much money he received in a monetary settlement from the auto accident (Tr. 91).

Petitioner testified that he initially saw Dr. Song in the hospital on November 15, 2022 at Hinsdale Hospital ER (Tr. 59). He testified that he went to Rush the day before and was given a shot of Toradol which did not improve his condition (Tr. 59). He felt he could not move his legs and was in excruciating pain. He reported he had to crawl to the front room to get to a phone to call paramedics, as he could not move (Tr. 60). Petitioner testified that he has not seen any doctor since Dr. Song performed the second lumbar surgery (Tr. 57). Before seeing Dr. Song petitioner was treating with Dr. Salvador in Springfield, Dr. Ross in Savannah, GA, and Rush Oak Park Hospital. (Tr. 61). Since the surgery, he testified that both legs are numb (Tr. 57).

The petitioner testified to prior education at Moody Bible Institute, National Technical Institute, and DeVry Technical Institute. In addition, he went to Malcom X College for three years. He previously worked as a forklift operator, and did manufacturing and palletizing. He also worked security for Arch and Bright Security at ORD and did temp work for Manpower. Lastly, he testified that he worked for the U.S. Postal Service (pp. 93-94). Mr. Loving was asked about his desire as expressed to Mr. Belmonte to move to California and become a script writer and becoming an alderman or congressman (Tr. 94). He stated he talked with Mr. Clint Eastwood a couple times and another black star, but they were not interested in his scripts (Tr. 95).

He also suggested that when working with Mr. Belmonte they showed he was getting As and Bs on the testing, but that he was asleep and they went into his computer and put the As and Bs in there for him (Tr. 96).

Mr. Loving testified that Dr. McGinness, his PCP and current physician, at the present still has petitioner temporarily and totally disabled, and completely off work. (Tr. 51-52) Presently, Petitioner testified that both of his legs go numb. (Tr. 57) Petitioner testified he has not looked for work within the restrictions given, as his body is no good (Tr. 64). The petitioner testified that currently he has ongoing pain and does not sleep at night. He is unable to clean and he has a maid from the State who comes to clean his house and cook his dinners (Tr. 69). He also received Meals on Wheels in Countryside, Illinois. (Tr. 69). Presently Petitioner stated he does not really feel like a man without being able to work and being infirmed. (Tr. 70) Mr. Loving is currently on Medicare and social security disability. (Tr. 73) Mr. Loving testified that he knows he cannot work and just underwent another back surgery in 2022. (Tr. 74) Petitioner stated he still has 10 rods and two brackets still in his lumbar spine. (Tr. 75) Petitioner has fallen to the ground twice after his second back surgery with Dr. Song. (Id.) Mr. Loving testified he has never, not been able to work until these four work related injuries occurred. (Tr. 104

On cross examination, the Petitioner testified he did not recall being seen on multiple dates in the years prior to the work accidents for low back pain. (Tr. 1-85) He did testify he previously suffered from migraines but did not recall who he had seen for them (Tr. 81). When presented with the medical records of prior low back pain complaints, he stated, "To me, it seems like there is consistency of going to the doctor for my back. I don't remember if it was" (Tr. 86). Petitioner was specifically asked about seven prior doctors' visits from March 1999 through August 2004, with/at St. Luke's, Dr. Leavitt, Dr. McGinness and Dr. Lenhardt for complaints relating to the low back, migraines and right upper arm. (Tr. 81-85).

Testimony of David Aranda- Respondent witness

The respondent introduced the surveillance video evidence with the testimony of David Aranda, the investigator. The petitioner was surveilled on March 5 and March 7, 2020. (RX 8a/8b) The petitioner is seen going on several errands. On March 7, 2020 the petitioner went to a church for an event. The video shows him walking freely and without pain. He is seen lifting and moving two traffic cones and lifting and carrying a piece of luggage. This is all done without any apparent limitation.

Medical Record Summary

On November 16, 1999 the petitioner was seen by Dr. J. Leavitt where he complained of both lower and upper back pain. Dr. Leavitt ordered an x-ray of the right hip and pelvis and suggested taking Motrin. As is noted by Dr. Leavitt in a visit with the petitioner on March 7, 2000, the petitioner never went to get the prescribed x-rays and he never took the suggested Motrin. Petitioner was still complaining of lower back pain at this time.

On August 23, 2002 petitioner presented to Anchor Medical Group complaining of chest pain, kidney pain, and right lower abdomen pain. The report is handwritten but petitioner was assessed in part with mechanical back pain. (Rx. 5)

On November 4, 2002 petitioner presented to Anchor Medical Group again complaining of back pain that appeared to be causing pain in his right upper arm. (RX 5, Pg. 8)

On April 6, 2004 Dr. Kurtzman authored a letter to Dr. McGinness for referring petitioner to him. Dr. Kurtzman recommended petitioner see a neurologist and obtain an MRI of the brain because of his history of migraine headaches that recently increased.

Petitioner went again to Oak Park Anchor Medical Group with complaints of back pain again on May 17, 2004. (RX 5, Pg. 13)

On June 28, 2004 petitioner complained of back pain and difficulty breathing during his visit at Anchor Medical Group. (RX 5, Pg. 14)

On July 12, 2004, petitioner was seen in follow up. (RX 5, Pg. 15-16) An x-ray of the dorsal spine was taken that showed apparent generalized increased sclerosis throughout the lower thoracic spine. A bone scan was recommended by the radiologist. On July 31, 2004 a bone scan showed no abnormalities.

On August 12, 2004 Dr. Lernhardt authored a letter to Dr. McGinnis regarding a recent evaluation of right posterior pleuric discomfort and back pain that petitioner stated was ongoing the prior 10 weeks. Dr. Lernhardt opined petitioner's back pain was very likely related to musculoskeletal discomfort and the mild pleuritic component was related to the same. He recommended petitioner continue analgesics and minimize heavy lifting.

On November 4, 2004 petitioner complained of right pelvic, hip, and back pain. (RX 5, Pg.8)

On April 15, 2005 petitioner complained severe headaches with dizziness during his visit at Anchor Medical Group. (RX 5, Pg. 21)

Petitioner was seen at UIC Medical Center at O'Hare November 4, 2005. (PX 20) He reported lifting heavy bags on his knees in the pit when he twisted the wrong way with a heavy bag. He reported feeling pain in his low back area.

The petitioner was seen on December 23, 2005 at UIC at O'Hare. (PX 20). He reported he had a lumbar sprain November 4 and was sent back to full duty on the date of accident but reported continued pain with lifting since that time and acute increase in low back pain and radiation into left thigh when lifting a heavy bag this afternoon. He reported no pain distal to the knee and no numbness, weakness or tingling. Neurological testing was normal. Petitioner was ordered to do light duty work and prescribed tramadol and naproxen.

The petitioner was seen again at UIC at O'Hare on December 29, 2005. He reported his pain was worse and he had trouble getting out of bed this morning. The impression was lumbar strain and he was referred to an ortho. (PX 20).

Petitioner was seen on January 10, 2006 at Rush Oak Park Physician's Group complaining of back pain, left abdominal pain and left ear pain. He reported that he injured himself at work on December 8, 2005 when he pulled something in his back. (RX 5, Pg. 28)

Petitioner then sought treatment at Celar Chiropractic with Dr. Celar beginning on January 11, 2006. Petitioner continued to be seen at that facility on a weekly basis for low back pain, left shoulder pain, and upper back pain. (PX 10)

On January 11, 2006 an x-ray of the lumbar spine was taken and showed: (1) spinal biomechanical alterations; (2) facet tropism; (3) facet arthrosis; and (4) degenerative disc disease at L5.

On February 22, 2006 Dr. Celar completed a work status form that indicated petitioner was to work full duty. Petitioner continued attending chiropractic sessions.

Petitioner was seen at Celar Chiropractic on March 14, 2006 for a new injury. On March 14, 2006, Dr. Celar opined petitioner had an acute rotator cuff/deltoid sprain/strain from the work injury and might need an MRI. He reported he was injured while lifting up and tossing a heavy bag. Petitioner reported pain in the right arm and upper back. PX 10.

On April 13, 2006 petitioner followed up at Rush Oak Park Physicians Group for pain in his right arm. (RX 5, Pg. 32)

On April 17, 2006, the petitioner was taken by Chicago Fire Department Ambulance to Resurrection Medical Center. The fire department ambulance records specifically note he had no neck or upper back pain. (Px 7)

The petitioner was seen at Resurrection Medical Center on April 17, 2006 for low back pain while lifting a suitcase. (PX 7). A pain diagram also indicates pain only in the low back. Petitioner stated he bent over to pick up a luggage bag and felt something pull in his back. He was ambulatory. Petitioner again reported he felt something in his lower back go crunch after he bent over and lifted a piece of luggage out of a small cargo area. (PX 7). At the time of petitioner's discharge, he reported his pain was much better. X-rays of the lumbar spine were normal with vertebral heights and intervertebral spaces maintained.

On April 18, 2006, the petitioner presented for evaluation of low back pain at Rush Oak Park Physicians Group after claiming he hurt his back at work on April 17, 2006. (RX 5, Pg. 34) He reported that while bending over to pick up some luggage, he felt a crackle in his right lower back.

An MRI of the right shoulder was performed on April 18, 2006. (RX 6, Pg 240) The study showed a possible Hill-Sachs deformity and associated marrow edema compatible with subacute injury. There was no conclusive evidence of a Bankart lesion. There were findings suggesting a strain of the distal aspect of the common tendon of the rotator cuff, however, it was noted a partial thickness tear could give a similar appearance

Petitioner was seen again by Dr. McGinness on April 26, 2006 for right lower back which radiated to the thigh with numbness to the right kneecap. (RX 5, Pg. 38)

On May 2, 2006, the Anchor Medical notes reflect that the injury was most likely a muscle sprain in the lower back. They refilled his hydrocodone and gave petitioner a prescription for Flexeril. An MRI was ordered.

Petitioner was seen on May 4, 2006 by Dr. Trish Palmer for evaluation of injuries to the left low back and right arm. (Rx 6, pg 46) Petitioner reported on March 10, 2006 he was lifting a heavy bag in his job as luggage handler. When he went to place it on the belt, he felt immediate pain. He complained of pain over the lateral anterior aspect of the right shoulder. Petitioner stated the low back pain began on April 17, 2006 while lifting a very heavy bag in a forward flexed position. Dr. Palmer diagnosed radicular back pain and right shoulder pain due to rotator cuff irritation or partial tear of the supraspinatus. As there was no frank tear, Dr. Palmer recommended a subacromial cortisone injection and physical therapy for the shoulder and the back. Dr. Palmer performed an injection into the subacromial space.

An MRI of the lumbar spine was performed on May 9, 2006 and demonstrated spondylitic and degenerative changes, a broad-based mild disc herniation at L4-L5, and a less pronounced herniation at L5-S1 to the right with associated right foraminal stenosis. (RX 6, pg 237)

When the petitioner returned to Dr. Palmer on May 15, 2006, he reported that the shoulder injections had completely relieved his pain for three days. (Rx 6, pg 44) His back symptoms were fairly consistent with the MRI results and Dr. Palmer recommended continued physical therapy. The petitioner was referred to Dr. Nicholson for further evaluation of the shoulder and was referred to Dr. April Fetzer for consideration of an epidural injection. Dr. Palmer continued monitoring the petitioner's Lyrica and Vicodin dosing, but noted she was limited as to what further she could offer the petitioner. The petitioner was seen in follow up by Dr. Palmer on June 12, 2006 with similar findings and recommendations. (Rx 6, pg 42)

The petitioner was next seen on June 19, 2006 by Dr. Palmer. (Rx 6, pg 40) He reported improvement in his back pain but was still complaining of a catching sensation with forward flexion in the shoulder. His back was improving with PT and he was referred to Dr. Nicholson for the shoulder. (Rx 6, pg 41)

A physical therapy progress note dated June 27, 2006 indicated that petitioner continued to have stiffness in his right upper extremity with continued decrease in range of motion. Overall though, petitioner felt his trunk range of motion and lumbar symptoms had improved. Active range of motion of the upper extremity was still limited which caused overhead activity deficits. On July 17, 2006, petitioner saw Dr. Palmer who opined petitioner might have a SLAP tear which did not show up on the MRI. (Rx 6, pg 38) Dr. Palmer referred petitioner to a shoulder specialist.

The petitioner was seen by shoulder specialist, Dr. Gregory Nicholson on August 1, 2006. (Rx 6, pg 86) Dr. Nicholson noted that as he started to examine the petitioner, he jumped out of the chair. The petitioner could not even tolerate even simple motion or isometrics. In reviewing the MRI, he noted there was a high signal within the bursa, however there did not appear to be a Hill Sachs deformity. The doctor noted the possibility of a small interior partial tear of the supraspinatus. He found the petitioner's pain to be out of proportion to his physical findings in the right shoulder. Dr. Nicholson noted the petitioner had a subacromial pathologic process including a small partial tear and subacromial bursitis. That being said, his pain was tremendously out of proportion to the physical findings. Dr. Nicholson opined that it would be dangerous to institute physical therapy or treatment until his back issues were sorted out. Dr. Nicholson was concerned about the petitioner's symptom magnification, as it was out of proportion to his physical findings for this type of pathology. (Rx 6, pg 87)

The petitioner was evaluated by Dr. April Fetzer on August 4, 2006. (Rx 6, pg 35) Petitioner reported that he initially injured himself on November 4, 2005 with right-sided axial low back pain and right thigh symptoms. He was treated by a United Airlines physician with a muscle relaxant and chiropractic treatment, however his symptoms never fully resolved. He continued working and reinjured himself on April 17, 2006. Dr. Fetzer diagnosed right L4 and L5 radiculopathy and recommended epidural steroid injections. Mr. Loving did not want to undergo same, and instead requested surgery. The petitioner was referred to Dr. Edward Goldberg for evaluation.

On August 14, 2006, Dr. Palmer noted a positive Spurling test on the right for reproduction of shoulder pain. (Rx 6, pg 33) This was noted to be a new finding. As this suggested that the shoulder pain may be originating in the neck, an MRI of the cervical spine was recommended. Id.

Dr. Goldberg evaluated the petitioner on August 18, 2006. (RX 6, pg 80) Dr. Goldberg opined that the petitioner sustained a disc herniation and aggravated his degenerative disc disease with the work-related accident. He recommended a laminectomy and discectomy at L4-L5 and posterolateral fusion at L4-L5 and L5-S1 with iliac bone crest and pedicle screw instrumentation.

Correspondence was issued by Dr. Nicholson on August 29, 2006 indicating that while petitioner may need physical therapy for his shoulder, he felt it would be counter-productive to have him get into the program and aggravate his low back condition. Dr. Nicholson noted that he had examined the patient and that his pain was out of proportion to his physical findings. (RX 6, pg 77) His complaints were noted to be "quite histrionic." The doctor further noted he was an extremely difficult gentleman to examine. Dr. Nicholson advised that he did not feel that there was a rotator cuff tear and suggested they instead address the lumbar situation.

On September 19, 2006 Dr. Goldberg performed the right L4-L5 hemilaminotomy and discectomy, and posterolateral spinal fusion at L4-L5 and L5-S1. The diagnosis was degenerative disk disease L4-L5 and L5-S1 with superimposed central herniated nucleus pulposus L4-L5. (RX 6, pg 117)

Following surgery, petitioner followed-up with Dr. Goldberg on October 4, 2006. (Rx 6, pg 75) Overall he was doing well. Petitioner's chief complaint was difficulty with sexual function. The doctor explained that it was extremely unlikely that this was caused by the spine surgery due to the fact that this was a posterior approach.

The petitioner was seen by Dr. Goldberg on October 23, 2006 at six weeks status post surgery. He was doing well and was neurologically intact. X-rays showed the instrumentation to be well positioned at L4-S1 with good fusion mass.

The MRI of the cervical spine was performed on November 10, 2006 and demonstrated C4-C5 right bulging disc, C5-C6 central broad-based bulging disc abutting the anterior border of the spinal canal producing mild to moderate spinal stenosis with mild to moderate narrowing of the intervertebral foramina, and C6-C7 central broad-based bulging disc with mild narrowing of the spinal canal. (RX 6, pg 234)

On November 13, 2006 petitioner met with Dr. Palmer to discuss the cervical MRI. (Rx 6, pg 26) As it was possible petitioner's shoulder pain was derived from disk problems in his neck, on December 4, 2006, Dr. Palmer suggested he see Dr. Fetzer for a cervical injection.

On December 6, 2006 Dr. Goldberg noted petitioner was doing quite nicely with respect to his low back. (Rx. 6, pg 67) He recommended six more weeks of therapy for the lumbar spine after which it was possible that light duty could be started. (Px 16)

The petitioner was seen by Dr. Fetzer on December 8, 2006. (Rx 6, pg 22) He had full active range of motion of the cervical spine in all planes and the cervical Spurling's maneuver was negative bilaterally. While he stated he could not actively raise his right arm above his head, on examination, he raised it to approximately 110 degrees of abduction. The doctor explained that Neer's, Hoffman's and supraspinatus testing were all positive. Shoulder internal and external rotation was both 5/5. She felt that the petitioner's symptoms may be somewhat exaggerated on exam. The differential diagnosis could include right C5 radiculopathy versus right rotator cuff pathology. A diagnostic right C5 selective nerve root injection was ordered.

The petitioner underwent a right C5 selective nerve root block on December 19, 2006. (Rx 6, pg 19) The petitioner was seen by Dr. Fetzer on January 16, 2007 after undergoing a right C5 selective nerve root block. (Rx. 6, pg 17) He denied any further radicular symptoms. As he had improved, Dr. Fetzer recommended they hold off on any additional epidural steroid injections and instead recommended work conditioning.

On January 17, 2007, four and one-half months status post-fusion L4 to S1, the petitioner's only complaint was pain over the left iliac crest donor site. (Rx. 6, pg 63) X-rays showed a very good fusion forming. His radicular pain and back pain had markedly improved. Dr. Goldberg recommended work conditioning for six weeks for the cervical and lumbar spine.

IME- Dr. Wehner

An IME was performed by Dr. Wehner on February 9, 2007. (Rx. 1, Dep Ex. 2) Dr. Wehner noted the history of treatment and provided a diagnosis of low back pain. She noted he had a fusion for some degenerative disc disease at L4-L5 and L5-S1. He was progressing slower than would be anticipated. She did not see anything in the cervical spine warranting surgery. He was not at maximum medical improvement and should continue with physical therapy prior to any work hardening. She cautioned against any other surgery given his fairly high pain complaints despite the fairly minor MRI findings and the overall response to surgery.

The petitioner was seen in follow up on February 13, 2007 by Dr. Fetzer. (Rx 6, pg 13) While the doctor had previously recommended a work conditioning program, Mr. Loving had not undergone any work conditioning. He instead reported that he had opted to do home exercises on his own. He reported a past history of migraines for which he would take Imitrex provided by his primary care physician Dr. McGinnis. Examination of the cervical spine was negative/normal. The doctor recommended a six-week course of work conditioning followed by a functional capacity evaluation and a second right C5 nerve root block. A right C5 selective nerve root block was performed on February 20, 2007. (Rx 6, pg 11)

On February 26, 2007 an initial baseline Physical Performance Test found petitioner demonstrated functional ability between the light and light to medium work demand levels. (Px 24) Work conditioning was prescribed.

Petitioner began work conditioning on February 27, 2007. A progress note dated March 7, 2007 reported petitioner had made “inappropriately slow progress in Work Conditioning due to the client’s refusal to perform resistive activities due to subjective complaints of pain without correlating clinical objective findings.” (RX 6, pg 215) Additionally, it was noted he required verbal cues and supervision to remain on task. The therapist asserted this was an “invalid” performance in work conditioning and noted petitioner had been given verbal warnings for non-compliance after receiving specific instructions in the proper conduct for participation. The petitioner demonstrated poor body mechanics and the therapist noted that “One would expect a client with a high level of low back pain to perform this activity with proper body mechanics to minimize the stress in the low back and to maximize the efficiency of the lift.” (RX 6, pg. 216) An FCE with emphasis on validity was recommended.

Dr. Goldberg saw the petitioner on March 7, 2007. (Rx. 6, pg 61) After additional work hardening, the doctor noted he could now lift 40 pounds occasionally from floor to waist, 25 pounds waist to shoulder, and overhead 20 pounds occasionally. Some invalidity was noted by the examiner during his evaluation. Dr. Goldberg authorized the petitioner to return to work within the work conditioning recommendations. Dr. Goldberg opined he was at MMI with respect to the lumbar spine and should see Dr. Fetzer regarding the cervical condition.

The petitioner was seen by Dr. Palmer on March 12, 2007. (Rx 6, Pg. 59) Petitioner reported that he had three injections to the neck with Dr. Fetzer. Due to an increase in pain from the right lateral neck to the superior shoulder into the forearm and fingers, Dr. Palmer referred him back to Dr. Goldberg for evaluation of the neck and shoulder.

The petitioner was seen at Accelerated Rehabilitation Center for a functional capacity evaluation on March 26, 2007 ordered by Dr. Fetzer. (RX 6, Pg. 207) A physical demand level could not be determined due to petitioner failing eighteen out of twenty-five objective validity criteria. The results were found to be invalid due to the submaximal effort given by petitioner. Notably, he also scored positive on four out of five Waddell's signs for low back pain. It was felt that he was capable of functioning at a higher category of work than he demonstrated in the testing.

The petitioner was seen on April 3, 2007 again by Dr. Fetzer after undergoing the functional capacity evaluation. (RX 6, pg 8) Dr. Fetzer noted that it was found to be an invalid study secondary to sub-maximal effort with 4/5 Waddell's nonorganic signs being positive on this evaluation. On physical examination, Dr. Fetzer noted, "Mr. Loving exhibits some Waddell signs today including overreaction simulation and he does not participate in our exam." (RX6, pg 8) The doctor noted that based on his failure of all reported treatment in combination with his multiple non-organic signs and the invalid functional capacity evaluation, the doctor believed he was at maximum medical improvement for his symptoms at this time. He was released to return to work full time and full duty. (Rx 6, pg 8)

The petitioner was seen at Rush Oak Park Outpatient Physical Therapy for a lumbar, cervical and spine evaluation on April 5, 2007. It was noted that his back pain began in 2004 when he hurt himself at work while lifting luggage. His neck pain began in 2007 and was of insidious onset. The petitioner reported he was depressed and unable to perform activities. He was on medication for depression and had significant difficulty performing almost any activity. It was recommended they do physical therapy three times a week for eight weeks.

Petitioner was seen by Dr. Palmer on April 11, 2007. (Rx 6, pg 57) The doctor noted he had not gone back to work, although he had been advised to do so. He rated his pain at 9/10, but on physical examination the petitioner was in no acute distress. He had no psychomotor agitation and neurological examination revealed give-way weakness. Dr. Palmer reviewed the notes of Dr. Fetzer and Dr. Goldberg and noted that he had multiple non-organic signs and an invalid FCE. **He was at MMI for the cervical spine and lumbar spine. Dr. Palmer recommended he return to work with restrictions per Dr. Fetzer for his neck and per Dr. Goldberg for his back.**

Dr. Fetzer evaluated the petitioner on April 13, 2007. (RX 6, pg. 127) On exam, he exhibited some waddell signs today including overreaction simulation and he did not participate in the exam. He would not actively range his arms above 70 degrees. Motor testing showed give-way throughout the bilateral upper extremities. She noted that given the failure of all reported treatment attempts in combination with his multiple nonorganic signs that are present and the invalid functional capacity evaluation, she placed the petitioner at MMI and released him to return to work at full time, full duty. (RX 6, pg 127)

On May 15, 2007, the petitioner presented to Rush Oak Park Physicians Group with complaints of low back pain and shoulder pain. (RX 5, Pg. 42) . He was noted to be currently taking Atarax and Vicodin. The petitioner returned to the Rush Oak Park on June 21, 2007 with continued complaints of back pain with radiation down his right leg. (RX 5, Pg.44)

On July 9, 2007, Dr. Sandeep Amin on referral from Dr. McGuinness, discussed various options including medical management versus surgical re-evaluation or repeat epidural injections. The petitioner was not interested in considering surgery, a stimulator implant, or an epidural injection. He was started on Topamax.

The petitioner was seen for back pain at Rush Oak Park Physicians Group on August 28, 2007. (RX 5, Pg. 48) The petitioner was next seen at Rush Oak Park on December 20, 2007 for complaints of back pain and left first finger pain. (RX 5, Pg. 48)

On February 21, 2008, petitioner underwent MRI of lumbar spine with and without contrast. The study showed spondylotic changes of with degenerative disks at L4-L5 and L5-L1. Also noted was the posterior fusion with fixation devices in place extending from L4-L1 and central protrusion of the disc at L5-L1. The was a moderate degree of stenosis at L2-L3 and L3-L4, mild stenosis at L4-L5

The petitioner returned to Rush Oak Park on May 16, 2008 complaining that his back pain started worsening in the past 3-4 days despite his medication. (RX 5, Pg.54) The petitioner was referred for steroid injections. At additional visits on July 1, 2008 and August 14, 2008, the petitioner complained of back and neck pain.

Motor Vehicle Collision

The petitioner was involved in an auto accident where he was rear ended on August 19, 2008. Following the automobile accident, the petitioner was seen at Loyola Hospital ER. (RX 7) The petitioner presented on August 19, 2008 as a restrained driver who was rear-ended injuring his neck, back, chest and left jaw. (Rx. 7, Pg. 175) He reported he was thrown forward, hitting his chest on the steering wheel. He was restrained, but the seat belt did not lock and he hit the steering wheel. In addition to pain in the chest, the petitioner also complained of worsening low back pain, neck pain and right shoulder pain. He also had complaints of pain in the hips. A CT scan of the cervical spine showed no evidence of acute fracture or subluxation. Imaging of the shoulder/hip/spine was negative for acute fracture or dislocation X-rays of the lumbosacral spine showed a posterior spinal fusion L4 to S1 with trace retrolisthesis L5-S1. X-rays of the cervical spine showed slight right convex curvature, which may be related to muscle spasm or patient positioning. There was also straightening of the cervical spine likely related to muscle spasm or cervical collar. CT scans of the lumbar and cervical spine were suggested if the petitioner remained symptomatic. The petitioner was admitted to general medicine for a workup of chest pain, evaluation of back mass and pain control.

The hospital discharge summary reflects that the petitioner is a 49-year-old male with primary history of chronic low back pain, status post laminectomy, who presented to the emergency department with chest pain following a motor vehicle accident. (RX 7, Pg.150) He was restrained, but the seat belt did not lock and he hit the steering wheel. The air bag did not deploy. The petitioner complained of non-radiating numbness and a burning sensation in the left side of the chest. This was relieved with oxygen in the field and morphine was provided in the emergency department. The petitioner also complained of worsening low back pain, neck pain and right shoulder pain. He denied any focal weakness or loss of motion. Imaging of the shoulder/hip/spine was negative for acute fracture or dislocation. A CT of the neck incidentally noted a soft tissue nodule. The petitioner was discharged with Flexeril and Vicodin for musculoskeletal pain. He was referred to physical therapy which was scheduled to begin on August 22, 2008.

Dr. McGinnis completed a cervical spine residual functional capacity questionnaire, headache residual functional capacity questionnaire and lumbar spine functional capacity questionnaire on August 24, 2008. (PX 19) The cervical spine functional capacity questionnaire indicated the petitioner had cervical radiculopathy with chronic pain and paraesthesias. The headache, residual functioning capacity questionnaire indicated he had migraines, cervical radiculopathy and lumbar radiculopathy for a period of six years. He would get headaches lasting three days. The doctor felt he was unable to work because of these and again noted he was incapable of even a low stress job. The lumbar assessment similarly indicates that it has been present for six years and that the petitioner is unable to work. (PX 19).

Following the auto accident, the petitioner was seen at West Suburban Medical Center on August 28, 2008. (PX 28) He reported pain in his head, chest, hips and back. He reported he was sitting at a red light when he was rear-ended by a driver going 35 to 40 miles per hour. He was in Loyola Medical Center for two days and was still having significant low back pain and shooting pain down the right leg, as well as into the right neck and shoulder pain. This was constant with numbness and tingling into the hands and fingers. He was on Fentanyl and Darvocet and his pain was noted to be more intense since the auto accident. It was also noted the petitioner had a history of migraine headaches and was requesting an Imitrex refill. He was diagnosed with upper and lower back muscle spasms following a motor vehicle accident and musculoskeletal chest pain. Physical therapy was ordered, as well as Valium and Norco. He was directed to continue Fentanyl, Darvocet and Norco. He had continued pain on September 9, 2008.

Petitioner was next seen for a follow up at Rush Oak Park on August 29, 2008. (RX 5, Pg. 60) He complained of back pain, right shoulder pain, neck pain, and migraine headaches. Additionally on August 29, 2008 Dr. McGinness completed a Lumbar Spine Residual Functional Capacity Questionnaire. This indicated petitioner back pain was ongoing for six years and he was diagnosed with lumbar radiculopathy.

On September 8, 2008 petitioner was assessed by Dr. Lenny Cohen, a neurologist of Rush Oak Park. (PX 19) Petitioner reported a history of chronic back pain in the lumbar and cervical spine. Dr. Cohen recommended an EMG of the upper and lower extremities, trigger point injections, stopping temazepam, cyclobenzaprine, diazepam, propoxyphene, fentanyl, and limiting Vicodin. A prescription for Amrex was recommended.

A CT of the neck with contrast was performed September 24, 2008 for a left neck nodule, which had been identified on the prior cervical CT done following the auto accident on August 19, 2008. Resolution was limited below C4 and there was concern for a disc herniation in the lower cervical spine. Further evaluation was advised. There was no evidence of acute fracture or subluxation.

When he was seen in follow-up at West Suburban Medical Center on September 26, 2008, he reported ongoing neck, shoulder and back pain. (PX 28) He also reported depression since the auto accident. It was noted he had been seeing a therapist and psychiatrist and had been started on Cymbalta. He reported passive suicidal ideation and thoughts of ending his life on occasion. The records of this date also indicate the petitioner was no longer using a cane. was status post MVA with depression and the patient acknowledged a "long road ahead" to recovery. (PX 28)

He again followed up at West Suburban Medical Center on October 3, 2008 for his motor vehicle accident and resulting neck and back pain. (PX 28) It was noted that he was moving slowly, with his gait slightly forward at waist. He continued to follow up for neck and back pain related to his motor vehicle accident, including cervical, thoracic and lumbar somatic dysfunction, for which he underwent manipulation through at least February 26, 2009. In March of 2009, he was referred for functional capacity testing. (PX 28)

On October 23, 2008 Dr. Goldberg prescribed physical therapy for lumbar range of motion and strengthening for three times a week for six weeks. Dr. Goldberg had assessed status post lumbar fusion at L4-5 and L5-S1.

The petitioner continued to follow up regularly at West Suburban Medical Center status post motor vehicle accident through March 2009. (PX 28)

Second IME- Dr. Wehner

The respondent obtained an independent medical evaluation from Dr. Julie Wehner on January 7, 2009. (Rx 1, Dep Exhibit 3) At the IME evaluation, the petitioner reported his pain level at 9/10. His pain complaints and abnormal posturing were not explained by the radiographic findings or the surgery that was performed. Dr. Wehner opined that the petitioner had reached maximum medical improvement for any work injury and could return to work with a 25-pound lifting restriction. She also agreed that he should be weaned off narcotic pain medications due to the high predilection for addiction.

Petitioner followed-up at Rush Oak Park on January 19, 2009, February 17, 2009 and March 24, 2009 but the Arbitrator notes the reports are not entirely legible. Petitioner also followed up at Rush Oak Park on August 3, 2009 and October 6, 2009 with complaints of neck and back pain.

On January 7, 2010 petitioner received a Partially Favorable decision from the Social Security Administration for disability benefits. (PX 40)

On August 26, 2010 the petitioner called Dr. McGinness' office and stated that he needed an order for an MRI.

On September 2, 2010 an MRI of lumbar spine suggested the mild diffuse disc protrusions at the L5-S1 and L4-L5 were stable. There was spinal stenosis at L3-L4, milder at L2-L3 with no significant change since earlier examination. An MRI of cervical spine showed a disc protrusion with spinal stenosis and C3-C4, C5-C6, and C6-C7. There was relative spinal stenosis at C4-C5 and a tiny benign cyst within the central spine canal at the T4 level.

The petitioner was seen by Dr. Edward Goldberg on September 8, 2010 after a significant gap in treatment with the doctor, for complaints involving his neck and right arm. (Rx. 6, pg 55) The petitioner complained of central neck pain radiating down the top of the right shoulder and the lateral aspect of his upper arm into his forearm as well as the third and fourth digits. He reported that he had been constantly in pain for the last three weeks. Dr. Goldberg noted he had some prior treatment relating to a C4-C5 disc herniation in the past and had been treated with epidural steroid injections. The doctor reviewed the MRI of September 2, 2010 and felt he had multi-level cervical spondylosis causing radiculopathy and cord stenosis. As he exhibited a clinical picture of myeloradiculopathy, Dr. Goldberg recommended an anterior cervical discectomy and fusion at C3-C4 and C4-C5. Dr. Goldberg noted that they discussed the natural course and history of his myelopathy.

IME-Dr. Lami

On January 5, 2011 petitioner attended an IME with Dr. Lami to address the proposed cervical surgery. (RX 2, Dep Ex. 2) After a review of petitioner's medical history, Dr. Lami opined petitioner had subjective neck pain and right anterior shoulder pain with degenerative changes seen on the MRI. Dr. Lami opined that the cervical issues were not related to the work accident and opined that he did not need cervical surgery. Petitioner only needed a home exercise program. Regarding the cervical spine, Dr. Lami opined petitioner needed no work restrictions. Regarding the lumbar spine, Dr. Lami noted the invalid FCE and opined that a lifting restriction of 25-30 pounds would be reasonable. Petitioner was at MMI.

On February 28, 2011, petitioner met with Dr. Riley for a tender lymph node. Petitioner was assessed with lymphadenopathy and Dr. Riley noted petitioner did not complete his antibiotics as prescribed. Of note, petitioner mentioned back pain and stated his pain was 10 out of 10 but Dr. Riley opined he did not show evidence of this.

On October 19, 2011 Dr. McGinness prescribed petitioner Norco. This was again prescribed along with Tagamet on February 28, 2012. Another prescription of Norco was made on May 2, 2012. More medication refill requests were made on August 1, 2012; November 15, 2012; January 15, 2013; and February 18, 2013.

The petitioner saw Dr. McGinnis on March 14, 2013 complaining of back pain, chronic neck pain and depression. He now complained of facial and dental pain and an ache in his left forearm. He also had back pain and cramping in his left leg. He complained of depression which they noted they had treated him for in 2008 with Cymbalta. The doctor prescribed Fentanyl patches, Viagra and Cymbalta. Petitioner was living in Atlanta but was in town this week for an IME.

Second IME- Dr. Lami

On March 15, 2013, petitioner attended another IME, with Dr. Lami who opined petitioner's current symptoms were unrelated and out of proportion to the report injury on April 17, 2006. (RX 2, Dep Ex. 3) Dr. Lami opined petitioner was at MMI for the sprain he sustained on April 17, 2006. Dr. Lami also opined any complex regional pain syndrome was not related to his work injury and neither would be the proposed neck surgery. Dr. Lami could not support that petitioner was totally disabled because of the invalid FCE and psychosocial factors at play. He opined a lifting restriction of 25-30 pounds again would be reasonable. No further treatment was recommended.

On March 18, 2013, Dr. Goldberg authored a letter to petitioner's attorney, Mr. Gallagher. (RX 6, pg 53) Petitioner complained of posterior neck pain that radiated into the right shoulder, cramping in all four extremities, low back pain, and bilateral lower extremity paraesthesias. Dr. Goldberg suggested a possible assessment of cervical myelopathy and recommended another cervical MRI. Additionally, he recommended another lumbar MRI to determine if there was an adjacent level problem.

On May 22, 2013, Dr. McGinness prescribed Norco and Tagamet again. Norco was again prescribed on July 10, 2013. The petitioner requested medication refills on: August 15, 2013; August 28, 2013; September 27, 2013; November 8, 2013; December 2, 2013; January 9, 2014; February 3, 2014; and February 26, 2014.

Third IME- Dr. Lami

Dr. Lami issued a report on August 15, 2013. (RX 2, Dep Ex. 4) He opined he could not support surgery for myelopathy to be related to any of the work accidents. That would be a chronic compression of the spinal cord and no sign of same was found by Dr. Goldberg in 2010. A cervical MRI would be reasonable if Dr. Goldberg truly found myelopathic symptoms at this time. The requested lumbar MRI was not reasonable as petitioner showed a solid lumbar fusion without any neurologic deficit and only subjective pain. Additionally, Dr. Lami opined petitioner's spinal fusion was unrelated to the work accidents and his work restrictions were due to that. His work restrictions were not causally related to any of the work accidents.

Dr. Goldberg authored a March 7, 2014 letter responding to the petitioner's attorney's request for a summary of treatment. (Rx 6, pg 49) Dr. Goldberg opined petitioner's work accidents aggravated his degenerative disease of the lumbar spine and that the lumbar spine surgery and therapy were appropriate to relieve petitioner of the effects of his work accident. Dr. Goldberg did not comment on petitioner's right shoulder complaints and deferred to Dr. Palmer's and Dr. Nicholson's opinions.

On March 7, 2014 the petitioner returned to Dr. McGinnis for assessment of back pain, cervical radiculopathy, depression, migraines, gastroesophageal reflux disease, palpitations, erectile dysfunction, prostatitis and fatigue.

On July 3, 2014 petitioner presented to SIU Center for Family Medicine and met with Dr. Khattak. An x-ray of the lumbar spine was stable from previous imaging. After examination, Dr. Khattak diagnosed petitioner with chronic lower back pain that was likely secondary to arthritis. Petitioner refused physical therapy. Dr. Khattak advised petitioner to treat with exercise, stretches, heating pads, and Meloxicam. (Px. 11)

On August 4, 2014 petitioner was initially evaluated for physical therapy at Koke Mill. His diagnoses included lumbago, back pain, and neck pain. Therapy was planned for 1-3 times a week for twelve weeks. Petitioner attended physical therapy which included aqua therapy. Petitioner underwent occupational therapy at Memorial Rehabilitation Services at Koke Mill from August 6, 2014 through November 3, 2014. (PX 3).

Petitioner saw Dr. Khattak on September 4, 2014 and complained of low back pain and neck pain. Examination showed tenderness to palpation over the C4-5 and lower lumbar area. Petitioner had full range of motion and full strength. He ambulated with a cane. Dr. Khattak ordered MRIs of the cervical and lumbar spine and provided an orthopedic referral. (Px. 11)

On September 19, 2014, petitioner presented to Memorial Medical Center for an MRI of his cervical and lumbar spine. The cervical spine MRI revealed multilevel degenerative changes with mild central canal stenosis at C5-C6 and C6-C7 and multilevel moderate to severe neural foraminal encroachment. The lumbar spine MRI revealed multilevel degenerative most severe at L2-L3 and L3-L4 with severe central canal stenosis. There was also multilevel moderate to severe neural foraminal encroachment. (Px 11)

Petitioner presented to Dr. Venkat Ganapathy on September 24, 2014 with complaints of neck and back pain. (PX 12) The assessment was cervical myelopathy at C6-C7, posterolateral disc herniation at the right C4-C5 disc space, multi-level degenerative disc disease at the cervical spine and central stenosis, lateral recess and foraminal stenosis at L2-L3 and L3-L4 as well as multi-level degenerative disc disease and facet hypertrophy in the lumbar spine. The recommendations were an anterior cervical decompression and fusion and a subsequent posterior lumbar decompression and fusion. Petitioner was directed to obtain a lumbar spine CT due to a question of pars fractures at L2-L3 and L3-L4 and an EMG of the upper extremities for possible carpal tunnel syndrome on the left.

An EMG performed by Dr. Trudeau found right C5 and C7 radiculopathy which was moderately severe, but which was characterized as an older or chronic finding. There were also moderately severe bilateral median neuropathies at the wrist, moderately severe on the left and mild on the right. There was no current evidence of cervical radiculopathy, brachioplexopathy, or mononeuritis multiplex. (PX 21)

The CT of the lumbar spine performed on September 26, 2014 showed the prior fusion from L4-S1. (Px. 11) It was noted that unless there were prior CTs to demonstrate stable position, the short fixation screws which were threaded into the posterior aspect of each pedicular screw were displaced. (Dr. Goldberg later testified the loose screws were not causing any symptoms.)

On November 8, 2014, petitioner underwent an MRI of the cervical spine, which revealed: (1) minimal change since the earlier examination; (2) spinal stenosis was stable at C3-C4, C5-C6, and C6-C7; (3) left neural foraminal stenosis stable at C5-C6 and milder neural foraminal narrowing on the right at C5-C6 and bilaterally at C4-C5 as well as narrowing related to uncovertebral joint degenerative change; (4) osseous and disc degenerative changes; and (5) straightening of the cervical spine.

The petitioner was seen in follow up by Dr. Ganapathy on November 18, 2014. (PX 12) The doctor noted the petitioner had a difficult problem with long term opioid use, multiple sources of pain with axial as well as radicular pain. He also had myofascial pain which was non-dermatomal and pressure point pain. X-rays of the cervical spine showed mild degenerative disc disease from C4-C5 to C6-C7 with no change in alignment to suggest instability. The doctor noted he may still have radiculopathy, but it was difficult to assess in this setting as there were multiple other pain generators. The doctor also bolded the statement that, “I am not convinced that he has myelopathy as today’s exam was not in keeping with the exam finding from last visit.” Dr. Ganapathy felt they needed to understand which of the discs were causing the problems. He therefore recommended a C5 root block injection and a bilateral C7 selective root block injection, performed at separate times, to determine which of these was the offending level.

The petitioner was seen by Dr. Paul S. Smucker on November 21, 2014 on referral from Dr. Ganapathy to perform the root block injection. (PX 3, pg 4) The doctor noted that his “symptoms of pain and paresthesias were not consistent during the time of my discussion with him”. The neurologic exam showed no upper or lower extremity atrophy and balance and coordination were normal. Lower extremity neural tension signs were negative bilaterally. His lumbar range of motion was limited, but there was no focal mechanical reproducible pain. Cervical range of motion was normal. Shoulder impingement was inconsistently positive on the left. Motor strength testing featured break away weakness through the proximal and distal bilateral upper and lower extremities. Straight leg raising was negative bilaterally, as was Tinel’s at the carpal and cubital tunnels. The doctor reviewed the cervical radiographs which showed multi-level mild spondylosis but well preserved intervertebral disc space heights throughout the cervical spine. The cervical MRI from September 19, 2014 showed mild degenerative disc disease at multiple levels. There was moderate to severe neuroforaminal narrowing on the right at C4-5 and bilaterally at C5-C6. There was no severe significant canal stenosis at any level. Lumbar X-rays showed post-operative changes with hardware fusion at L4-L5 and L5-S1. The lumbar MRI of July 3, 2014 showed multi-level degenerative disc disease with facet arthropathy. These combined to create severe canal stenosis at L2-L3 and L3-L4. There was bilateral neuroforaminal narrowing at L2-L3 and L3-L4 as well.

Dr. Smucker noted the petitioner had non-physiologic findings with diffuse inconsistent breakaway weakness on exam. There was diffuse muscular tenderness consistent with myofascial pain syndrome. There was mild to moderate cervical degenerative disc disease with mild central stenosis at C5-C6 and C6-C7. The petitioner was status post L4-S1 fusion with multi-level neuroforaminal stenosis. There was a possible element of neurogenic claudication, although this was difficult to discern through the diffuse complaints he had to offer.

The doctor did not see evidence on his overall presentation including physical exam of cervical myelopathy. Dr. Smucker did not believe that the requested diagnostic cervical selective nerve root blocks would be valid in this individual given the widespread inconsistency of exam and described symptoms. Included with the records of Dr. Smucker is a note in which the petitioner called the office on December 8, 2014 to discuss the November 21, 2014 visit with Dr. Smucker. (PX 3, pg 8) He was frustrated that Dr. Smucker changed the procedure plan suggested by Dr. Ganapathy. The petitioner was advised that the dictation by Dr. Smucker would not be changed, as it was the doctor's medical opinion after the evaluation. The petitioner also requested no records were to be released without his prior approval. A right C5 selective nerve root block was performed on January 22, 2015 and a left C7 selective nerve root block was performed January 23, 2015. A final injection/nerve root block at the right C7 was performed February 11, 2015.

Dr. McGinness saw the petitioner on June 19, 2015. Petitioner stated that he had been seen by a neurosurgeon and was told surgery would not get rid of his pain, therefore he was not planning to undergo surgery.

The petitioner returned to Dr. Goldberg on September 9, 2015, with ongoing cervical and lumbar complaints. Dr. Goldberg recommended MRIs of the cervical and lumbar spine, as well as a functional capacity evaluation. As the petitioner continued to be myelopathic, Dr. Goldberg continued to recommend cervical surgery.

The MRI of the cervical spine, performed on September 11, 2015, re-demonstrated degenerative changes causing mild spinal canal stenosis at C3-C4, C4-C5, and C5-C6, with mild to moderate stenosis at C6-C7. There was severe right foraminal stenosis at C4-C5, which was more pronounced than the prior study. The lumbar MRI was read as showing moderate canal stenosis with massive hypertrophy causing lateral recess and neural foraminal stenosis at L2-L3 and L3-L4. Following review of the MRIs on October 2, 2015, Dr. Goldberg felt that the petitioner was now having an adjacent level breakdown due to the prior lumbar fusion. He therefore recommended decompression at L2 through L4 with laminectomy and/or possible fusion to address the low back pain. In addition, Dr. Goldberg continued to recommend the cervical fusion from C3 through C7. Mr. Loving, however, did not want to consider surgical treatment at this time, and instead the doctor recommended pain management. The petitioner advised Dr. Goldberg that he would be spending the winter in Savannah, Georgia, with his brother. The doctor provided him with a referral to take to Georgia to obtain pain management physician there as well. The recommendation included epidural steroid injections and chronic pain management.

The medical records document physical therapy performed at Saint Joseph's/Candler Health System in Savannah, Georgia from October 6, 2015 through November 19, 2015. (PX 18) The notes of November 2, 2015 indicate the petitioner washed, waxed and detailed his car this weekend. On October 21, 2015, the petitioner reported feeling well and "I feel like I could play football." At the time of discharge, the petitioner reported a significant amount of improvement and was excited that he was feeling better in time for the holidays. He made excellent rehab progress meeting all short and long term goals with the exception of hip extension range of motion.

Petitioner returned for 12 sessions of aquatic/physical therapy at St. Joseph's/Candler in Savannah from March 17, 2016 to April 28, 2016. (PX 18)

Dr. McGinness treated petitioner on September 21, 2016 for continued all over pain. He reported new pain and popping in the right shoulder for two weeks. At the time of the appointment, petitioner ambulated without a cane, but requested a form for a disability card for transportation. Dr. McGinness updated petitioner's diagnosis to include acute right shoulder pain.

Petitioner followed-up with Dr. McGinness on November 3, 2016 with complaints of worsening neck and back pain since August. Petitioner reported pain down the arm to the hand and down the leg and around the groin Physical therapy was not helping his pain. Dr. McGinness provided petitioner with a prescription of Oxycodone and Lidoderm patches and referred petitioner to the pain clinic for treatment.

Petitioner was seen by Dr. Matthew Jaycox on January 19, 2017 for pain in the low right back and pain in the upper and lower extremities. He was assessed with cervical radiculopathy, degenerative disc disease, myelopathy and facet arthropathy in the cervical spine. He was to be scheduled for cervical epidural steroid injections at C7 through T1. If no relief, they would refer him for surgery.

On January 26, 2017, Dr. Dennis Gumbrecht treated petitioner at the Rush University Medical Center Department of Anesthesia Pain Service. Petitioner reported pain in the cervical spine, specifically midline pain that radiated into the bilateral upper extremities to the fingers. A cervical epidural steroid injection was performed.

Petitioner was seen by Dr. McGinness on January 26, 2017 and reported continued neck and back pain and stated that his right leg buckled several times a week. A left trigger finger diagnosis was also noted. Dr. McGinness refilled petitioner's pain medications.

Dr. Gumbrecht performed a cervical epidural steroid injection on March 9, 2017. A second cervical epidural steroid injection was performed on May 11, 2017.

Petitioner presented to Dr. McGinness on January 16, 2018 and reported pain in his back, neck and right knee.

Petitioner presented to Dr. McGinness on May 8, 2018 and reported continued neck and back pain and that he did not feel the lumbar surgery improved his function enough so that he would contemplate neck surgery. Petitioner reported he had as much lumbar pain as he had prior to surgery.

On October 18, 2018, petitioner returned to Dr. McGinness for back and neck pain and reported he was taking long lasting hydrocodone only when his pain is at a 10/10. Mood was noted as okay on an anti-depressant. Petitioner reported he was going to the gym. According to this note the history of a fall was on June 21, 2018. The assessment was lumbar radiculopathy, depression and cervical radiculopathy. The plan was a refill of hydrocodone.

Petitioner started a new course of physical therapy on January 24, 2019 at NovaCare on referral by Dr. McGinness with a diagnosis of lumbar radiculopathy and cervical radiculopathy. Petitioner reported the pain started in 2006 when he felt pain in his low back and neck when carrying and pushing many bags and containers at work which weighed over 100 pounds. Petitioner attended 11 sessions through March 4, 2019.

The petitioner was seen again by Dr. Jaycox on March 19, 2019 for pain in the right shoulder up into his head and back pain with shooting pain down his right leg and migraines. It was noted the petitioner had returned after an 18 month absence. He was living in Savannah, Georgia and had since returned to Illinois with a return of his neck and arm pain with radiation at the right upper extremity as well as occasional low back pain into the right leg.

The petitioner underwent cervical epidural steroid injections on March 21, 2019 and April 25, 2019 at C7-T1. The petitioner was seen on May 30, 2019 in follow up and reported feeling approximately 75% better with increased activity levels. It was noted he gets out of the house to walk and exercise three to four times per week.

Petitioner was seen at Rush Oak Park Physical Therapy for a spine evaluation on October 9, 2019. It was recommended he continue physical therapy twice a week for six to eight weeks. The physical therapy progress note from October 28, 2019 indicated significant self-limiting tendencies, and noted "observed movements and behaviors inconsistent with subjective reports." The notes of November 4, 2019 again indicate the self-limiting tendencies and inconsistent observed movements and behaviors which were inconsistent with subjective reports. He also performed all activities in a slow and deliberate manner. By November 6, 2019, he had improved neck symptoms and wished to focus on the low back pain.

The petitioner was seen by Dr. Jaycox on December 18, 2019 for a follow up of upper back and neck pain. His pain had been 7/10 and worse on the right side with radiation into the arm. He also described weakness in the grip on the right side. The petitioner underwent cervical epidural steroid injection on December 31, 2019.

The petitioner presented on March 9, 2020 to the Emergency Department at Rush Oak Park Hospital. He stated he had low back pain which was uncontrollable with Norco. He was given an injection of Toradol. He was given a prescription for physical therapy on discharge.

The petitioner was seen by Dr. Jaycox on May 28, 2020 for follow up after cervical epidural injections performed in December 2019. He felt about 50% better, but had not increased his activity levels. He reported that he gets out to exercise two to three times per week. The pain in the right arm and hands was unchanged and the remaining pain was now in the neck. It was recommended that they perform bilateral cervical facet injections from C3 through C7.

On June 20, 2020, the petitioner underwent bilateral cervical facet joint injections at C2-C3, C3-C4, C4-C5 and C5-C6.

Respondent Records Review- Dr. Mather

An orthopedic surgeon, Dr. Steven Mather, issued a records review report on August 5, 2021. (Rx 3, Dep Exh 2) The petitioner was a status post L4-L5-S1 fusion with unrelated lumbar spinal stenosis at L2-L3 and L3-L4. Dr. Mather found the lumbar stenosis was not work related. Dr. Mather found the petitioner sustained disc herniations at L4-L5 and L5-S1, but the appropriate surgery would have been a simple discectomy, and it is unclear why the patient underwent a fusion as this did not meet the standard criteria for such a procedure. There was no evidence of instability, advanced, degenerative disc disease or any condition that would require a fusion.

Dr. Mather also found the cervical spine showed typical degenerative changes/osteophytes which were also unrelated to any work injury. The C3-C4 disc herniation was first noted on the September 5, 2017 MRI. While the petitioner may have sustained an aggravation of the right C4-C5 osteophyte/stenosis, this would've resolved by April 3, 2007 when his exam had returned to normal and he was released to return to work by Dr. Fetzer. Further, Dr. Fetzer had noted he had multiple positive Waddell findings at the time of his discharge from care, and he had no signs of any ongoing neurologic compression as his neurologic exam had completely returned to normal. Dr. Mather noted there were demonstrated inconsistencies and nonorganic pain findings when presenting to his treating physician, Dr. Fetzer and Dr. Nicholson. This indicated many of his symptoms were simply subjective in nature and not supported by clinical physical examination. Patients with multiple positive Wadell signs almost always have psychogenic sources of pain rather than objective organic sources of pain, and he felt this case was no exception. He also noted the patient provided maximum effort and exaggerating his complaints. (Rx 3, Dep Exh 2)

Petitioner presented to U Chicago Medicine Advent Health Hinsdale November 8, 2022 for progressive worsening of his low back pain with increased lower back pain becoming progressively worse over the last few days. Dr. Song in neurosurgery was consulted. An MRI showed severe central stenosis at L2-L3 and L3-L4 which was thought to be causing his complaints. The petitioner was admitted and Dr. Song performed L2-L4 PSF surgery. (PX 2, p. 10). On November 15, 2022, x-rays of the lumbar spine showed the hardware in the lower lumbar spine to be in proper position. At the time of the November 22, 2022 discharge, post-operative back pain had improved but was still present.

On December 6, 2022, petitioner presented to Dr. Song for his first post-operative visit. The numbness, tingling and weakness in his anterior thighs and ankle were unchanged. Petitioner was overall happy and reported his chronic low back pain had essentially resolved. Petitioner was discharged on December 7, 2022. (PX 2, p. 4). (PX 3)

At the next follow up on December 20, 2022. He reported his strength was improving in his bilateral lower extremities. Petitioner reported numbness in his right thigh and complained of a strong burning sensation in his calves and shins bilaterally. Dr. Song recommended he continue physical therapy and opined his neuropathic complaints may take time to improve.

Petitioner presented for his third post-operative visit on February 7, 2023. Petitioner opined his leg symptoms were 90% resolved and the right leg symptoms were 63% resolved. A diagnosis was made of spinal stenosis of the lumbar region.

On February 14, 2023, petitioner returned to Dr. Song to review his legal case and the request sent by his attorney. Dr. Song could not make comment until it passed through the Adventist legal team. Dr. Song opined petitioner had adjacent segment disease related to prior lumbar fusion which was “apparently” causally related to his work injury in 2006 and 2014. Petitioner also complained of neck pain and severe right arm pain that radiated down the arm to the hand and was complicated by petitioner’s carpal tunnel surgery. X-rays of the cervical spine were ordered for a diagnosis of cervical radiculopathy.

Petitioner underwent an MRI of the cervical spine on February 24, 2023 at UChicago Medicine. The study showed hypertrophic degenerative changes with moderate spinal stenoses at C3-4, C4-5, C5-6 and C6-7 levels and moderate to severe foraminal narrowing on the left at C3-4, bilaterally at C4-5, C5-6 and C6-7 levels and on the left at the C7-T11 level.

Petitioner returned to Dr. Song to discuss imaging results on March 7, 2023. He continued to complain of neck pain with numbness, tingling and weakness into the right deltoid and into his arm. The numbness in his fingers had resolved after his bilateral carpal tunnel surgery. Dr. Song was uncertain whether petitioner would have any relief with surgery but if petitioner wished to proceed, Dr. Song would consider a C4-5 and C5-6 ACDF. Dr. Song noted it was hard to determine if his findings on his cervical spine were normal degenerative changes or related to his work injury that happened 17 years ago. An assessment was made of spinal stenosis of the lumbar region and cervical radiculopathy and petitioner was instructed to return to the office as needed.

IME- Dr. Mather

Dr. Mather performed an independent medical evaluation on March 28, 2024 (RX 3, Dep Exh 3) Dr. Mather opined that the recent fusion surgery was due to normal degenerative changes and that as it had been 16 years since the previous surgery therefore, in his opinion, the need for same was unrelated to that original fusion done L4-L5-S1.” (Rx 3, dep exh 3) The petitioner also had positive Waddell’s signs. Upon examination, the petitioner had no tenderness to lumbar spine, but with any simulated axial rotation, he would wince and yell out loudly and nearly collapsed to the floor. However, he had was found to have no real pain with actual axial compression of the spine. The doctor also found him to have diffuse non-dermatomal numbness in the right lower extremity.

Deposition Testimony

Testimony of Dr. Goldberg- treating surgeon

Dr. Edward Goldberg testified on **April 11, 2016** regarding the 2006 discectomy and fusion. (Px 41, pg 11) The doctor testified after review of the MRI he felt Petitioner had some disk degeneration of both L4-5, L5-S1 with an annular tear at both levels. He also felt that he had a central herniation at L4-5. (Px41, pg. 10) On 9/19/06 Dr. Goldberg performed the following: a discectomy at L4-5 for the herniation and then an instrumented fusion at L4-5 and L5-S1 with pedicle screw instrumentation and iliac crest bone graft. (Px41, pg 13-14) As of 8/18/06, the doctor had petitioner off of work and following surgery as well through 3/7/07 when he was released with permanent restrictions. (Px41, pg 11 & 29) As of 12/6/06, Petitioner was enrolled in physical therapy and was reporting some low back pain and stiffness to Dr. Goldberg, but denied any radicular or leg pain. (Px41, pg 19) The doctor found him to be neurologically intact, and the fusion to be healing nicely at both this visit and the January 2007 visit, following x-rays performed. (Id at 24)

Regarding the history reported to him, Dr. Goldberg testified petitioner initially injured his low back on 11/4/05 when he lifted and developed acute right sided low back pain and then pain into the anterior thigh on right side. Then petitioner suffered a reinjury on 4/17/06 again “after lifting and twisting”. (Px41, pg9) The only information Dr. Goldberg had as to how the petitioner was injured working on a ramp was that he was lifting. (PX 41, pg 16) At no time from August 18, 2006 to January 7, 2007 did the petitioner mention any other than his back and at no time did the petitioner have any complaints about his cervical pain. (PX 41, pg 24-25) When asked if it was possible to have cervical pain that was masked by shoulder pain, the doctor said it was unlikely as they were very independent body parts. (PX 41, pg 25-26)

On the 3/7/07 last visit following the fusion, Dr. Goldberg wrote that Petitioner testified to finishing work conditioning and since then had increasing neck pain and reported some low back pain. He denied radicular pain, he had good lumbar motion but limited painful range of motion in his cervical spine. (Px41, pg 28) Regarding work capabilities, Petitioner was now capable of lifting 40 pounds occasionally from floor to waist, overhead 20 pounds, frequent basis lift 20 pounds floor to waist and 10 pounds overhead; when reviewing the work conditioning note it indicated petitioner was required to lift 70 pounds for his original work position. (Px41, pg 28) At this point in time, 3/7/07, Dr. Goldberg testified he was at MMI for the lumbar spine and could go back to work within the work restrictions as well as follow up with Dr. Fetzer for the cervical spine she was treating him for. (Id. at 29)

Dr. Goldberg testified the petitioner injured both the cervical and lumbar spine at work. (PX 41, pg 52-53) He was aware of only the November 4, 2005 and April 17, 2006 accidents. (PX 41, pg 58) When asked about whether his current conditions were related to the work accident, Dr. Goldberg seemed to equivocate and stated only that he had an injury was seen by his partners, had some temporary improvement and it had not progressed. (PX 41, pg 54) **Dr. Goldberg placed the petitioner at maximum medical improvement and released him to return to work with restrictions consistent with the work hardening reports on March 7, 2007. (PX 41, pg 62)**

He did not see him again until September 8, 2010 when he saw him for cervical complaints. Petitioner reported neck pain radiating to the top of the right shoulder and that the pain was constant for past 3 weeks. He reviewed an MRI and given the findings on his exam, discussed surgery. Specifically, the doctor found he had disk herniations at C3-4 and C4-5 and smaller ones at C5-6 and C6-7, and that the C3-4 and C4-5 herniations were causing some impingement on the spinal cord. (PX 41, pg 32-34) Dr. Goldberg discussed possibility of cervical spine surgery due to the change in symptoms and herniations on MRI but the petitioner did not wish to proceed with surgery. (PX 41, pg 34 and 52)

Regarding his history with petitioner, Dr. Goldberg testified that for the initial treatment starting in August 2006, he was primarily treating petitioner's back however he did previously review the cervical spine MRI in November 2006. (Px41, pg 35) The doctor opined that the prior MRI showed there were disk herniations at C3-4 and C4-5; at C3-4 it was central, at C4-5 it was central to the right; and there was a smaller herniation at C5-6 and C6-7. (Id.) Regarding prior cervical treatment in 2006, the doctor testified that Dr. Fetzer had done an epidural which provided good relief and that second epidural was not done since there was good relief. (Id.) From March 2007 through September 2010, Dr. Goldberg was not aware whether petitioner was working and he did not comment on petitioner's ability to work. (Px41, pg 36).

As of the 3/18/13 visit, that was the last examination of petitioner where he reported posterior neck pain, cramping in all four extremities from neck into right shoulder, low back pain and bilateral lower extremity paresthesia's; he had been seeing Dr. McGinness and taking hydrocodone, Cymbalta for depression and using Fentanyl patch; not been working; reported unsteadiness with ambulation; he had limited lumbar range in motion, cervical range was 50 percent normal; x-rays of lumbar spine showed healed fusion but a locking nut at L4 appeared to disengage from screw but incidental finding; cervical x-ray showed disk narrowing particularly at C5-6." (Px41, pg 37-39) Dr. Goldberg testified that he was concerned petitioner had some cervical cord involvement called myelopathy, recommended new MRI of lumbar spine to assess whether was any adjacent, meaning next level pathology, because when the doctor treated petitioner for the lumbar spine in 2006-2007, his radicular pain had resolved and now petitioner was having bilateral lower extremity new complaints. (Px41, pg, 39) As of the 3/18/13 visit, Petitioner had not been working. (Px41, pg.41)

Dr. Goldberg testified that in his March 2014 report (requested by Petitioner's lawyers), he noted that Dr. Palmer reflected in her notes, neck, right shoulder and back pain and that as of April 2006 Dr. Palmer gave work restrictions. (Px41, pg 42-43) He understood that Dr. Palmer was treating petitioner's cervical and right shoulder complaints prior to his involvement with petitioner in August 2006. (Id.) He testified that in his report where he wrote "I do believe that his lumbar condition is due to the work accident as well as the cervical condition based upon my review of these records", refers to Dr. Palmer and Dr. Fetzer's records from his office. (Px41, pg43-44). Specifically, he testified that Dr. Palmer thought it was a shoulder injury from March 2006, refers patient to Dr. Nicholson for injection with no improvement then refers to Dr. Fetzer who does a C5 selective nerve root block which improves neck pain such that the doctor recommended work conditioning. (Id.) Dr. Goldberg testified that he formulated the opinion that

both the lumbar and cervical conditions were related to work based on the record review mentioned above. (Id.)

On the December 2014 visit, the doctor found 5 out of 5 strength in upper and lower extremities but unsteady gait which could be due to spinal cord compression, which petitioner was using a cane; petitioner had abnormal Hoffman's signs; and he recommended cervical surgery again. (Px41, pg 45-46). The doctor opines at this visit that the cervical and lumbar conditions are due to the work accident and encouraged treatment and discussed signs and symptoms of myelopathy, or spinal cord compression. (Id. at 46) At the September 2015 visit, Petitioner presented with lumbar and cervical complaints for which the doctor recommended a MRI. (Id. at 47) Dr. Goldberg testified that there was significant stenosis at C4-5, C5-6 and C6-7; lumbar MRI showed no ongoing compression from L4 to S1 where original surgery was but "there was some moderate spinal stenosis at L2-3 and L3-4...in other words, adjacent level problems." (Px41, pg.48). Surgery was once again recommended but never scheduled. (Id.)

The last visit was on October 2, 2015 where cervical surgery was recommended but not approved, and petitioner was referred to pain management and he was not working, on disability. (Px41, pg. 50) Dr. Goldberg testified that he reviewed the new cervical and lumbar MRIs as of September 2015 and he felt there was significant stenosis at C4-5 and C5-6 and C6-7; he felt the lumbar spine showed no going compression L5-S1 where the original surgery was but did note at L2-3 and L3-4 there was some moderate spinal stenosis centrally and in the lateral recesses, in other words adjacent level problems. (Px41, pg 48) The doctor testified when he saw petitioner last he did not wish to proceed with cervical surgery. (Px41, pg52)

Dr. Goldberg testified that regarding the lumbar spine petitioner had two injuries in November 2005 and he continued to work then exacerbation in April 2006. (Px41, pg. 52-53) Specifically, petitioner had low back right leg radicular type symptoms that the doctor felt was due to the work accident and then regarding the cervical spine, his opinions were predicated upon notes from Drs. Palmer and Fetzer. (Id.) He testified that the records do reflect that petitioner did injure his shoulder and neck and that his treatment for back and neck since November 2005 was reasonable, necessary and related to the work accidents. (Id.) Further, Dr. Goldberg testified the subjective complaints consistent with objective findings as well (Id.) However, the doctor stated that "it's not until a few years later where he's getting bilateral leg pain now and there's new pathology at other levels"; regarding cervical complaints, "he had neck towards right shoulder originally, over the course of time it appeared to progress into some early myelopathic findings." (Px41, pg 54) He thought petitioner's symptoms were what MRIs showed. (Id.)

Regarding causation for the back and neck and whether Petitioner's present condition of ill being is caused in whole or in part by any of the four work related accidents, the doctor testified the lumbar yes in whole part because "unfortunately he developed adjacent level problems." (Px41, pg. 54) Regarding the neck, he testified "all I can state is he did have an injury, he was treated by some of my partners, had some temporary improvement its not progressed." (Id.)

On cross examination, Dr. Goldberg testified he did not review any medical records from prior to the work accidents and he did not have any information regarding the 3/10/06 or 12/23/05 work accidents. (Px41, pg. 57-58) He opined the lumbar spine injury appeared to be caused initially on 11/4/05 and an exacerbation on 4/17/06. (Id.) Regarding the 3/10/06 accident, all Dr. Goldberg had was Dr. Palmer's notes which included that patient works as luggage handler and he has pain in the right anterior aspect of his right shoulder from accident on 3/10/06. (Px41, pg. 58) Regarding Dr. Nicholson, Dr. Goldberg doesn't know why he did not review his records but testified he does know that Dr. Nicholson did not feel petitioner's complaints were related to the shoulder. (Id. at 59). Dr. Goldberg acknowledged that Dr. Nicholson found pain complaints to be out of proportion to physical findings regarding the shoulder. (Id. at 60). Dr. Goldberg had not seen the FCE results at the time he released petitioner with restrictions as the FCE was after; but he did note that work conditioning showed some concerns about invalidity. (Px41, pg. 62). He then saw petitioner three years later and then again on 9/8/10. (Id.)

In the 6 year period between March 7, 2007 and March 18, 2013, the petitioner was seen by the doctor, only on September 8, 2010. (PX 41, pg 32,36,37) The doctor testified that he did not have any information regarding his symptoms or treatment during those periods, other than petitioner reporting he saw Dr McGinness who was prescribing Norco and Darvocet. (PX 41, pg 65 & 67) Dr. Goldberg also did not have any information regarding the automobile accident which occurred in 2008 and testified petitioner did not report the auto accident to him when he saw him in September 2010. (PX 41, pg 66) The doctor agreed an automobile accident could cause or aggravate his cervical and lumbar conditions. (Id.) The doctor testified that the cervical MRI from 2006 showed abutting the cord at C3-4 and C4-5, resulting in stenosis. (Id.)

The doctor acknowledged he saw petitioner on 3/18/13 at the request of his attorney and he was not aware of any treatment petitioner had from September 2010 through March 2013. (Px41, pg. 67). Dr. Goldberg did not review any 2008 records regarding the automobile accident and could not say to what extent that accident or injury aggravated petitioner's cervical or lumbar conditions. (Px41, pg 70) The doctor did not review records from Dr. Smucker, did review some records from Dr. Ganapathy, but was not aware the doctors noted that petitioner did not have findings consistent with cervical myelopathy in November 2014; however this did not alter his opinions because when Dr. Goldberg examined petitioner, he did "find some hyperreflexia, some Hoffman's, consistent with some myelopathy but myelopathy as we stated can wax and wane." (Px41, pg 71) He further testified he did not think the dislodged locking nut had any bearing on petitioner's clinical symptoms and are in the soft tissue nowhere near spinal canal/nerves; and that he had good decompression of the levels of the fusion. (Id. at 72) .

Testimony of Dr. Lami- Respondent IME

The deposition of Dr. Lami, the respondent's IME examiner, was completed on **January 18, 2017**. (RX 2) Dr. Lami is a board-certified orthopedic spine surgeon. (Rx 2, pg 5) Dr. Lami testified that the petitioner's condition of ill being in the cervical spine was not causally related to the work accident of April 17, 2006, or to any of the other work accidents. (Rx 2, Pg 9-10)

Dr. Lami explained that he personally reviewed the MRI findings from November 9, 2006, which failed to show myelopathy, traumatic findings or other significant pathology, but did show: some bulging of the disc with no compression at C4-5; at C5-6 a central disc protrusion which was degenerative in nature, C6-7 protruding disc without any significant compression of the cord. (Rx. 2, Pg. 8-9) In addition, on examination, the cervical spine exam was negative for any significant abnormalities or signs of injury. Based on the doctor's exam of March 15, 2013, he was unable to support any need for cervical surgery related to the April 17, 2016 Work accident. (Rx. 2 Pg. 14)

The petitioner described to Dr. Lami that at the time of the April 17, 2006 accident he felt a crack in his lower back. The notes from the emergency room showed no cervical spine issues or did the records of the initial providers. It wasn't until later in the medical records, where there was a suggestion of right shoulder pain which developed overtime into cervical spine type issues. (Rx 2 Pg. 10) In addition, doctor opined the MRI from 2006 showed no significant pathology only degenerative changes. (Rx 2, Pg 10) Regarding work restrictions, Dr. Lami opined that given the two level lumbar fusion, he recommended maximum lifting from 25 to 30 pounds. (Rx2, pg 11) Dr. Lami also agreed with the treating physicians that he was at MMI on 4/3/07. (Id.) The doctor opined that the need for any cervical surgery would not be related to the 4/17/06 work accident because he did not feel petitioner suffered a cervical spine injury on 4/17/06. (Rx2, pg14) The doctor did not find evidence of myelopathy on the MRIs or on examination of petitioner but did agree with Dr. Goldberg that it can be a progressive condition. (Rx2, pg 15) On cross examination, the doctor acknowledged that a neck injury can have pain in the arm and that sometimes cervical injuries causing pain in the arm can be misdiagnosed as a shoulder injury, "if it is evaluated by an appropriate doctor, its not likely". (Rx2, pg 23) When asked if the shoulder symptoms could have masked the neck injury in the case of Mr. Loving, Dr. Lami testified that it could not. (Rx 2, Pg. 32-34) If the petitioner had a neck injury which resulted in myelopathy; this would be traumatic and would be obvious at the time of the injury. This did not occur in Mr. Loving's case. On redirect, Dr. Lami was asked about Dr. Fetzer's December 2006 report where petitioner stated he was moving luggage at his job, moving forward with arms extended and he felt a pop in his right shoulder. (Rx2, pg 35) The doctor opined this is not something that would cause an injury in your neck. (Id.)

Testimony of Dr. Wehner- Respondent IME

Dr. Julie Wehner is a board-certified orthopedic spine surgeon who testified on **February 17, 2017**. who performed an IME on February 9, 2007 and January 7, 2009. (RX 1) On exam, Dr. Wehner found was no clonus or positive Hoffman's or Babinski signs to support a diagnosis of cervical myelopathy. (Rx 1, Pg. 10) The doctor opined that after review of the medical records and her first examination of petitioner, she gave a diagnosis of low back pain and that he was status post-fusion for degenerative disk disease at L4-5 and L5-S1 (Rx1, pg 8) Regarding the cervical spine, the doctor did not see anything on the MRI that warranted surgery and that the MRI findings did not match clinical findings for level of pain petitioner was demonstrating. (Id.) Dr. Wehner opined Petitioner did not need cervical surgery because petitioner has degenerative findings at C4-5, C5-6 and C6-7, they were not causing cord or nerve root impingement and because "the level of his pain complaints on clinical exam did not correlate with this mild degree of finding." (Rx1, pg. 9) The doctor did not find that petitioner had myelopathy but that he should complete post operative therapy. (Rx1, pg.10)

The doctor testified that the two-level lumbar fusion performed by Dr. Goldberg in 2006 was not appropriate and that the surgery performed was unlikely to provide a good outcome for petitioner, for the MRI findings that were present. (Rx 1, Pg. 12, 30) She indicated that the patient had symptom magnification and pain complaints which were out of proportion to the diagnostic findings at the 2009 exam. (Rx 1, pg 14-15) As such, she felt that he did not have a good prognosis and surgery was unlikely to provide a good outcome. (Rx 1, Pg. 9,10-12) In addition, Dr. Wehner testified that the petitioner exhibited signs of symptom magnification. (Id.) Further the doctor reviewed the 2008 lumbar spine MRI and diagnosed petitioner with chronic pain syndrome following the 2009 IME. (Rx1, pg.15) Specifically, she explained petitioner has ongoing pain that's usually longer than six months duration and that pain complaints were much higher than one would expect after this type of surgery, petitioner was two years out from surgery, high doses of pain medications that are not medically appropriate at that point, normal neurological exam, symptom magnification behaviors and a MRI that did not show any problems with actual surgery performed, (Id.) Regarding the narcotic usage, the doctor testified that is was not medically appropriate and that petitioner was taking Doxepin- anti depressant, Abilify, and Cymbalta which were different mood stabilizing drugs. (Rx1, pg.16) Then petitioner was on Hydrocodone- narcotic, Fexofenadine- narcotic, Fentanyl – very strong narcotic pain medication, Celebrex- anti-inflammatory, then he had patches; petitioner also was on Topmax probably for headaches (Id.) Dr. Wehner opined that it is strongly discouraged that people use this type of doses of narcotics and mixing all different classes of medications. (Id.)

Dr. Wehner as of the last IME recommended Petitioner go back to work with no lifting more than 25 pounds and that he did not need any further medical treatment for his back and that he should be weaned off his narcotic pain medications. (Rx1, pg. 17) The doctor did not believe that the petitioner had any condition of ill-being with respect to the cervical or lumbar spine that was related to the work accident other than a lumbar strain. (Rx 1, Pg. 18,19) Further the doctor found petitioner did not need further treatment for the neck. She testified that his pain levels did not correlate to the radiographic findings. (Rx 1, Pg. 19) She noted there were no acute findings on the first lumbar MRI and that Petitioner had pre-existing degenerative changes of the lumbar spine (Rx. 1 Pg. 18) Despite having a invalid FCE, Dr. Wehner acknowledged petitioner still required the 25 pound permanent restriction because he underwent surgical intervention, and based on the type of surgery done and his age, some people might need restrictions to get back to work in some capacity. (Rx1, pg. 20)

The petitioner had a cervical injection which was a diagnostic tool to ascertain if pain complaints were stemming from the cervical spine or shoulder. (Rx. 1, Pg 33, 37) Dr. Wehner testified that as he did not improve with the injection, this would signify that there was not a problem stemming from the cervical spine. (Rx 1, Pg. 37) As of the date of the deposition, the doctor had not seen petitioner since January 2009. (Id.)

Testimony of Dr. McGinnis- Treating physician

The deposition of Dr. Catherine McGinnis was completed on **December 2, 2016**. (PX 42) Dr. McGinnis testified that she is board certified in family medicine not orthopedic medicine and does not perform any surgeries. (PX 42, Pg 6) Further, she testified she referred petitioner to various other doctors for his back and shoulder/neck. (Px42, pg. 86)

It is Dr. McGinnis' opinion that the petitioner's neck and back pain was causally related to the injuries sustained at work. (Px 42, pg 83) The doctor testified that Petitioner saw her office for low back pain after a work injury on 4/17/06 and petitioner stated he was loading luggage on the plane when he felt a crackle in his right lower back. (Px 42, pg 15) Her assessment at that time was muscle sprain and she refilled his pain medications. (Id.) However, when cross-examined, the doctor testified she had no information regarding any accidental injuries other than the injury to his arm throwing luggage which he reported at the visit on April 13, 2006. (Px 42, pg 99) She specifically denied having any information regarding the accident on November 4, 2005 or the injury on December 23, 2005. (pg. 100)

Dr. McGinness testified that at the 12/20/07 visit Petitioner had severe low back pain and back muscle spasms and needed an x-ray for his finger. (Px42 pg. 26) She treated him for erectile dysfunction and "wrote a letter for work that he was not able to do his job. (Id.) Specifically, the letter she wrote was for "back pain relating to the herniated disc, not being able to participate in his retraining classes at this time because his narcotic medication put him to sleep and because his back pain requires him to get up and walk around frequently." (Px42 pg. 27) Dr. McGinness testified she wrote this letter "based upon his complaints". (Id.)

The Arbitrator notes that the doctor appears to have mentioned neck pain for the first time in her records, in her testimony, following receipt of a letter from pain doctor, Dr. Amin, around March 2008. (Px42, pg 29) When asked about keeping Petitioner off of work, she testified that both the specialists and herself kept petitioner off of work during this period of time prior to March, 10, 2008. (Px42 pg. 30) The doctor testified that Petitioner "now developed pain in the neck radiating down the left arm and right arm" as of 7/1/08 visit she had with him. (Px42, pg. 33)

On the 6/5/09 visit, Dr. McGinness notes that Petitioner would no longer be employed by United and that he understood United would not take back an employee with duty restrictions and that he would never be able to return to unrestricted duty. (Px42, pg 42). Dr. McGinness testified to numerous refill phone call notes for pain medications for the back, migraines, depression and stomach issues from August 2012 through March 2014, where petitioner was not seen in the office (Px42, pg 56) There was only one visit during this time, in March 2013, that the doctor appears to have seen/examined Petitioner. (Id.) The Arbitrator notes that this corresponds with the time period that Petitioner testified to be living out of state, as documented by Dr. McGinness as well.

Dr. McGinness opined that Petitioner's problems to his neck and back are the direct result of his work injuries and that his treatment received was reasonable and necessary. (Px42, pg82) She testified that his subjective complaints were always consistent with her objective findings, specifically with his neurologic exam, physical exam and MRI clearly show targets. (Px42, pg. 83)

When asked why she opined that Petitioner's present condition of ill being as it relates to both the back and neck (as of the deposition date of 12/2/16) was caused in part or by any of the four work related incidents, Dr. McGinness testified: "This --this is a man who'd been seeing us for decades and prior to his injuries he was not what you would call a frequent flier, he was in--- he did have occasional musculoskeletal complaints as a results of hard, physical labor prior to these injuries but you would not see him for months at a time, he was never drug seeking, he would occasionally need a statement for work, and then he had the injuries and he had pain ever since." (Px42, pg. 83-84)

When asked about work restrictions, the doctor testified she believed he was never able to return to work after April 2006, and that she thinks they tried to send him back with restrictions but Petitioner was not able to. (Px42 pg. 84) Dr. McGinness, also opined that Petitioner was permanently and totally disabled and the basis for the opinion was "He has limited strength. He can't get his arms above his head. Baggage handlers have to be able to lift a suitcase that if it doesn't have a heavy tag on it, it weighs 100 pounds and stack it into awkward positions; they may be in a squat, they may be on their knees. The nature of his job is not something you can do with weakness in both hand and both legs due to nerve compression." (Px42, pg84-85)

On cross examination, the doctor acknowledged she did not have all the Midwest Orthopedic records and that she was not aware or did not see that Dr. Fetzer released petitioner to return to work full time and full duty on 4/3/07 given the results of the FCE, positive Waddell's findings, and multiple nonorganic signs. (Px42 pg 87) The doctor also testified that she didn't know Dr. Palmer also reviewed the records and on 4/11/07 released petitioner to return to work in accordance with recommendations from Dr. Fetzer and Dr. Goldberg. (Id.) The doctor was also not aware that Dr. Goldberg, the orthopedic surgeon he was referred to for his back, placed him at MMI and released him to return to work lifting 40 pounds occasionally on 3/7/07. (Px 42, pg88)

Dr. McGinness testified she disagreed with Petitioner's orthopedic treating doctors, Dr. Fetzer, Dr. Palmer, Dr. Goldberg and Dr. Nicholson, who believed Petitioner could return to work full duty or with a 40pound lifting restriction in 2007. (Px42, pg88) She stated she disagreed because of the nature of his job and that he cannot do it with nerve compression. (Px42, pg89) Dr. McGinness opined that even if the orthopedic doctors released him to work with the 40 pound restriction, Petitioner could not return to work in some capacity. (Px42, pg 89) She opined she was in a better position than the orthopedic doctors to make that determination because she looks at Petitioner's total body and level of function and Petitioner could not work.(Id.) On cross exam, the doctor further admitted she was not aware of the inconsistencies in the work conditioning reports by the physical therapists, or in the examinations by Dr. Nicholson and Dr. Fetzer. (Px42 90) Despite not knowing about the above or the invalid FCE, Dr. McGinness testified that her opinions regarding work ability and restrictions remain the same because "given the nature of his job and abnormal MRIs and abnormal nerve conduction studies it is my belief that this man is never able to return to work." (Px42, pg 90)

Dr. McGinness opined that the right shoulder complaints were related to the neck after “looking at how it was evolving over time. But the nerve- but his MRI of his neck demonstrates things that certainly cause shoulder pain.” (Px 42, 90) The doctor discussed in her direct testimony that she “certainly did enough letters” regarding his work status; however, when it was pointed out on cross examination that there are only two letters authorizing petitioner off work at any time, she suggested that off-work notes were instead being written by his orthopedic physicians. (Px. 42 pg 91) The doctor testified migraines preexisted the work accident. (Px42, 97)

The doctor testified that she continued to refill her patient’s medication with phone calls while the petitioner was living in Georgia and she did not see any records from Georgia during this period. After 2009, the petitioner saw Dr. McGinnis for annual medical visits on October 6, 2009, August 17, 2010, June 16, 2011, July 25, 2012, March 14, 2013, March 7, 2014, and September 11, 2015. While he did at some appointments complain of neck and back pain, he was seen for medication refills, swollen glands, abdominal pain and gastrointestinal issues.

Dr. McGinnis testified that prior to the work accidents, she had seen him for back pain on November 4, 2002. (PX 42, pg 101) She saw him May 17, 2004 for neck , muscle spasms and back pain (PX 42, pg 103), and upper back pain June 28, 2004 (PX 42, pg 104), back and hip pain on November 25, 2004 PX 42, pg 104).

Dr. McGinness also admitted on cross examination that she was not aware of Petitioner’s automobile accident in August 2008. She also did not review the medical records from the ER for this automobile accident. (Px42, pg 104-105).

Testimony of Dr. Song- treating surgeon

Dr. Song is a board-certified neurosurgeon. (Px. 45, pg 6) The doctor initially saw the petitioner as an inpatient at Hinsdale Hospital on **November 15, 2022**. He performed a laminectomy from L2 to L4 with fusion. (Px 45, pg. 9) **When asked about whether the prior low back surgery, had any effect on his need for a low back surgery in 2022, the doctor stated, “I don’t have a strong opinion on that. As I said, I could opine on what could have caused the patient’s most recent problems. But whether or not the previous fusion was involved, I can only say possibly.”** (Px 45, pg 13) **When asked to specify his opinion as to what caused his most recent problems, the doctor stated, “well, the differential, as we said, could have been the previous surgery. It could have been any other injury he had in the intervening 15 years or just normal degenerative changes.”** (Px. 45, pg 13) Dr. Song testified he was unaware of the auto accident in 2008. (Px 45, pg 13-14, 24)

On cross examination, Dr. Song did confirm that an automobile accident could be a competent cause of an injury to the low back. (Px. 45, pg 24). The doctor was asked about his report of February 14, 2023, which stated that his lumbar fusion was “apparently causally related” to the adjacent segment disease from his prior lumbar fusion (Px 45, pg. 18), however when asked about that statement on cross examination, the doctor stated that information “must have been from a direct interview with the patient.” (Px 45, pg. 27)

The doctor described adjacent segment disease as “this is a condition where people...had a prior fusion...so over time the remaining segments that were not operated on theoretically can develop more – you know, have to do more work to get the same range of motion. So if they do more work, theoretically, they can wear out quicker.” (Px45, pg.17) Dr. Song testified that he performed a laminectomy from L2 to L4 associated with a posterior lumbar fusion and that he last saw Petitioner on March 7, 2023. (Px45, pg. 19-20) The doctor did not address petitioner’s ability to work in his notes and testified he would defer to Dr. Goldberg or whoever originally gave petitioner the work-related restrictions. (Px45, pg.20)

On cross examination, Dr. Song testified he did not think he had any information specifically written in his notes about what petitioner alleges occurred at work in 2005 or 2006. (Px45, pg. 23) He had not reviewed any prior medical records and testified his opinions regarding a work-related injury or whether it caused any condition of ill being with the neck and back were based on what the petitioner told him about the causal relationship and not from any independent information. (Px 45, pg. 23-24) The doctor had no independent knowledge of the alleged work related injuries or the petitioner’s medical treatment prior to coming under his care. (Px 45, Pg 23-24) Dr. Song did not have any opinion as to whether there was any injury to the cervical spine as a result of any work related accident in 2005 or 2006. (Px 45, pg. 24.)

Dr. Song testified that did not review any medical records regarding an automobile accident Petitioner had in 2008 and that an automobile accident could be a competent cause of injury to the lower back. (Px45, pg 24) In reviewing the medical records from the petitioner’s admissions to the hospital in November 2022, the doctor testified the diagnosis would be low back pain and findings would have been lumbar stenosis and a lumbar degenerative spondylosis. (Px 45, pg. 25) The doctor explained that stenosis is narrowing of the spinal canal or neural foramen can be a degenerative condition but could also be narrowed for any reason. Degenerative spondylosis is arthritis. (Px 45, pg. 26) Following the surgery, the petitioner did well and the doctor’s note of December 6, 2022 stated the petitioner was happy and his chronic low back pain had essentially resolved. (Px 45, pg. 26) On February 7, 2023, the petitioner reported that his left leg symptoms were 80 to 90% resolved and his right leg symptoms were 63% resolved page (px45, pg. 26–27). **Dr. Song testified that he had not issued any work restrictions and would defer to the 25 lb. restriction issued by Dr. Goldberg in 2007.**

Dr. Song was asked about the statement made that the prior lumbar fusion was “apparently causally related” to his work injury in 2006 and also 2014. The doctor explained he did not review any records so the opinion of “ “apparently causally related” must have been from a direct interview with petitioner. (Px45, pg. 27) The doctor also testified regarding petitioner having right arm symptoms and possible right C5-C6 radiculopathy that was complicated by bilateral carpal tunnel surgery he also had. (Px45, pg28)

Dr. Song testified that if the prior lumbar fusion was related to a work accident or injury, and the doctor diagnosed petitioner with adjacent segment disease and that led to the most recent surgery, then the surgery does appear to be causally related to a work injury. (Px45, pg. 30). Even if the prior fusion was not related to a work injury, the doctor testified that “the current issue or most recent issues are still related at least partially to the prior lumbar fusion.” (Id.)

Dr. Song testified that he did not review any of the medical since the prior fusion, did not review Dr. Goldberg's records or prior operative report and has not issued any work restrictions at any time. (Px45, pg.31) The doctor was asked "so, hypothetically, if Dr. Goldberg has stated that the reason why he did the fusion in the first place was a work-related injury, my hypothetical is correct, then. Your causal connection opinion is correct where you say it's causally related because I'm fixing an adjacent segment disease that was caused by a work-related fusion. The doctor answered "I think... As I said before, I believe it is a factor. But, again, is it a major factor? I'm not sure if that's significant. It is a factor, but with so much time in between, it's hard to say how big of a role that played." (Px 45, pg. 32-33)

Testimony of Dr. Mather- Respondent IME

Dr. Steven Mather is a board-certified orthopedic surgeon who testified on **September 5, 2024**. (Rx 3, Pg. 5) Dr. Mather opined that based on the diagnostic films he reviewed, the petitioner had a right L4-L5 and L5-S1 disc herniations. For this condition, if conservative treatment failed, the standard recommended by the American Board of Orthopedic Surgery would be to perform a discectomy. (Rx 3, Pg. 8) He testified fusions are only used to stabilize something or if the patient had an unusual history of chronic back pain for many years which continued and then ruptured the disc. (Rx 3, Pg. 8) **Dr. Mather testified that with respect to the cervical spine, the petitioner sustained only a cervical soft tissue strain or a temporary aggravation of Petitioner's right C4-C5 stenosis which had resolved itself at least by April when his symptoms resolved.** (Id.) The MRI showed only normal degenerative changes of the cervical spine. (Rx 3, Pg. 7-8)

Dr. Mather testified that he found the petitioner to have positive Waddell findings. (Rx 3, Pg. 9) These maneuvers are not supposed to provoke pain and are done to determine if there are any inconsistencies, symptom magnification or functional pain that cannot be medically explained. (Rx 3, Pg.10). Dr. Mather testified that many of the work restrictions were imposed purely based on what the patient said they could do, however, this would be suspect when a patient has a positive Waddell findings as the patient is magnifying their symptoms. (Rx 3, Pg. 13) Dr. Mather also pointed out that the petitioner would go to IMEs and show up with a cane, but then when he was seeing his regular treating doctors, he would not have the cane. He felt this was a clear example of the patient grossly magnifying symptoms. **Despite this, Dr. Mather agreed as a result of the first fusion surgery, the petitioner should have a 25 pound lifting restriction with bending no more than eight times per hour based on the lumbar fusion performed.** (Rx 3, Pg. 13) **In accordance with petitioner's treating physicians at the time, Dr. Mather agreed the petitioner was at maximum medical improvement for the lumbar spine in March 7, 2007 and for the cervical spine on April 3, 2007.** (Rx 3, Pg. 12) The doctor also testified that cervical was non occupational because his own treating physicians placed him at MMI back in 2007 as he didn't really have any significant clinical findings. (Rx3, pg18)

Dr. Mather testified the fusion performed by Dr. Song in 2022 was not related to the work accident and was instead just normal age appropriate or age-related degeneration. (Rx 3, Pg. 19) **In support of this, he pointed out that three years after the original fusion, the patient was already showing stenosis two levels away which strongly indicates it was present to some degree prior to the fusion and progressed in a typical fashion for type of**

degeneration. (Rx 3, Pg. 19) Dr. Mather did agree that as a result of the initial lumbar fusion in 2007, the petitioner required permanent 25 pound lifting restrictions with bending and twisting only eight times per hour. This restriction would preclude his returning to work as a ramp serviceman.

Dr. Steven Mather testified with respect to the cervical spine, the petitioner suffered only a cervical strain or aggravation of the pre-existing stenosis at C4-C5. The petitioner was at maximum medical improvement by April 3, 2007. He did not agree that cervical surgery would be appropriate as there were no indications of myelopathy or any neurological impingement stemming from the cervical pathology at C4-C5. Specifically, he found that even though petitioner has a C3-4 herniation, Petitioner does not have myelopathy or C4 radiculopathy because Petitioner did not have certain positive findings and that the herniations cause tingling as opposed to real pain. (Rx3, pg. 11)

The petitioner was at maximum medical improvement for the lumbar spine as of March 7, 2007 consistent with his treating physicians who initially placed him at MMI. He does not believe petitioner required any further treatment after that date for the lumbar spine. He testified that the fusion surgery performed by Dr. Song in 2022 was due to ongoing degenerative pathology and stenosis noted previously on the MRI done in 2010.

On cross examination, Dr. Mather agreed that petitioner would not be able to return back to work as a baggage handler after a two level fusion and the weightlifting requirements for a baggage handler was at least 50 pounds. (Rx3, pf 26)

David Patsavas- Vocational Rehabilitation counselor

The deposition of David Patsavas, the petitioner's vocational expert, was taken on September 9, 2022. (PX 43) Mr. Patsavas testified he prepared a report in 2019 with medical records reviewed, the petitioner's employment history and his opinion is that there is no stable labor market for Mr. Loving. (Px 43, pg 20-22) He testified that Petitioner could not return as a baggage handler nor could he have returned to any kind of employment as of the time of his assessment, because of petitioner's "lack of transferrable skills, required medication levels, and physical limitations. (Px43, pg21-22). Mr. Patsavas did not perform a labor market survey or do any vocational testing, nor did he perform any computer testing. (Px 43, pg 24-25). When asked what functional restrictions he used in determining there was no stable labor market for Mr. Loving, he appeared to have difficulty answering the question. (Px 43, pg 28-29). He indicated that one of Mr. Loving's physicians indicated he was permanently and totally disabled; he incorrectly suggested another indicated that he should have sedentary restrictions, while he suggested the invalid FCE found he should have a 25-pound restriction. When asked which of these restrictions he used, he could not clearly answer the question and appeared to use various restrictions of light category restrictions and also sedentary restrictions (Px 43, pg 29). He testified that Mr. Loving has not, at any time, looked for alternate employment or provided job search logs. (Px 43, pg 28). In meeting with the petitioner, Mr. Loving also did not express any desire to find employment. (Px 43, pg 28).

Mr. Patsavas' report indicated that the petitioner had a police record. When questioned, Mr. Patsavas did not have any further information regarding that issue. He testified that having a

criminal record could impact types of jobs the petitioner might be able to perform but he did not ask the petitioner to ascertain the impact on any vocational prospects. (Px 43, pg 26-27). When asked what jobs he considered for the petitioner, Mr. Patsavas answered, "none." (Px 43, pg 30).

Testimony of Joe Belmonte- Vocational Rehabilitation counselor

Joseph Belmonte was retained by Respondent to provide vocational services to the petitioner in 2007 following his discharge from care by the physicians at Midwest Orthopedics at Rush. (RX 4.) Mr. Belmonte testified on **November 11, 2022**. Dr. Goldberg the treating surgeon had provided restrictions of 40 lbs. floor to waist, frequent lift of 20 lbs floor to waist, frequent lift of 15 lbs waist to shoulder, occasional lift of 20 lbs. overhead and frequent lift of 10 lbs. overhead. (Rx 4, pg. 51) Mr. Belmonte testified that the petitioner was eligible for employment in a stable labor market at that time within his restrictions. (RX4, Pg. 35) The anticipated likely wage range was \$10 to \$14.50/hour (Rx. 4, Pg. 16)

Following the initial interview and in accordance with the petitioner's restrictions and employment history, a number of different positions were identified which it was felt the petitioner could likely perform. (PX 44, Pg. 15) These included truck dispatcher, aircraft dispatcher, assembler, newspaper circulation clerk and security guard supervisor. (Rx. 4, Pg. 15-16) After administering various tests to identify the petitioner's strengths and weaknesses, additional potential employment opportunities were identified which were a match with the petitioner's abilities. These included charge account clerk, shipping order clerk, route delivery clerk, nutritional aide, electronics utility worker, security gate guard, stock control clerk, information clerk, expeditor, service order expeditor. (RX 4, Pg 23-24)

In addition, Mr. Belmonte testified regarding concerns which were raised as to the petitioner's compliance, interest and motivation in finding work. Mr. Belmonte issued correspondence to Mr. Loving on December 21, 2007 addressing the lack of compliance in the vocational process. (Rx 4, Pg. 29) The concerns centered around three issues. The first involved issues of cooperation, timeliness, attendance, absences and early departures. In addition, there were inappropriate verbal and written comments in response to guidance given to him in good faith by the Vocamotive staff. Finally, there was inappropriate identification of job targets such as Hollywood script writer, congressman or alderman coupled with no apparent effort to identify meaningful job targets consistent with his work history and educational level. (Rx 4, pg 30) Mr. Belmonte requested that Mr. Loving verify whether he was actually willing to cooperate with the job search process and provide an answer by December 26, 2007. (Rx 4, Dep Exh 3)

Mr. Belmonte testified he told the petitioner that "it was my professional opinion that he was not motivated to participate in the service, getting a job was not a priority and that he wasn't cooperating and that I felt that he should be discharged from the service." (Rx 4, Pg. 30) They were willing to give him another chance, however, he Mr. Belmonte laid out that he needed to be realistic in understanding job targets. Mr. Belmonte informed petitioner that he was clearly employable in jobs such as order picking, security, cashier, entry level customer service, mailroom clerk and other jobs. (Rx 4, pg 31)

Mr. Belmonte admitted that during his work with the petitioner, a report was issued prematurely commenting on petitioner's honesty and Mr. Belmonte issued an apology to the petitioner and his attorney on December 21, 2007. (Rx 4 pg 33) They included raw notes which should have been edited down and reviewed by Mr. Belmonte, though through administrative error that did not happen in this case. (Rx 4 pg 33-34)

The records introduced regarding the vocational placement indicate multiple issues raised by Mr. Loving in connection with his efforts. They include that "Mr. Loving stated that he had decided that he wanted to relocate to California and become a Script Writer" (Rx 4, Dep Exh 2) At one point Mr. Loving indicated that he left his last employer as the business was closed. He was questioned on this as United Airlines had not closed, to which he responded, "You told me to answer the questions; I didn't know you wanted the truth." The petitioner is noted not to have completed job search leads or applied to the jobs he was directed to apply for. (Rx 4, Dep exh 2).

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim *O'Dette v. Industrial Comm'n*, 79 Ill. 2d 249, 253 (1980) including that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 63 (1989) It is well established that the Act is a humane law of remedial nature and is to be liberally construed to effect the purpose of the Act - that the burdens of caring for the casualties of industry should be borne by industry and not by the individuals whose misfortunes arise out of the industry, nor by the public. *Shell Oil v. Industrial Comm'n*, 2 Ill.2nd 590, 603 (1954).

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). 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 demeanor of the witness and any external inconsistencies with his/her testimony. Where a claimant's testimony is inconsistent with his/her 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). The Arbitrator, as the trier of fact in this case, has the responsibility to observe the witnesses testify, judge their credibility, and determine how much weight to afford their testimony and the other evidence presented. *Walker v. Chicago Housing Authority*, 2015 IL App (1st) 133788, ¶ 47.

In the case at hand, the Arbitrator observed Petitioner during the hearing and finds him to be only a partially credible witness and his overall testimony is not entirely reliable or credible. He was also a poor historian. The Arbitrator notes Petitioner denied prior low back injuries despite evidence of multiple prior doctor visits for the back pain. Petitioner clearly had some prior back complaints however his work accident on 4/17/06 created a significant change and worsening of Petitioner's lumbar spine. The Arbitrator also finds it important that Petitioner's own treating physicians, including multiple physicians at various medical institutions throughout the years, note

petitioner to have subjective complaints that do not match objective findings or noted symptom magnification.

The Arbitrator further notes that Petitioner is seen on 2020 surveillance video in evidence (Rx8 a, b), volunteering or working with his church, carrying items of unknown weights including clothing, a suitcase and construction cones. The petitioner testified these items and his conduct on surveillance are nonetheless within Dr. Goldberg's permanent restrictions from 2007. The Arbitrator tends to agree that the items are likely within the weight restrictions for carrying/lifting, but notes that this also shows Petitioner is somewhat more active than he testified and likely capable of working within those same restrictions despite testifying that he never attempted to find work within said restrictions. The Arbitrator does not find it reasonable based on the facts of the case and medical evidence, that Petitioner never attempted to find work within the permanent restrictions he was given by Dr. Goldberg in 2007.

Petitioner is and was likely able to do more than be completely off work following his examinations and release from care by Dr. Goldberg and Dr. Fetzer in March and April 2007. However, Petitioner testified that he relied on his PCP, Dr. McGinness, not his orthopedic surgeon and specialists, that he is completely off of work and unable to work. The Arbitrator does not afford the findings and opinions of Dr. McGinness much weight as they are not supported by the record as a whole in this matter. The Arbitrator also notes that despite testifying that he was under doctor's care and/or relying on Dr. McGinness regarding his ability to work from the first date of accident through present, the Arbitrator notes there are also numerous gaps in treatment with Dr. McGinness as elaborated on below: October 2009- August 2010, September 2010- October 2011, October 2011- March 2013 (other than prescription refills with Dr. McGinness), October 2015- March 2016, April 2016-September 2016, May 2017-January 2018, only three visits total in 2018 with Dr. McGinness, May 2019- October 2019 and June 2020 through November 2022. The Arbitrator does note that Petitioner did move a handful of times during this time period which could possibly explain some gaps in care but not all.

Further, the Arbitrator notes Petitioner claims lumbar spine, cervical spine and right shoulder injuries as it relates to his work injuries. The Arbitrator finds petitioner to be credible enough regarding the work accidents and injuries initially sustained, however the Arbitrator has not been convinced that Petitioner's ongoing and current cervical spine, lumbar spine and or right shoulder/arm complaints and progressively worsened conditions, are causally related to the original accidents at work. Despite petitioner's testimony, the Arbitrator finds it to be significant regarding causation, that there was an intervening 2008 rear end motor vehicle collision that occurred, injuring petitioner's low back and neck among other injuries, as well as a large 15 year gap from Dr. Goldberg's issuance of permanent restrictions and Petitioner's necessitating a second lumbar fusion surgery with Dr. Song. It is clear from the medical evidence that petitioner's cervical spine and lumbar spine were injured in the motor vehicle collision requiring medical care. The Arbitrator finds it important that Petitioner's own PCP Dr. McGinness also determined petitioner was injured to the extent following this collision, to be completely taken off a work within a week after that collision.

Regarding the medical witnesses and experts in this case, the Arbitrator finds that overall, the treating physicians, Section 12 examiners and vocational rehabilitation counselors, except for Dr. McGinness, are credible witnesses, however, only finds the opinions of Dr. Goldberg and Drs. Palmer and Fetzer regarding the lumbar spine and cervical spine, Dr. Mather regarding the lumbar spine in part, as well as Mr. Belmonte regarding work capabilities, to be persuasive in making her findings and award as further explained below. The Arbitrator is not persuaded by the opinions of Dr. McGinness, Dr. Song, Dr. Wehner, Dr. Lami and Mr. Patsavas. See below for further discussion.

Issue F, whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds as follows:

To obtain compensation under the Act, a claimant must prove that some act or phase of his employment was a causative factor in his ensuing injuries. It is not necessary to prove that the employment was the sole causative factor or even that it was the principal causative factor, but only that it was a causative factor. *Tolbert v. Ill. Workers' Comp. Comm'n*, 2014 IL App (4th) 130523WC, ¶ 1, 11 N.E.3d 453. "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 Com.*, 93 Ill. 2d 59, 63 442 N.E.2d 908 (1982). Proof of the state of health of an employee prior to and down to the time of the injury, and the change immediately following the injury and continuing thereafter, is competent as tending to establish that the impaired condition was due to the injury. *Kress Corp. v. Industrial Commission*, 190 Ill. App. 3rd 72, 82 (1989).

Therefore, based on a chain of events analysis the evidence shows a causal relationship between the 3/10/06 incident at work and the cervical spine and right shoulder injuries only. Further, based on a chain of events analysis the evidence shows a causal relationship between the 4/17/06 incident at work and the lumbar spine injury that necessitated a fusion surgery and permanent restrictions. The Arbitrator further notes that Petitioner sustained minor lumbar spine injuries at work for Respondent on 11/4/05 and 12/23/05 as well. Petitioner was working full duty without restrictions for Respondent until his first work accident on 11/4/05. Following the 4th accident of 4/17/06, his lumbar spine condition significantly worsened requiring him to seek medical care, be taken off work etc. Regarding the cervical spine, there are clearly some degenerative changes noted on the MRI as well as on the lumbar MRI, however, Petitioner appears to have injured his cervical spine or aggravated it at a minimum, per the Midwest Orthopedic doctors, following the 3/10/06 work accident. Overall, the Arbitrator concludes Petitioner sustained work-related injuries to the lumbar spine and cervical spine but does not find petitioner's current condition of ill-being for both injuries to be causally related. Petitioner reached MMI for all work-related injuries on 4/3/07, per Drs. Goldberg, Fetzer and later Mather.

For the case at hand, Petitioner clearly had prior back pain and some visits with doctors or chiropractors before his four work accidents occurred. The Arbitrator acknowledges that the 2006 lumbar and cervical MRI findings after his work accidents also show some degenerative findings as well but it is still clear to the Arbitrator that the last two work accidents at a minimum, aggravated and worsened Petitioner's cervical and lumbar spine to the point that he required extensive medical treatment for the lumbar spine and needed to be taken off work by his doctors. Even though petitioner was not entirely credible on this issue at trial, medical evidence supports there was some prior back medical history for Petitioner. However, Petitioner was nonetheless working full duty without restrictions for Respondent at the time of first work accident of 11/4/05, and there is no evidence to the contrary. Petitioner also returned to work three times for Respondent before his final work accident on 4/17/06.

The Arbitrator notes that there are questions regarding how the first three accidents occurred. In each case, the accident as testified to by the petitioner does not entirely correlate with the medical history in the contemporaneous medical records.

The petitioner testified that on November 4, 2005, he was hooking up containers for the luggage which weighed about 1,700 pounds. As he was going to clamp the container on the tug he was driving, he slipped on the ice, tried to catch himself and hurt his back (Tr. 24). The medical records from that date at UIC Medical Center at O'Hare indicated instead that he reported lifting heavy bags on his knees in the pit when he twisted the wrong way with a heavy bag. (PX 20)

For the December 23, 2005 accident, the petitioner testified he was hooking up containers to a tug when he injured his back, legs, and hips (Tr. 28). The medical records from December 23, 2005 at UIC at O'Hare instead reflect the petitioner reported continued pain with lifting since the prior injury and acute increase in low back pain and radiation into left thigh when lifting a heavy bag this afternoon. (PX 20).

On March 10, 2006, the petitioner testified that as he was taking luggage out of the containers, he felt something pop in his neck, arm and right shoulder (pp. 29-30). The medical records reflect the petitioner was seen at Celar Chiropractic on March 14, 2006 reporting a new injury while lifting up and tossing a heavy bag. He reported pain in his right shoulder at that time and a shoulder MRI was ordered shortly thereafter.

The foregoing accident issues notwithstanding, the petitioner did not lose any time from work and sought more minimal treatment until the fourth alleged accident in April. On April 17, 2006, the petitioner was in the belly of a plane lifting luggage when he felt a crackle in his low back. He collapsed and was taken by Chicago Fire Department Ambulance to Resurrection Medical Center. The arbitrator finds that the first two accidents of November 4, 2005 and December 23, 2005 involved lumbar strains and the March 10, 2006 accident involved a right shoulder strain and aggravation of cervical spine injury. The injuries from these accidents were superseded by the April 17, 2006 accident.

In reviewing the medical records, they are replete with concerns about symptom magnification and the petitioner falsifying his presentation to his examining physicians. From the first visit with Dr. Nicholson on August 1, 2006, there were concerns about the petitioner's symptom magnification, as his presentation was out of proportion to his physical findings or the pathology seen on the MRI. (Rx 6, pg 87) Dr. Fetzner also noted that on exam he reported he could not actively raise his right arm above his head, however, he then did raise it to approximately 110 degrees of abduction. She outright expressed concern that the petitioner's symptoms were exaggerated. (Rx 6, pg 22)

The work conditioning notes also reflect "the client's refusal to perform resistive activities due to subjective complaints of pain without correlating clinical objective findings." (RX 6, pg 215) He required verbal cues and supervision to remain on task. The therapist went so far as to call this an "invalid" performance in work conditioning. The petitioner was given verbal warnings for non-compliance after receiving specific instructions in the proper conduct for participation. After continuing to demonstrate improper techniques, the therapist noted that "One would expect a client with a high level of low back pain to perform this activity with proper body mechanics to minimize the stress in the low back and to maximize the efficiency of the lift." (RX 6, pg. 216) It was at that point that an FCE with emphasis on validity was recommended. When the FCE was then performed, it was invalid due to submaximal effort from the petitioner. He in fact failed 18 out of 25 objective validity criteria (PX 24). Additionally, he had four out of five positive Waddell's signs for non-organic signs of low back pain. They specifically found that, "Mr. Loving is employable at this time." (PX 24).

This pattern of falsifying his presentation to his examining physicians was also pointed out in the records petitioner submitted related to the decision from the Social Security Administration. (PX 40). The report states,

"As can be seen from the records in this matter, the claimant has severe complaints with respect to his neck and back pain. The record shows that the claimant underwent surgery in September, 2006. All indications in the records show that although the claimant has continued to have severe complaints following the surgery, the objective findings have been minimal. During the physical examinations noted above subsequent to the surgery, it has been noted that the claimant has limitation of motion in the cervical and lumbar spine and the only signs supporting a diagnosis of radiculopathy have been some mild loss of sensation in the right thigh. The claimant has severe complaints which have been out of proportion to the objective evidence. The record is clear that the claimant does not have any limitations in the use of his arms or hands. The restrictions noted by Dr. McGinness are not supported by the record as a whole in this matter. As noted above, there are no treating notes of record to support the severe limitations noted by Dr. McGinness. As a result, the undersigned cannot afford the opinions of Dr. McGinness significant weight. The claimant's overall testimony in this matter was not fully credible. He has alleged very severe symptoms and limitations. He has stated that he has such severe back and neck pain that he cannot stand, walk or sit. However, it is noteworthy that he has not followed through with any epidural steroid injections and has apparently stopped trying any type of physical therapy. The functional capacity evaluation performed on the claimant on March 26, 2007 (Exhibit 16F) shows that claimant was attempting to portray himself much more limited than he actually was." (PX 40, p. 7 of 11).

The Social Security Administration found that while he would have some residual limitations, these would not prevent him from performing sedentary work. They note that with sedentary work there were 1,800 jobs available in the Chicago Metropolitan area for assembly, 1,200 jobs for hand packager, and 1,000 jobs for inspector. The report further indicates,

“The claimant is not persuasive. He said he cannot sit or stand for more than a few seconds and was up and down at the hearing. However, when it was noted he had to sit in the car for more than a few seconds when he goes to appointments and to get to the hearing, the claimant claimed that at every stoplight he opens the car door and stretches his legs out the door. This is rather hard to believe. It is noted that the claimant stated he has not driven since his back surgery in September, 2006. While it was pointed out that he was driving when he was involved in the motor vehicle accident in August, 2008 (Exhibit 11F), the claimant asserted that that was the only time he has driven since surgery. He claimed that his son was driving him to the doctor and got lost, so he had to take over the driving and then got into the motor vehicle accident. Other inconsistencies include the claimant testifying he cannot handle finances, he has done no cooking in the past two years and doing dishes, but information in Exhibits 4E and 8E suggest otherwise.” (PX 40, pg. 7 of 11)

The report further notes that while the claimant stated he had been using a cane for two years, an exam on November 13, 2007 indicated the petitioner did not have a cane and his gait was within normal limits.

The Arbitrator notes that a finding from the Social Security Disability Administration has no precedence. The Arbitrator does take note of the fact that inconsistencies were found, and that the trier of fact found the petitioner not credible with respect to his presentation and the testimony presented. This is consistent with the inconsistencies found in petitioner’s treatment at Midwest Orthopaedics at Rush and the functional capacity evaluation, among other records.

Later medical records also suggest that petitioner is not being forthright. The PT records from Saint Joseph’s/Candler Health System in Georgia include that petitioner washed, waxed and detailed his car over the weekend and then a week later he reported feeling well and “I feel like I could play football.” These comments were made in October 2015, the same month that Dr. Goldberg saw him and recommended cervical surgery. The Rush Oak Park Physical Therapy notes also repeatedly indicate significant self-limiting tendencies, and noted “observed movements and behaviors inconsistent with subjective reports” on October 28, 2019. Also on November 4, 2019, they again indicate the self-limiting tendencies and inconsistent observed movements and behaviors which were inconsistent with subjective reports.

All of these issues raise concerns regarding the petitioner’s presentation. Notwithstanding those concerns, the Arbitrator still finds that the petitioner suffered an injury to his low back on April 17, 2006 which necessitated a lumbar fusion. Dr. Goldberg who evaluated the petitioner on August 18, 2006 opined that the petitioner sustained a disc herniation and aggravated his degenerative disc disease with the work-related accident.

While Dr. Wehner could not substantiate any injury other than a sprain and Dr. Mather opined that a discectomy would have been more appropriate in light of the pathology on the MRI, the Arbitrator still agrees it was reasonable for the petitioner to follow the surgical recommendation of Dr. Goldberg. Dr. Goldberg was persuasive and credible in his testimony regarding his diagnosis of Petitioner's lumbar spine and the fusion surgery that was needed. Following the surgery, the petitioner had a favorable result to surgery. Despite the petitioner's testimony as to a "failed fusion", there is no evidence in the record to substantiate such a diagnosis. Instead, the records show he had an uncomplicated postoperative course and described successful resolution of his symptoms. Dr. Goldberg authorized the petitioner to return to work lifting 40 pounds occasionally from floor to waist, 25 pounds waist to shoulder, and overhead 20 pounds occasionally and placed the petitioner at MMI on March 7, 2007. (Rx. 6, pg 61) Regarding the cervical spine, Dr. Fetzer released to return to work full time and full duty on April 3, 2007 following the invalid FCE (Rx 6, pg 8)

Upon follow up questions by the arbitrator at trial, Petitioner testified that he felt a crackle and pain in the neck with the injury of April 17, 2006. This, however, is not supported by the medical records. Based on the Ambulance records and when the petitioner was seen at Resurrection Medical Center on April 17, 2006, he reported only low back pain. (PX 7). The history given was that he bent over to pick up a luggage bag and felt something pull in his back. A pain diagram also indicates pain only in the low back. The Chicago Fire Department ambulance records specifically note he had no neck or upper back pain. The petitioner described he felt something in his lower back go crunch after he bent over and lifted a piece of luggage (PX 7). Contrary to what the petitioner advised the Arbitrator, there was no injury to the neck or upper back reported at the time of the April 17, 2006 work accident. That said, based on the medical records and testimony by Dr. Goldberg, the Arbitrator finds that Petitioner did sustain a cervical injury and aggravation of his neck condition on the 3/10/06 accident date.

The Arbitrator notes that the petitioner also suffered an auto accident in August of 2008 which resulted in increased neck and back pain. He treated at Loyola ER, then with West Suburban Medical through early 2009.

In August 2010, Petitioner called Dr. McGinnis to request a cervical MRI and then went to see Dr. Goldberg, who he hadn't seen since his discharge from care in 2007. He reported that he had been constantly in pain for the last three weeks. It is unclear what caused this exacerbation. Dr. Goldberg recommended surgery but the petitioner did not want to proceed. Dr. Lami then performed an IME and opined that he did not need cervical surgery.

The basis for the surgery recommendation was concern for myelopathy. The petitioner's tests for myelopathy at his exams, however were inconsistent. Dr. Ganapathy on November 18, 2014 noted myofascial pain which was non-dermatomal and stated, "I am not convinced that he has myelopathy as today's exam was not in keeping with the exam finding from last visit." He referred the petitioner to Dr. Smucker for a possible diagnostic injection, but Dr. Smucker found his "symptoms of pain and paraesthesias were not consistent during the time of my discussion with him".

The neurologic exam showed no upper or lower extremity atrophy and balance and coordination were normal. Lower extremity neural tension signs were negative bilaterally. His lumbar range of motion was limited, but there was no focal mechanical reproducible pain. Cervical range of motion was also normal. Shoulder impingement was inconsistently positive on the left. Motor strength testing featured break away weakness through the proximal and distal bilateral upper and lower extremities. Dr. Smucker was concerned about the non-physiologic findings with diffuse inconsistent breakaway weakness on exam. The doctor did not see evidence of any cervical myelopathy, as such, he did not believe that the requested diagnostic cervical selective nerve root blocks would be valid in an individual with widespread inconsistencies on exam and in described symptoms.

Dr. Lami testified that the petitioner's condition of ill being in the cervical spine was not causally related to the work accident of April 17, 2006, or to any of the other work accidents. Dr. Mather testified that with respect to the cervical spine, the petitioner sustained only a cervical soft tissue strain or a temporary aggravation of Petitioner's right C4-C5 stenosis which had resolved itself at least by April when his symptoms resolved. Dr. Goldberg testified the petitioner injured both the cervical and lumbar spine at work, however, when asked about whether his current conditions were related to the work accident, Dr. Goldberg seemed to equivocate and could not affirmatively answer the question. He also was not aware of the automobile accident in 2008. Dr. Song also offered no opinion on whether the petitioner's condition of ill-being with respect to his cervical spine was causally related to the employment.

Overall, the Arbitrator finds that Petitioner sustained a cervical injury and right shoulder injury on 3/10/06 and a lumbar spine injury on 4/17/06. The petitioner also sustained more minor back injuries on 11/4/05 and 12/23/05. Regarding causation for Petitioner's current condition of ill being, the Arbitrator overall relies on the opinions and findings of both Dr. Goldberg in part and Dr. Mather, in part, in finding that: 1) Petitioner sustained work related lumbar spine and cervical spine injuries 2) Petitioner required lumbar fusion surgery and related care as provided by Midwest Orthopedics at Rush to his neck and back and 3) Petitioner was at MMI for his cervical spine in April 2007 and for the lumbar spine, March 2007 4) Petitioner required permanent restrictions and could not return to his prior job as a ramp agent for Respondent. The Arbitrator finds it reasonable that Dr. Wehner and Dr. Lami agree with the permanent restrictions of 25 pounds regarding the lumbar spine due to the fusion, but does not otherwise find their opinions to be persuasive. The Arbitrator does not find Dr. McGinness to be credible and is not persuaded by Dr. Song.

The Arbitrator relies on Dr. Goldberg's opinion when he gives causation for both the neck and back injuries as of the time he testified in 2016, however the Arbitrator does not agree that Petitioner's ongoing lumbar and cervical spine conditions as of 2016 are still related to the 2005 and 2006 work accidents. Unlike the IME physicians, Dr. Goldberg finds Petitioner did sustain a work-related cervical spine injury. However, there are no further treatment dates, opinions obtained or discussion with Dr. Goldberg regarding petitioner's conditions after his 2016 deposition. At this time, petitioner had still not had the 2022 second fusion, nor was Dr. Goldberg privy to the various IME opinions, deposition testimony and overall treatment records from 2016 to present. There are also no strong or persuasive opinions for causation of petitioner's current conditions after this deposition. The Arbitrator is also not persuaded

regarding Petitioner's current condition by Dr. Song who did not have all the records or a clear and complete picture of Petitioner's medical history. Dr. Song also deferred to Dr. Goldberg regarding work restrictions. Dr. Goldberg the treating surgeon, previously had provided restrictions of 40 lbs. floor to waist, frequent lift of 20 lbs floor to waist, frequent lift of 15 lbs waist to shoulder, occasional lift of 20 lbs. overhead and frequent lift of 10 lbs. overhead.

Regarding the lumbar surgery: while Dr. Mather's opinions are somewhat persuasive, the arbitrator more so relies on Dr. Goldberg's opinions which are convincing regarding the lumbar spine and the need for the fusion surgery he performed in 2006 and that was successful in helping petitioner's right leg complaints. The Arbitrator also finds it important that Dr. Goldberg testified that when Petitioner originally saw him regarding the lumbar spine, he has right leg symptoms improve after surgery, and it is not until a few years later where petitioner is getting bilateral leg pain and new pathology at other levels. Regarding the cervical, Petitioner had neck towards the right shoulder originally, over the course of time it appeared to progress into some early myelopathic findings. (Px41, pg54) It is clear per Dr. Goldberg that there was a change in petitioner's lumbar spine and cervical spine over the years, from the 2007 release from care with permanent restrictions and the 2010, 2013 and 2015 visits (last visit) with Dr. Goldberg.

It is noted that Dr. Goldberg last saw Petitioner in October 2015. Regarding causation for the back and neck and whether Petitioner's present condition of ill being is caused in whole or in part by any of the four work related accidents, the doctor testified the lumbar yes in whole part because "unfortunately he developed adjacent level problems." (Px41, pg. 54) Regarding the neck, he testified "all I can state is he did have an injury, he was treated by some of my partners, had some temporary improvement its not progressed." (Id.) The Arbitrator notes that the doctor found some adjacent level issues, however he also found that there was a stable lumbar fusion and he did not recommend further lumbar surgery. It important to note that the doctor did not change petitioner's work status or provide any additional opinions that changed the prior permanent restrictions he imposed in March 2007 for the lumbar spine.

In addition, regarding the neck, Dr. Goldberg did not find the condition to be worsening in 2015 but continued to recommend cervical surgery that petitioner declined and was also not approved. Dr. Goldberg as the treating surgeon was in the best position to opine as to Petitioner's conditions in 2006 and 2007, regarding the lumbar spine as well as cervical spine for finding a work related injury. He personally saw petitioner and examined him multiple times. He took numerous MRIs and reviewed many of them. He relied on his own medical records and those of his colleagues at Midwest Orthopedics. He was involved early on with petitioner's care and treatment and saw him from 2006 through 2015 (on and off). He testified that his opinions on the cervical spine was predicated on his review of Drs.' Palmer and Fetzer notes as well. Specifically, he testified that his colleagues thought petitioner had a shoulder condition and records reflect that petitioner injured his right shoulder and neck as well. The Arbitrator finds it important and persuasive that the doctor's objective findings matched petitioner's subjective complaints during his treatment of him, despite other treating physicians and IME doctors finding symptom magnification. There was clearly symptom magnification documented by numerous treating physicians per the extensive medical records in this case but it appears that with Dr. Goldberg, Petitioner was more credible with his pain complaints. All of the IME doctors

also documented symptom magnification and/or unexplained subjective complaints which goes towards credibility of Petitioner.

Regarding his history with petitioner, Dr. Goldberg testified that for the initial treatment starting in August 2006, he was primarily treating petitioner's back however he did previously review the cervical spine MRI in November 2006. (Px41, pg 35) The doctor opined that the prior 2006 MRI showed there were disk herniations at C3-4 and C4-5; at C3-4 it was central, at C4-5 it was central to the right; and there was a smaller herniation at C5-6 and C6-7. (Id.) It is therefore appears to the arbitrator that Petitioner sustained a right shoulder and neck injuries as described above by Dr. Goldberg, in the 3/10/06 injury. Importantly, Petitioner, per Dr. Goldberg had herniations on his cervical MRI as of November 2006.

It was reasonable for Dr. Goldberg to give permanent restrictions in this case Dr. Goldberg provided restrictions following work hardening of 40 lbs. floor to waist, frequent lift of 20 lbs floor to waist, frequent lift of 15 lbs waist to shoulder, occasional lift of 20 lbs. overhead and frequent lift of 10 lbs. overhead. Despite not agreeing with Dr. Goldberg in performing a fusion surgery, Dr. Mather agreed as a result of the first fusion surgery, the petitioner should have a 25 pound lifting restriction with bending no more than eight times per hour based on the lumbar fusion performed. (Rx 3, Pg. 13) This is reasonable to the Arbitrator. In accordance with petitioner's treating physicians at the time, Dr. Mather agreed the petitioner was at maximum medical improvement for the lumbar spine in March 7, 2007 and for the cervical spine on April 3, 2007. (Rx 3, Pg. 12)

Dr. Mather testified that with respect to the cervical spine, the petitioner sustained only a cervical soft tissue strain or a temporary aggravation of Petitioner's right C4-C5 stenosis which had resolved itself at least by April when his symptoms resolved. (Id.) The Arbitrator is persuaded by this opinion based on his testimony and the record as a whole. Dr. Mather, like the other IME doctors in this case, testified that he found the petitioner to have positive Waddell findings. (Rx 3, Pg. 9) These maneuvers are not supposed to provoke pain and are done to determine if there are any inconsistencies, symptom magnification or functional pain that cannot be medically explained. (Rx 3, Pg.10). Dr. Mather also pointed out that the petitioner would go to IMEs and show up with a cane, but then when he was seeing his regular treating doctors, he would not have the cane. He felt this was a clear example of the patient grossly magnifying symptoms. Dr. Mather further opined that petitioner was at maximum medical improvement for the lumbar spine as of March 7, 2007 consistent with his treating physicians who initially placed him at MMI. He does not believe petitioner required any further treatment after that date for the lumbar spine. The Arbitrator agrees. He testified that the fusion surgery performed by Dr. Song in 2022 was due to ongoing degenerative pathology and stenosis noted previously on the MRI done in 2010. The arbitrator finds this opinion to be persuasive. On cross examination, Dr. Mather agreed that petitioner would not be able to return back to work as a baggage handler after a two level fusion and the weightlifting requirements for a baggage handler was at least 50 pounds. (Rx3, pf 26)

The Arbitrator finds that Dr. McGinness is not entirely credible and is not more credentialed than the board-certified surgeons, both neuro and orthopedic who testified in this case. Petitioner testified that the doctor kept him off of work and he relied on her for his work status, appearing to disregard Dr. Goldberg's permanent restrictions. Further, Dr. McGinness was not aware that Petitioner had been released from Midwest Orthopedic surgeons and doctors with permanent restrictions. Despite being later informed, the doctor testified she was still more qualified to opine on restrictions for petitioner. This is not reasonable to the Arbitrator, that a primary care physician would possibly disregard work conditioning and/or FCE testing results and permanent restrictions imposed by the medical group Dr. McGinness apparently referred petitioner to because she is not a specialist or orthopedist.

The Arbitrator also finds it important to note that there were large gaps in care with Dr. Goldberg where petitioner treated with various other doctors and it appears petitioner never informed Dr. Goldberg or his other doctors of the MVC in August 2008 where he injured his neck and back, and also complained of chest pain. Dr. Mather is the sole doctor to have reviewed all of the treating records and was aware of the various medical opinions and additional treatment after the 2016 Dr. Goldberg deposition, as well as the 2008 MVC. While the Arbitrator finds causation for the injuries, that causation cuts off in 2007 when Petitioner is released from care. The lumbar fusion performed by Dr. Goldberg as well as all of Petitioner's care and treatment through April 2007 would also be causally related to the work injuries he sustained.

The Arbitrator agrees that petitioner's cervical spine and lumbar spine injuries to an extent, would be related to the work accidents. However, petitioner's current condition of ill-being for both injuries would cut off as of Dr. Goldberg's 2007 release from care. Regarding the myelopathy diagnosis, the Arbitrator notes Dr. Goldberg's findings and that the doctor testified it is a diagnosis that can wax and wane but the arbitrator is not persuaded this is work related due to numerous other doctors (treater and IME alike) not finding the same at any other examination over the years and because of the gaps in medical care among the numerous treating doctors . Therefore, the petitioner more than likely, at a minimum, aggravated both his neck and low back based on some of the generative findings shown on MRI scans and treating records, in these work accidents. In summary, his ongoing issues for many years after the 2007 release from care by Midwest Orthopedics at Rush, would not be related to his work accidents with Respondent.

The Arbitrator finds based off the extensive medical over 20 years, 8 depositions, the record as a whole that Petitioner sustained a neck injury and right shoulder injury in the 3/10/16 work accident and injured his low back in the 4/17/06 accident, in addition to injuring his lumbar spine in both 2005 work accidents as well. Despite his testimony at trial that he injured his neck on 4/17/06, the Arbitrator agrees with the IME doctors that the medical does not support that the cervical spine injury occurred on the 4/17/06 date. Regardless, like Dr. Mather opines, Petitioner sustained a cervical injury that would have resolved by the April 2007 release from care by his treating doctors.

Psychological

Petitioner introduced records of Dr. Gierl into evidence. (PX 14) The Arbitrator notes these are handwritten and difficult to decipher. Dr. Gierl issued a report dated February 18, 2019 to the Veterans Administration noting he had been seeing the petitioner since March 7, 2014 for severe depression. He noted that on or about August 16, 2017, the petitioner reported PTSD symptoms and reported trauma and abuse to the doctor from when he was in military training. The petitioner described suffering physical, verbal and emotional abuse to the doctor. He states this has been verified as he was discharged from the military after this abuse came to light. He reported this was still causing nightmares, flashbacks and severe emotional distress. It was his recommendation he receive his medication through the Veterans Administration due to PTSD symptoms which are the result of trauma and abuse experienced during military training. (PX 14).

In addition, when he was seen for treatment of the auto accident at West Suburban Medical Center on September 26, 2008, the Arbitrator notes he reported depression since the auto accident. (Px 28) The petitioner did not appear to testify to any ongoing psychological condition and the medical introduced supports an alternate cause of any psychological condition. Accordingly, the Arbitrator finds that there is insufficient evidence to support that any condition of ill-being with respect to petitioner's psychological condition is related to the work injuries.

Issue K, whether Petitioner is entitled to temporary total disability benefits, the Arbitrator finds as follows:

A claimant is temporarily totally disabled from the time an injury incapacitates him from work until such time as he is as far recovered or restored as the permanent character of his injury will permit. *Westin Hotel v. Indus. Comm'n*, 372 Ill.App.3d 527, 542 (1st Dist. 2007). In determining whether a claimant remains entitled to receiving TTD benefits, the primary consideration is whether the claimant's condition has stabilized and whether she is capable of a return to the workforce. *Interstate Scaffolding, Inc. v. Illinois Workers' Comp. Comm'n*, 236 Ill.2d 132, 148 (2010). Once an injured employee's physical condition stabilizes, she is no longer eligible for TTD benefits. *Archer Daniels Midland Co. v. Indus. Comm'n*, 138 Ill.2d 107, 118 (1990). To be entitled to TTD benefits, it is the claimant's burden to prove not only that he did not work but also that he was unable to work. *Holocker v. Illinois Workers' Compensation Comm'n*, 2017 IL App (3d) 16036WC, P35 (3rd Dist., 2017). The fundamental purpose of the Act is to provide injured workers with financial protection until they can return to the work force. *Id.* When determining whether an employee is entitled to TTD benefits, the test is whether the employee remains temporarily totally disable as a result of a work-related injury and whether the employee is capable of returning to the work force. *Id.* The touchstone for determining whether claimant is entitled to TTD is whether the claimant's conditions had stabilized to the extent that they are able to reenter the workforce. *Id.* at P40.

The Arbitrator finds based on the facts as discussed above, that the petitioner reached MMI for the lumbar spine on March 3, 2007 as was found by Dr. Goldberg his treating surgeon and MMI full duty for the cervical spine on April 3, 2007 per Dr. Fetzer.

The petitioner was released to return to work with permanent restrictions per Dr. Goldberg. As he was authorized off work from April 17, 2006 until he is placed at MMI, the petitioner is owed TTD benefits from April 17, 2006 to April 3, 2007, or 50 2/7 weeks at a TTD rate of \$723.85/week.

After April 17, 2006, work restrictions were imposed by Dr. Goldberg which precluded his return to work in his prior capacity as a ramp serviceman. Vocational rehabilitation was provided by the respondent through Vocamotive. Despite the personnel issues that eventually occurred with Vocamotive with Petitioner, the Arbitrator finds that Petitioner did not appear to actively cooperate in that process and terminated vocational services on December 21, 2007. The petitioner testified and the record confirms that he did not at any time look for alternate employment within his restrictions. While the petitioner testified that he was kept off work by Dr. McGinness, there are not medical records which support this and this is contrary to all of the other doctors involved in his case. It appears there was no opinion provided that the petitioner could not return to work or was permanently disabled until Dr. McGinness testified on December 2, 2016. Dr. McGinness addressed work restrictions at her deposition on December 2, 2016 and in only two work restriction notes which are dated May 2, 2006 and November 5, 2007 (PX 19, pg 242 and 243). The doctor testified that the petitioner's treating orthopedic physicians were instead responsible for addressing his work status. His treating orthopedists all returned him to work in some capacity. The Arbitrator did not find Dr. McGinness to be a credible or persuasive witness.

Accordingly, maintenance benefits are awarded from April 4, 2007 to December 21, 2007 when petitioner terminated vocational rehabilitation and quit any effort to look for alternate employment within his restrictions. Respondent is given a TTD credit for the \$71,350.62 in benefits paid prior to trial.

Issue L, the nature and extent of the injury, the Arbitrator finds as follows:

As Petitioner's accidents occurred before September 1, 2011, adherence to Section 8.1b(b) of the Act is not required for establishing permanent partial disability but it is helpful to the Arbitrator in analyzing the permanency of the injury Petitioner sustained. In determining PPD benefits, Section 8.1b(b) of the Act directs the Commission to consider: "(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." 820 ILCS 305/8.1b(b); *Con-Way Freight, Inc. v. Illinois Workers' Compensation Comm'n*, 2016 IL App (1st) 152576WC, ¶ 22, 67 N.E.3d 959. "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b). "None of the factors set forth in section 8.1b is to be the sole determinant of the claimant's disability." *Corn Belt Energy Corp. v. Illinois Workers' Compensation Comm'n*, 2016 IL App (3d) 150311WC, ¶ 49.

As the claimant's disability is not limited in nature that he is obviously unemployable, and as there is no medical evidence to support a claim of permanent total disability, the burden is upon the petitioner to establish the unavailability of employment to a person in his circumstances. *Valley Mould & Iron Co. v. Industrial Comm'n*, 84 Ill. 2d 538, 546-47 (1981).

An employee is totally and permanently disabled when he is unable to make some contribution to industry sufficient to justify payment of wages to him. *A.M.T.C. of Illinois v. Ind. Comm'n*, 77 Ill.2d 482, 487(1979). It is the petitioner's burden to establish that he falls into the 'odd lot' category either by showing that evidence of a diligent but unsuccessful attempt to find work, or by showing that because of his age, skills, training, experience and education that he cannot find regular employment. The Petitioner here has not presented sufficient evidence of either. He has not looked for any work and the restrictions are not so limiting to establish that there is no employment available to him. The Arbitrator was not persuaded by the opinions of Mr. Patsavas for reasons previously explained.

The petitioner's request for a permanent total disability award pursuant to Section 8(f) of the Act is not supported by the evidence. Overall, the long timeline of petitioner's injuries and treatment appear to show Petitioner sustained a serious and permanent lumbar spine injury that required lumbar spine fusion surgery. He also suffered right shoulder injury that was misdiagnosed and/or developed into a cervical spine injury. The Arbitrator finds that Petitioner should have attempted to work within the permanent restrictions his surgeon Dr. Goldberg provided, as he was found at MMI by his treating physicians by April 2007. Despite this, Petitioner admitted during testimony, he never attempted to find work. Dr. Mather, one of Respondent's IME, also agreed that Petitioner required lumbar surgery (disagreed with a fusion) and permanent restrictions and could not return to his old job. Dr. Lami and Dr. Wehner, also agreed with the permanent restrictions Dr. Goldberg gave in 2007. Dr. Song, petitioner's most recent neurosurgeon/treater never gave work restrictions and also testified that he would defer to Dr. Goldberg's restrictions. The Arbitrator finds Petitioner to have suffered a significant low back injury that permanently injured him to the point he could never return to work as a ramp agent for Respondent, as he was given permanent restrictions. This is and was a loss of trade injury as of 2007. However, the Arbitrator is not convinced Petitioner is permanently and totally disabled after review of the numerous medical evidentiary records over the last 20 years, eight depositions and other professional vocational opinions provided. See further analysis below regarding permanency.

The restrictions imposed by Dr. Goldberg were restrictions to lifting 40 pounds occasionally from floor to waist, 25 pounds waist to shoulder, and overhead 20 pounds occasionally. Even if the petitioner was limited to lifting 25 lbs as suggested by the invalid FCE, the IME doctors and Dr. Song, the restrictions were not so onerous as to make the petitioner not employable. Following petitioner's discharge with restrictions, the respondent provided vocational services through Vocamotive. He was not, however, cooperative with the process. Mr. Belmonte identified jobs for the petitioner within his restrictions which included truck dispatcher, aircraft dispatcher, assembler, newspaper circulation clerk, security guard supervisor, order picking, security, cashier, entry level customer service, mailroom clerk and other jobs. As a lead ramp agent, the petitioner was responsible for making sure the plane goes out on time and everything was on the plane that was supposed to be loaded. Accordingly, the petitioner was equipped to perform supervisory duties.

Rather than undertake a good faith effort to participate, the petitioner appeared to make excuses, stated he wanted to relocate to California, and proposed that he be a Senator or Hollywood script writer. He reported he couldn't complete his job search assignments as he had to have Christmas lights installed.

Petitioner refused to participate in any job search activities on days that he was not at Vocamotive. Rather than applying for job leads provided to him, he apparently left inappropriate commentary on his computer. This further demonstrates that Mr. Loving was not taking the job search seriously. The Arbitrator notes there was testimony regarding petitioner's pain levels and effect of pain medications on him at Vocamotive. Some of his testimony regarding these issues was mentioned in the treating records and some of petitioner's poor performance at vocational rehabilitation would be explained by his pain medications/ sleepiness but not all. Since 2007, it is clear from the record that the petitioner has not at any time undertaken a job search of any kind.

The Arbitrator finds the report Mr. Patsavas undertook in 2019 insufficient to prove petitioner is not employable. It appears that the report was not prepared in effort to find the petitioner alternate employment. Mr. Loving also did not express any desire to find employment to Mr. Patsavas. Nor was Mr. Patsavas able to identify any jobs he considered for Mr. Loving. Mr. Patsavas did not conduct an interest inventory to assess what areas of employment may be appropriate for the petitioner. He did not evaluate whether the petitioner was a candidate for a retraining program or any classes which would improve his employment prospects. No explanation was provided as to why the petitioner could not work in one of the employment sectors identified by Mr. Belmonte as within the petitioner's restrictions per his treating surgeon, Dr. Goldberg. In short, Mr. Patsavas, the vocational expert hired by the petitioner's attorney, did not do any testing or evaluation of the petitioner other than meeting briefly with the petitioner to review his work restrictions, employment history and transferable skills.

Although Mr. Patsavas knew the petitioner had a criminal record and that this could impact what types of jobs he could perform, he did not request information from the petitioner at his intake evaluation as to the extent of that criminal record. Mr. Patsavas should have done more to properly assess petitioner's prospective job options and make further efforts to determine whether petitioner was employable or to assist petitioner in finding employment himself. His limited or more abbreviated report undermines the persuasiveness of his report to the Arbitrator.

The Respondent paid maintenance benefits and offered pay for vocational rehabilitation, including a job search. The petitioner terminated those services, has never requested any other vocational assistance and has not shown any interest in finding work. Accordingly, the petitioner has not proven an entitlement to permanent total disability benefits under Section 8(f).

The Arbitrator instead turns to an assessment of the petitioner's permanent partial disability. 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 ramp serviceman at the time of the accident and that he is not able to return to work in his prior capacity as a result of said injury and permanent restrictiond. The Arbitrator notes that this was a low skilled position, but because it is no longer available to the petitioner, the Arbitrator gives significant weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 46 years old at the time of the accident. Because he is now 65 years old and at retirement age, 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 that the petitioner has permanent restrictions of 25 lbs lifting as a result of the work accident and injury to his lumbar spine. That said, such a restrictions likely would not have impeded Mr. Loving from many potential occupations should he have had the desire to return to work from 2007 to present. Based on the opinions of the vocational expert Joseph Belmonte in 2007, the petitioner could have returned to work with earnings between \$10 and \$14.50/hour. The Arbitrator therefore gives greater 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 no records of any treatment after the discharge from Dr. Song on March 7, 2023, were introduced into evidence. In addition, Petitioner testified that he had not had treatment since that time. At that time, the petitioner complained of neck pain but there are no recorded complaints for his low back. There is little documentation of current lumbar spine disability in the medical records, however Petitioner was still precluded from returning to work as of March 2007 due to his serious lumbar injury. Despite not finding petitioner's current conditions of ill-being for the lumbar spine and cervical spine related to his work injuries, the Arbitrator relies on Dr. Goldberg assigning permanent restrictions which prevented Petitioner from returning to work for Respondent as a ramp agent as of his release from care. These restrictions were not disputed by Dr. Mather. IME doctors Dr. Lami and Dr. Wehner, also agreed with the imposition of permanent restrictions due to the lumbar fusion surgery performed. The Arbitrator therefore gives more 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 55% loss of use of the person as a whole pursuant to §8(d)2 of the Act. Respondent shall pay Petitioner permanent partial disability benefits of \$651.46/week for 275 weeks, because the injuries sustained caused 55% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

For the reasons stated above, Petitioner is entitled to an award of benefits under The Illinois Workers' Compensation Act consistent with the findings herein.

It is so ordered:



Jacqueline C. Hickey
Arbitrator

3/3/25
Date

March 4, 2025

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	07WC002653
Case Name	Shelton L Loving v. United Airlines
Consolidated Cases	06WC021799 06WC021800 06WC021815
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	25IWCC0502
Number of Pages of Decision	58
Decision Issued By	Carolyn Doherty, Commissioner

Petitioner Attorney	Donald Gallagher
Respondent Attorney	Karen Coon

DATE FILED: 12/19/2025

/s/ Carolyn Doherty, Commissioner

Signature

07 WC 2653

Page 1

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)
☐ Modify	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Shelton L. Loving,
 Petitioner,

vs.

No: 07 WC 2653

United Airlines, 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 causal connection, temporary total disability, maintenance, 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.¹

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 4, 2025, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under Section 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.

¹ Petitioner's Petition for Review refers to 06 WC 21799, which was tried together with the claims in 06 WC 21800, 06 WC 21815, and 07 WC 2653, and the Arbitrator issued four decisions. The Statement of Exceptions of both parties address the issues in all four claims. Accordingly, the Commission is issuing four separate decisions in this matter.

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.

December 19, 2025

O: 12/10/25

CMD/kcb

045

/s/ *Carolyn M. Doherty*

Carolyn M. Doherty

/s/ *Raychel A. Wesley*

Raychel A. Wesley

/s/ *Frank J. Soto*

Frank J. Soto

ILLINOIS WORKERS' COMPENSATION COMMISSION
DECISION SIGNATURE PAGE

Case Number	07WC002653
Case Name	Shelton L Loving v. United Airlines
Consolidated Cases	06WC021799; 06WC021800; 06WC021815;
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	55
Decision Issued By	Jacqueline Hickey, Arbitrator

Petitioner Attorney	Donald Gallagher
Respondent Attorney	Karen Coon

DATE FILED: 3/4/2025

/s/Jacqueline Hickey, Arbitrator
Signature

THE INTEREST RATE FOR THE WEEK OF MARCH 4, 2025 4.14%

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**

Shelton L. Loving

Employee/Petitioner

v.

United Airlines, Inc.

Employer/Respondent

Case # **07 WC 02653**

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 **Jacqueline Hickey**, Arbitrator of the Commission, in the city of **Chicago**, on **9/30/24**. 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 **4/17/06**, 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 **\$56,460.04**; the average weekly wage was **\$1,085.77**.

On the date of accident, Petitioner was 46 years of age, married with **4** dependent children.

ORDER

The Arbitrator finds Petitioner sustained work-related injuries with respect to the lumbar spine on 11/4/05, 12/23/05 and 4/17/06. Petitioner reached MMI with permanent restrictions, per Dr. Goldberg, on March 7, 2007.

The Arbitrator finds Petitioner sustained work-related injuries with respect to the cervical spine and right shoulder on 3/10/06. Petitioner reached MMI with full duty release, on April 3, 2007.

Respondent shall pay Petitioner TTD benefits of \$723.85/week for 50 2/7 weeks, commencing April 17, 2006 through April 3, 2007, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of \$723.85/week for 37 3/7 weeks, commencing April 4, 2007 through December 21, 2007, as provided in Section 8(a) of the Act.

Respondent shall be given a TTD credit of \$71,350.62 for benefits paid prior to trial.

Respondent shall pay Petitioner permanent partial disability benefits of \$651.46/week for 275 weeks, because the injuries sustained caused 55% 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

March 4, 2025

First Work Accident: 11/04/05

On November 4, 2005, the petitioner testified he was hooking up two containers for the luggage which weighed about 1,700 pounds. As he was going to clamp the container on the tug he was driving, he slipped on the ice, tried to catch himself and hurt his back (Tr. 24). The petitioner was seen at UIC Medical Clinic at O'Hare and was treated with muscle relaxers. The petitioner worked full duty until his second work accident and did not lose any time after this accident (Tr. 26-27).

Second Work Accident: 12/23/05

On December 23, 2005, the petitioner testified he was hooking up containers to a tug. He was hooking up two containers back-to-back and he injured his back, legs, and hips (Tr. 28). He once again was seen at UIC at O'Hare and then at Celar Chiropractic (Tr. 28). Petitioner testified he was also referred to and seen by Dr. McGinness, his primary care physician, by Celar. (Tr. 29). Again, the petitioner did not lose any time from work. (Id.)

Third Work Accident: 3/10/06

On March 10, 2006, the petitioner was handling luggage. As he was taking the luggage out of the containers to put on the belt, he felt something pop in his neck, arm and right shoulder (pp. 29-30). Petitioner sought treatment with Dr. McGinness, Celar Chiropractic, and Rush Oak Park Hospital (Tr. 31) but he continued working full duty (Tr. 31).

Fourth Work Accident: 4/17/06

On April 17, 2006, the petitioner was in the belly of a plane getting bags off the belt loader. Because he was working in an RJ jet, which was very tight, he was squatting to pick up luggage and heard something pop in his back (Tr. 33). He fell down and felt his neck pull because he was picking up the luggage and his back popped and went out and he fell (Tr. 33). He testified he could not move and the luggage started falling on him and he yelled for help. His coworkers stopped the belt and ran to get assistance (pp. 33-34). Petitioner was taken by ambulance to the hospital (Tr. 34). April 17, 2006 was the last day petitioner worked for Respondent, United Airlines (Tr. 35).

Petitioner's Testimony

After the ER, Petitioner was seen by his primary care physician Dr. McGinness who prescribed an MRI. (Tr. 35). After the MRI Mr. Loving was referred to Dr. Coe and Dr. Amin. (TR p 35). Petitioner was referred to Midwest Orthopedics at Rush and seen by Dr. Palmer a pain management doctor. (Tr. 36) Dr. Palmer eventually referred the petitioner to Dr. Goldberg for surgical consultation. (Id.) Petitioner also saw Dr. Nicholson from Midwest Orthopedics. (Tr.37) At Midwest Orthopaedics at Rush, Petitioner saw all of the following doctors: Dr. Nicholson, Dr. Goldberg, Dr. Palmer and Dr. April Fetzer (Tr. 36). Petitioner testified to the L4 through S1 fusion surgery performed by Dr. Goldberg but testified that it was a failed fusion and he got no relief from the surgery (Tr. 39). He subsequently followed up with Dr. Fetzer and got shots and pain management in his back, after the fusion. (Id.) He also received shots and physical therapy for his neck (Tr. 40).

Petitioner also testified that he relocated to Springfield in 2011 through 2014. (Tr. 40)

The petitioner began the vocational process with Joseph Belmonte at Vocamotive in September 2007 (Tr. 41). The petitioner had been released by Dr. Goldberg with lifting restrictions of 40 pounds from floor to waist, 25 pounds from waist to the middle of his chest and 10 pounds from his chest and up (Tr. 41-42). Petitioner testified he did not begin looking for jobs within those restrictions with Vocamotive as he was in a lot of pain and on a lot of heavy narcotics. (Tr. 42-43) He testified that he kept falling asleep with his head on the desk. He testified that he told Dr. McGinness he was having problems in class falling asleep due to the drugs and pain and that the doctor therefore took him out of school because of the narcotics (Tr. 44). The petitioner testified to the letter he received from Mr. Belmonte apologizing for the accusations regarding petitioner being called a liar and not getting hurt (Tr. 43-44) He testified that Vocamotive also had an employee who was less than professional and somewhat ill-will motivated with petitioner (Id.)

After stopping Vocamotive services, Petitioner testified that he treated with Dr. McGinness, in the basement of Oak Park Rush Physical Therapy Athletics in Countryside and did self-rehabilitation. (Tr. 52-53)

Petitioner testified in 2008 he was struck from behind in a car accident. The paramedics were called and an ambulance took him for medical treatment (Tr. 55). He was provided a pain shot and he began seeking treatment at West Suburban (Tr. 55). With reference to the auto accident in 2008, petitioner confirmed he was stopped at a stop sign and a lady ran into him going 35 to 40 miles per hour (Tr. 89). When he was seen at Loyola Hospital ER following the auto accident, he complained of pain to his neck, back, chest, and right shoulder (Tr. 90). He also treated for his neck and back with West Suburban Medical Center following the automobile accident (Tr. 90). He was unable to recall how much money he received in a monetary settlement from the auto accident (Tr. 91).

Petitioner testified that he initially saw Dr. Song in the hospital on November 15, 2022 at Hinsdale Hospital ER (Tr. 59). He testified that he went to Rush the day before and was given a shot of Toradol which did not improve his condition (Tr. 59). He felt he could not move his legs and was in excruciating pain. He reported he had to crawl to the front room to get to a phone to call paramedics, as he could not move (Tr. 60). Petitioner testified that he has not seen any doctor since Dr. Song performed the second lumbar surgery (Tr. 57). Before seeing Dr. Song petitioner was treating with Dr. Salvador in Springfield, Dr. Ross in Savannah, GA, and Rush Oak Park Hospital. (Tr. 61). Since the surgery, he testified that both legs are numb (Tr. 57).

The petitioner testified to prior education at Moody Bible Institute, National Technical Institute, and DeVry Technical Institute. In addition, he went to Malcom X College for three years. He previously worked as a forklift operator, and did manufacturing and palletizing. He also worked security for Arch and Bright Security at ORD and did temp work for Manpower. Lastly, he testified that he worked for the U.S. Postal Service (pp. 93-94). Mr. Loving was asked about his desire as expressed to Mr. Belmonte to move to California and become a script writer and becoming an alderman or congressman (Tr. 94). He stated he talked with Mr. Clint Eastwood a couple times and another black star, but they were not interested in his scripts (Tr. 95).

He also suggested that when working with Mr. Belmonte they showed he was getting As and Bs on the testing, but that he was asleep and they went into his computer and put the As and Bs in there for him (Tr. 96).

Mr. Loving testified that Dr. McGinness, his PCP and current physician, at the present still has petitioner temporarily and totally disabled, and completely off work. (Tr. 51-52) Presently, Petitioner testified that both of his legs go numb. (Tr. 57) Petitioner testified he has not looked for work within the restrictions given, as his body is no good (Tr. 64). The petitioner testified that currently he has ongoing pain and does not sleep at night. He is unable to clean and he has a maid from the State who comes to clean his house and cook his dinners (Tr. 69). He also received Meals on Wheels in Countryside, Illinois. (Tr. 69). Presently Petitioner stated he does not really feel like a man without being able to work and being infirmed. (Tr. 70) Mr. Loving is currently on Medicare and social security disability. (Tr. 73) Mr. Loving testified that he knows he cannot work and just underwent another back surgery in 2022. (Tr. 74) Petitioner stated he still has 10 rods and two brackets still in his lumbar spine. (Tr. 75) Petitioner has fallen to the ground twice after his second back surgery with Dr. Song. (Id.) Mr. Loving testified he has never, not been able to work until these four work related injuries occurred. (Tr. 104

On cross examination, the Petitioner testified he did not recall being seen on multiple dates in the years prior to the work accidents for low back pain. (Tr. 1-85) He did testify he previously suffered from migraines but did not recall who he had seen for them (Tr. 81). When presented with the medical records of prior low back pain complaints, he stated, "To me, it seems like there is consistency of going to the doctor for my back. I don't remember if it was" (Tr. 86). Petitioner was specifically asked about seven prior doctors' visits from March 1999 through August 2004, with/at St. Luke's, Dr. Leavitt, Dr. McGinness and Dr. Lenhardt for complaints relating to the low back, migraines and right upper arm. (Tr. 81-85).

Testimony of David Aranda- Respondent witness

The respondent introduced the surveillance video evidence with the testimony of David Aranda, the investigator. The petitioner was surveilled on March 5 and March 7, 2020. (RX 8a/8b) The petitioner is seen going on several errands. On March 7, 2020 the petitioner went to a church for an event. The video shows him walking freely and without pain. He is seen lifting and moving two traffic cones and lifting and carrying a piece of luggage. This is all done without any apparent limitation.

Medical Record Summary

On November 16, 1999 the petitioner was seen by Dr. J. Leavitt where he complained of both lower and upper back pain. Dr. Leavitt ordered an x-ray of the right hip and pelvis and suggested taking Motrin. As is noted by Dr. Leavitt in a visit with the petitioner on March 7, 2000, the petitioner never went to get the prescribed x-rays and he never took the suggested Motrin. Petitioner was still complaining of lower back pain at this time.

On August 23, 2002 petitioner presented to Anchor Medical Group complaining of chest pain, kidney pain, and right lower abdomen pain. The report is handwritten but petitioner was assessed in part with mechanical back pain. (Rx. 5)

On November 4, 2002 petitioner presented to Anchor Medical Group again complaining of back pain that appeared to be causing pain in his right upper arm. (RX 5, Pg. 8)

On April 6, 2004 Dr. Kurtzman authored a letter to Dr. McGinness for referring petitioner to him. Dr. Kurtzman recommended petitioner see a neurologist and obtain an MRI of the brain because of his history of migraine headaches that recently increased.

Petitioner went again to Oak Park Anchor Medical Group with complaints of back pain again on May 17, 2004. (RX 5, Pg. 13)

On June 28, 2004 petitioner complained of back pain and difficulty breathing during his visit at Anchor Medical Group. (RX 5, Pg. 14)

On July 12, 2004, petitioner was seen in follow up. (RX 5, Pg. 15-16) An x-ray of the dorsal spine was taken that showed apparent generalized increased sclerosis throughout the lower thoracic spine. A bone scan was recommended by the radiologist. On July 31, 2004 a bone scan showed no abnormalities.

On August 12, 2004 Dr. Lernhardt authored a letter to Dr. McGinnis regarding a recent evaluation of right posterior pleuric discomfort and back pain that petitioner stated was ongoing the prior 10 weeks. Dr. Lernhardt opined petitioner's back pain was very likely related to musculoskeletal discomfort and the mild pleuritic component was related to the same. He recommended petitioner continue analgesics and minimize heavy lifting.

On November 4, 2004 petitioner complained of right pelvic, hip, and back pain. (RX 5, Pg.8)

On April 15, 2005 petitioner complained severe headaches with dizziness during his visit at Anchor Medical Group. (RX 5, Pg. 21)

Petitioner was seen at UIC Medical Center at O'Hare November 4, 2005. (PX 20) He reported lifting heavy bags on his knees in the pit when he twisted the wrong way with a heavy bag. He reported feeling pain in his low back area.

The petitioner was seen on December 23, 2005 at UIC at O'Hare. (PX 20). He reported he had a lumbar sprain November 4 and was sent back to full duty on the date of accident but reported continued pain with lifting since that time and acute increase in low back pain and radiation into left thigh when lifting a heavy bag this afternoon. He reported no pain distal to the knee and no numbness, weakness or tingling. Neurological testing was normal. Petitioner was ordered to do light duty work and prescribed tramadol and naproxen.

The petitioner was seen again at UIC at O'Hare on December 29, 2005. He reported his pain was worse and he had trouble getting out of bed this morning. The impression was lumbar strain and he was referred to an ortho. (PX 20).

Petitioner was seen on January 10, 2006 at Rush Oak Park Physician's Group complaining of back pain, left abdominal pain and left ear pain. He reported that he injured himself at work on December 8, 2005 when he pulled something in his back. (RX 5, Pg. 28)

Petitioner then sought treatment at Celar Chiropractic with Dr. Celar beginning on January 11, 2006. Petitioner continued to be seen at that facility on a weekly basis for low back pain, left shoulder pain, and upper back pain. (PX 10)

On January 11, 2006 an x-ray of the lumbar spine was taken and showed: (1) spinal biomechanical alterations; (2) facet tropism; (3) facet arthrosis; and (4) degenerative disc disease at L5.

On February 22, 2006 Dr. Celar completed a work status form that indicated petitioner was to work full duty. Petitioner continued attending chiropractic sessions.

Petitioner was seen at Celar Chiropractic on March 14, 2006 for a new injury. On March 14, 2006, Dr. Celar opined petitioner had an acute rotator cuff/deltoid sprain/strain from the work injury and might need an MRI. He reported he was injured while lifting up and tossing a heavy bag. Petitioner reported pain in the right arm and upper back. PX 10.

On April 13, 2006 petitioner followed up at Rush Oak Park Physicians Group for pain in his right arm. (RX 5, Pg. 32)

On April 17, 2006, the petitioner was taken by Chicago Fire Department Ambulance to Resurrection Medical Center. The fire department ambulance records specifically note he had no neck or upper back pain. (Px 7)

The petitioner was seen at Resurrection Medical Center on April 17, 2006 for low back pain while lifting a suitcase. (PX 7). A pain diagram also indicates pain only in the low back. Petitioner stated he bent over to pick up a luggage bag and felt something pull in his back. He was ambulatory. Petitioner again reported he felt something in his lower back go crunch after he bent over and lifted a piece of luggage out of a small cargo area. (PX 7). At the time of petitioner's discharge, he reported his pain was much better. X-rays of the lumbar spine were normal with vertebral heights and intervertebral spaces maintained.

On April 18, 2006, the petitioner presented for evaluation of low back pain at Rush Oak Park Physicians Group after claiming he hurt his back at work on April 17, 2006. (RX 5, Pg. 34) He reported that while bending over to pick up some luggage, he felt a crackle in his right lower back.

An MRI of the right shoulder was performed on April 18, 2006. (RX 6, Pg 240) The study showed a possible Hill-Sachs deformity and associated marrow edema compatible with subacute injury. There was no conclusive evidence of a Bankart lesion. There were findings suggesting a strain of the distal aspect of the common tendon of the rotator cuff, however, it was noted a partial thickness tear could give a similar appearance

Petitioner was seen again by Dr. McGinness on April 26, 2006 for right lower back which radiated to the thigh with numbness to the right kneecap. (RX 5, Pg. 38)

On May 2, 2006, the Anchor Medical notes reflect that the injury was most likely a muscle sprain in the lower back. They refilled his hydrocodone and gave petitioner a prescription for Flexeril. An MRI was ordered.

Petitioner was seen on May 4, 2006 by Dr. Trish Palmer for evaluation of injuries to the left low back and right arm. (Rx 6, pg 46) Petitioner reported on March 10, 2006 he was lifting a heavy bag in his job as luggage handler. When he went to place it on the belt, he felt immediate pain. He complained of pain over the lateral anterior aspect of the right shoulder. Petitioner stated the low back pain began on April 17, 2006 while lifting a very heavy bag in a forward flexed position. Dr. Palmer diagnosed radicular back pain and right shoulder pain due to rotator cuff irritation or partial tear of the supraspinatus. As there was no frank tear, Dr. Palmer recommended a subacromial cortisone injection and physical therapy for the shoulder and the back. Dr. Palmer performed an injection into the subacromial space.

An MRI of the lumbar spine was performed on May 9, 2006 and demonstrated spondylitic and degenerative changes, a broad-based mild disc herniation at L4-L5, and a less pronounced herniation at L5-S1 to the right with associated right foraminal stenosis. (RX 6, pg 237)

When the petitioner returned to Dr. Palmer on May 15, 2006, he reported that the shoulder injections had completely relieved his pain for three days. (Rx 6, pg 44) His back symptoms were fairly consistent with the MRI results and Dr. Palmer recommended continued physical therapy. The petitioner was referred to Dr. Nicholson for further evaluation of the shoulder and was referred to Dr. April Fetzer for consideration of an epidural injection. Dr. Palmer continued monitoring the petitioner's Lyrica and Vicodin dosing, but noted she was limited as to what further she could offer the petitioner. The petitioner was seen in follow up by Dr. Palmer on June 12, 2006 with similar findings and recommendations. (Rx 6, pg 42)

The petitioner was next seen on June 19, 2006 by Dr. Palmer. (Rx 6, pg 40) He reported improvement in his back pain but was still complaining of a catching sensation with forward flexion in the shoulder. His back was improving with PT and he was referred to Dr. Nicholson for the shoulder. (Rx 6, pg 41)

A physical therapy progress note dated June 27, 2006 indicated that petitioner continued to have stiffness in his right upper extremity with continued decrease in range of motion. Overall though, petitioner felt his trunk range of motion and lumbar symptoms had improved. Active range of motion of the upper extremity was still limited which caused overhead activity deficits. On July 17, 2006, petitioner saw Dr. Palmer who opined petitioner might have a SLAP tear which did not show up on the MRI. (Rx 6, pg 38) Dr. Palmer referred petitioner to a shoulder specialist.

The petitioner was seen by shoulder specialist, Dr. Gregory Nicholson on August 1, 2006. (Rx 6, pg 86) Dr. Nicholson noted that as he started to examine the petitioner, he jumped out of the chair. The petitioner could not even tolerate even simple motion or isometrics. In reviewing the MRI, he noted there was a high signal within the bursa, however there did not appear to be a Hill Sachs deformity. The doctor noted the possibility of a small interior partial tear of the supraspinatus. He found the petitioner's pain to be out of proportion to his physical findings in the right shoulder. Dr. Nicholson noted the petitioner had a subacromial pathologic process including a small partial tear and subacromial bursitis. That being said, his pain was tremendously out of proportion to the physical findings. Dr. Nicholson opined that it would be dangerous to institute physical therapy or treatment until his back issues were sorted out. Dr. Nicholson was concerned about the petitioner's symptom magnification, as it was out of proportion to his physical findings for this type of pathology. (Rx 6, pg 87)

The petitioner was evaluated by Dr. April Fetzer on August 4, 2006. (Rx 6, pg 35) Petitioner reported that he initially injured himself on November 4, 2005 with right-sided axial low back pain and right thigh symptoms. He was treated by a United Airlines physician with a muscle relaxant and chiropractic treatment, however his symptoms never fully resolved. He continued working and reinjured himself on April 17, 2006. Dr. Fetzer diagnosed right L4 and L5 radiculopathy and recommended epidural steroid injections. Mr. Loving did not want to undergo same, and instead requested surgery. The petitioner was referred to Dr. Edward Goldberg for evaluation.

On August 14, 2006, Dr. Palmer noted a positive Spurling test on the right for reproduction of shoulder pain. (Rx 6, pg 33) This was noted to be a new finding. As this suggested that the shoulder pain may be originating in the neck, an MRI of the cervical spine was recommended. Id.

Dr. Goldberg evaluated the petitioner on August 18, 2006. (RX 6, pg 80) Dr. Goldberg opined that the petitioner sustained a disc herniation and aggravated his degenerative disc disease with the work-related accident. He recommended a laminectomy and discectomy at L4-L5 and posterolateral fusion at L4-L5 and L5-S1 with iliac bone crest and pedicle screw instrumentation.

Correspondence was issued by Dr. Nicholson on August 29, 2006 indicating that while petitioner may need physical therapy for his shoulder, he felt it would be counter-productive to have him get into the program and aggravate his low back condition. Dr. Nicholson noted that he had examined the patient and that his pain was out of proportion to his physical findings. (RX 6, pg 77) His complaints were noted to be "quite histrionic." The doctor further noted he was an extremely difficult gentleman to examine. Dr. Nicholson advised that he did not feel that there was a rotator cuff tear and suggested they instead address the lumbar situation.

On September 19, 2006 Dr. Goldberg performed the right L4-L5 hemilaminotomy and discectomy, and posterolateral spinal fusion at L4-L5 and L5-S1. The diagnosis was degenerative disk disease L4-L5 and L5-S1 with superimposed central herniated nucleus pulposus L4-L5. (RX 6, pg 117)

Following surgery, petitioner followed-up with Dr. Goldberg on October 4, 2006. (Rx 6, pg 75) Overall he was doing well. Petitioner's chief complaint was difficulty with sexual function. The doctor explained that it was extremely unlikely that this was caused by the spine surgery due to the fact that this was a posterior approach.

The petitioner was seen by Dr. Goldberg on October 23, 2006 at six weeks status post surgery. He was doing well and was neurologically intact. X-rays showed the instrumentation to be well positioned at L4-S1 with good fusion mass.

The MRI of the cervical spine was performed on November 10, 2006 and demonstrated C4-C5 right bulging disc, C5-C6 central broad-based bulging disc abutting the anterior border of the spinal canal producing mild to moderate spinal stenosis with mild to moderate narrowing of the intervertebral foramina, and C6-C7 central broad-based bulging disc with mild narrowing of the spinal canal. (RX 6, pg 234)

On November 13, 2006 petitioner met with Dr. Palmer to discuss the cervical MRI. (Rx 6, pg 26) As it was possible petitioner's shoulder pain was derived from disk problems in his neck, on December 4, 2006, Dr. Palmer suggested he see Dr. Fetzer for a cervical injection.

On December 6, 2006 Dr. Goldberg noted petitioner was doing quite nicely with respect to his low back. (Rx. 6, pg 67) He recommended six more weeks of therapy for the lumbar spine after which it was possible that light duty could be started. (Px 16)

The petitioner was seen by Dr. Fetzer on December 8, 2006. (Rx 6, pg 22) He had full active range of motion of the cervical spine in all planes and the cervical Spurling's maneuver was negative bilaterally. While he stated he could not actively raise his right arm above his head, on examination, he raised it to approximately 110 degrees of abduction. The doctor explained that Neer's, Hoffman's and supraspinatus testing were all positive. Shoulder internal and external rotation was both 5/5. She felt that the petitioner's symptoms may be somewhat exaggerated on exam. The differential diagnosis could include right C5 radiculopathy versus right rotator cuff pathology. A diagnostic right C5 selective nerve root injection was ordered.

The petitioner underwent a right C5 selective nerve root block on December 19, 2006. (Rx 6, pg 19) The petitioner was seen by Dr. Fetzer on January 16, 2007 after undergoing a right C5 selective nerve root block. (Rx. 6, pg 17) He denied any further radicular symptoms. As he had improved, Dr. Fetzer recommended they hold off on any additional epidural steroid injections and instead recommended work conditioning.

On January 17, 2007, four and one-half months status post-fusion L4 to S1, the petitioner's only complaint was pain over the left iliac crest donor site. (Rx. 6, pg 63) X-rays showed a very good fusion forming. His radicular pain and back pain had markedly improved. Dr. Goldberg recommended work conditioning for six weeks for the cervical and lumbar spine.

IME- Dr. Wehner

An IME was performed by Dr. Wehner on February 9, 2007. (Rx. 1, Dep Ex. 2) Dr. Wehner noted the history of treatment and provided a diagnosis of low back pain. She noted he had a fusion for some degenerative disc disease at L4-L5 and L5-S1. He was progressing slower than would be anticipated. She did not see anything in the cervical spine warranting surgery. He was not at maximum medical improvement and should continue with physical therapy prior to any work hardening. She cautioned against any other surgery given his fairly high pain complaints despite the fairly minor MRI findings and the overall response to surgery.

The petitioner was seen in follow up on February 13, 2007 by Dr. Fetzer. (Rx 6, pg 13) While the doctor had previously recommended a work conditioning program, Mr. Loving had not undergone any work conditioning. He instead reported that he had opted to do home exercises on his own. He reported a past history of migraines for which he would take Imitrex provided by his primary care physician Dr. McGinnis. Examination of the cervical spine was negative/normal. The doctor recommended a six-week course of work conditioning followed by a functional capacity evaluation and a second right C5 nerve root block. A right C5 selective nerve root block was performed on February 20, 2007. (Rx 6, pg 11)

On February 26, 2007 an initial baseline Physical Performance Test found petitioner demonstrated functional ability between the light and light to medium work demand levels. (Px 24) Work conditioning was prescribed.

Petitioner began work conditioning on February 27, 2007. A progress note dated March 7, 2007 reported petitioner had made “inappropriately slow progress in Work Conditioning due to the client’s refusal to perform resistive activities due to subjective complaints of pain without correlating clinical objective findings.” (RX 6, pg 215) Additionally, it was noted he required verbal cues and supervision to remain on task. The therapist asserted this was an “invalid” performance in work conditioning and noted petitioner had been given verbal warnings for non-compliance after receiving specific instructions in the proper conduct for participation. The petitioner demonstrated poor body mechanics and the therapist noted that “One would expect a client with a high level of low back pain to perform this activity with proper body mechanics to minimize the stress in the low back and to maximize the efficiency of the lift.” (RX 6, pg. 216) An FCE with emphasis on validity was recommended.

Dr. Goldberg saw the petitioner on March 7, 2007. (Rx. 6, pg 61) After additional work hardening, the doctor noted he could now lift 40 pounds occasionally from floor to waist, 25 pounds waist to shoulder, and overhead 20 pounds occasionally. Some invalidity was noted by the examiner during his evaluation. Dr. Goldberg authorized the petitioner to return to work within the work conditioning recommendations. Dr. Goldberg opined he was at MMI with respect to the lumbar spine and should see Dr. Fetzer regarding the cervical condition.

The petitioner was seen by Dr. Palmer on March 12, 2007. (Rx 6, Pg. 59) Petitioner reported that he had three injections to the neck with Dr. Fetzer. Due to an increase in pain from the right lateral neck to the superior shoulder into the forearm and fingers, Dr. Palmer referred him back to Dr. Goldberg for evaluation of the neck and shoulder.

The petitioner was seen at Accelerated Rehabilitation Center for a functional capacity evaluation on March 26, 2007 ordered by Dr. Fetzer. (RX 6, Pg. 207) A physical demand level could not be determined due to petitioner failing eighteen out of twenty-five objective validity criteria. The results were found to be invalid due to the submaximal effort given by petitioner. Notably, he also scored positive on four out of five Waddell's signs for low back pain. It was felt that he was capable of functioning at a higher category of work than he demonstrated in the testing.

The petitioner was seen on April 3, 2007 again by Dr. Fetzer after undergoing the functional capacity evaluation. (RX 6, pg 8) Dr. Fetzer noted that it was found to be an invalid study secondary to sub-maximal effort with 4/5 Waddell's nonorganic signs being positive on this evaluation. On physical examination, Dr. Fetzer noted, "Mr. Loving exhibits some Waddell signs today including overreaction simulation and he does not participate in our exam." (RX6, pg 8) The doctor noted that based on his failure of all reported treatment in combination with his multiple non-organic signs and the invalid functional capacity evaluation, the doctor believed he was at maximum medical improvement for his symptoms at this time. He was released to return to work full time and full duty. (Rx 6, pg 8)

The petitioner was seen at Rush Oak Park Outpatient Physical Therapy for a lumbar, cervical and spine evaluation on April 5, 2007. It was noted that his back pain began in 2004 when he hurt himself at work while lifting luggage. His neck pain began in 2007 and was of insidious onset. The petitioner reported he was depressed and unable to perform activities. He was on medication for depression and had significant difficulty performing almost any activity. It was recommended they do physical therapy three times a week for eight weeks.

Petitioner was seen by Dr. Palmer on April 11, 2007. (Rx 6, pg 57) The doctor noted he had not gone back to work, although he had been advised to do so. He rated his pain at 9/10, but on physical examination the petitioner was in no acute distress. He had no psychomotor agitation and neurological examination revealed give-way weakness. Dr. Palmer reviewed the notes of Dr. Fetzer and Dr. Goldberg and noted that he had multiple non-organic signs and an invalid FCE. **He was at MMI for the cervical spine and lumbar spine. Dr. Palmer recommended he return to work with restrictions per Dr. Fetzer for his neck and per Dr. Goldberg for his back.**

Dr. Fetzer evaluated the petitioner on April 13, 2007. (RX 6, pg. 127) On exam, he exhibited some waddell signs today including overreaction simulation and he did not participate in the exam. He would not actively range his arms above 70 degrees. Motor testing showed give-way throughout the bilateral upper extremities. She noted that given the failure of all reported treatment attempts in combination with his multiple nonorganic signs that are present and the invalid functional capacity evaluation, she placed the petitioner at MMI and released him to return to work at full time, full duty. (RX 6, pg 127)

On May 15, 2007, the petitioner presented to Rush Oak Park Physicians Group with complaints of low back pain and shoulder pain. (RX 5, Pg. 42) . He was noted to be currently taking Atarax and Vicodin. The petitioner returned to the Rush Oak Park on June 21, 2007 with continued complaints of back pain with radiation down his right leg. (RX 5, Pg.44)

On July 9, 2007, Dr. Sandeep Amin on referral from Dr. McGuinness, discussed various options including medical management versus surgical re-evaluation or repeat epidural injections. The petitioner was not interested in considering surgery, a stimulator implant, or an epidural injection. He was started on Topamax.

The petitioner was seen for back pain at Rush Oak Park Physicians Group on August 28, 2007. (RX 5, Pg. 48) The petitioner was next seen at Rush Oak Park on December 20, 2007 for complaints of back pain and left first finger pain. (RX 5, Pg. 48)

On February 21, 2008, petitioner underwent MRI of lumbar spine with and without contrast. The study showed spondylotic changes of with degenerative disks at L4-L5 and L5-L1. Also noted was the posterior fusion with fixation devices in place extending from L4-L1 and central protrusion of the disc at L5-L1. There was a moderate degree of stenosis at L2-L3 and L3-L4, mild stenosis at L4-L5

The petitioner returned to Rush Oak Park on May 16, 2008 complaining that his back pain started worsening in the past 3-4 days despite his medication. (RX 5, Pg.54) The petitioner was referred for steroid injections. At additional visits on July 1, 2008 and August 14, 2008, the petitioner complained of back and neck pain.

Motor Vehicle Collision

The petitioner was involved in an auto accident where he was rear ended on August 19, 2008. Following the automobile accident, the petitioner was seen at Loyola Hospital ER. (RX 7) The petitioner presented on August 19, 2008 as a restrained driver who was rear-ended injuring his neck, back, chest and left jaw. (Rx. 7, Pg. 175) He reported he was thrown forward, hitting his chest on the steering wheel. He was restrained, but the seat belt did not lock and he hit the steering wheel. In addition to pain in the chest, the petitioner also complained of worsening low back pain, neck pain and right shoulder pain. He also had complaints of pain in the hips. A CT scan of the cervical spine showed no evidence of acute fracture or subluxation. Imaging of the shoulder/hip/spine was negative for acute fracture or dislocation X-rays of the lumbosacral spine showed a posterior spinal fusion L4 to S1 with trace retrolisthesis L5-S1. X-rays of the cervical spine showed slight right convex curvature, which may be related to muscle spasm or patient positioning. There was also straightening of the cervical spine likely related to muscle spasm or cervical collar. CT scans of the lumbar and cervical spine were suggested if the petitioner remained symptomatic. The petitioner was admitted to general medicine for a workup of chest pain, evaluation of back mass and pain control.

The hospital discharge summary reflects that the petitioner is a 49-year-old male with primary history of chronic low back pain, status post laminectomy, who presented to the emergency department with chest pain following a motor vehicle accident. (RX 7, Pg.150) He was restrained, but the seat belt did not lock and he hit the steering wheel. The air bag did not deploy. The petitioner complained of non-radiating numbness and a burning sensation in the left side of the chest. This was relieved with oxygen in the field and morphine was provided in the emergency department. The petitioner also complained of worsening low back pain, neck pain and right shoulder pain. He denied any focal weakness or loss of motion. Imaging of the shoulder/hip/spine was negative for acute fracture or dislocation. A CT of the neck incidentally noted a soft tissue nodule. The petitioner was discharged with Flexeril and Vicodin for musculoskeletal pain. He was referred to physical therapy which was scheduled to begin on August 22, 2008.

Dr. McGinnis completed a cervical spine residual functional capacity questionnaire, headache residual functional capacity questionnaire and lumbar spine functional capacity questionnaire on August 24, 2008. (PX 19) The cervical spine functional capacity questionnaire indicated the petitioner had cervical radiculopathy with chronic pain and paraesthesias. The headache, residual functioning capacity questionnaire indicated he had migraines, cervical radiculopathy and lumbar radiculopathy for a period of six years. He would get headaches lasting three days. The doctor felt he was unable to work because of these and again noted he was incapable of even a low stress job. The lumbar assessment similarly indicates that it has been present for six years and that the petitioner is unable to work. (PX 19).

Following the auto accident, the petitioner was seen at West Suburban Medical Center on August 28, 2008. (PX 28) He reported pain in his head, chest, hips and back. He reported he was sitting at a red light when he was rear-ended by a driver going 35 to 40 miles per hour. He was in Loyola Medical Center for two days and was still having significant low back pain and shooting pain down the right leg, as well as into the right neck and shoulder pain. This was constant with numbness and tingling into the hands and fingers. He was on Fentanyl and Darvocet and his pain was noted to be more intense since the auto accident. It was also noted the petitioner had a history of migraine headaches and was requesting an Imitrex refill. He was diagnosed with upper and lower back muscle spasms following a motor vehicle accident and musculoskeletal chest pain. Physical therapy was ordered, as well as Valium and Norco. He was directed to continue Fentanyl, Darvocet and Norco. He had continued pain on September 9, 2008.

Petitioner was next seen for a follow up at Rush Oak Park on August 29, 2008. (RX 5, Pg. 60) He complained of back pain, right shoulder pain, neck pain, and migraine headaches. Additionally on August 29, 2008 Dr. McGinness completed a Lumbar Spine Residual Functional Capacity Questionnaire. This indicated petitioner back pain was ongoing for six years and he was diagnosed with lumbar radiculopathy.

On September 8, 2008 petitioner was assessed by Dr. Lenny Cohen, a neurologist of Rush Oak Park. (PX 19) Petitioner reported a history of chronic back pain in the lumbar and cervical spine. Dr. Cohen recommended an EMG of the upper and lower extremities, trigger point injections, stopping temazepam, cyclobenzaprine, diazepam, propoxyphene, fentanyl, and limiting Vicodin. A prescription for Amrex was recommended.

A CT of the neck with contrast was performed September 24, 2008 for a left neck nodule, which had been identified on the prior cervical CT done following the auto accident on August 19, 2008. Resolution was limited below C4 and there was concern for a disc herniation in the lower cervical spine. Further evaluation was advised. There was no evidence of acute fracture or subluxation.

When he was seen in follow-up at West Suburban Medical Center on September 26, 2008, he reported ongoing neck, shoulder and back pain. (PX 28) He also reported depression since the auto accident. It was noted he had been seeing a therapist and psychiatrist and had been started on Cymbalta. He reported passive suicidal ideation and thoughts of ending his life on occasion. The records of this date also indicate the petitioner was no longer using a cane. was status post MVA with depression and the patient acknowledged a "long road ahead" to recovery. (PX 28)

He again followed up at West Suburban Medical Center on October 3, 2008 for his motor vehicle accident and resulting neck and back pain. (PX 28) It was noted that he was moving slowly, with his gait slightly forward at waist. He continued to follow up for neck and back pain related to his motor vehicle accident, including cervical, thoracic and lumbar somatic dysfunction, for which he underwent manipulation through at least February 26, 2009. In March of 2009, he was referred for functional capacity testing. (PX 28)

On October 23, 2008 Dr. Goldberg prescribed physical therapy for lumbar range of motion and strengthening for three times a week for six weeks. Dr. Goldberg had assessed status post lumbar fusion at L4-5 and L5-S1.

The petitioner continued to follow up regularly at West Suburban Medical Center status post motor vehicle accident through March 2009. (PX 28)

Second IME- Dr. Wehner

The respondent obtained an independent medical evaluation from Dr. Julie Wehner on January 7, 2009. (Rx 1, Dep Exhibit 3) At the IME evaluation, the petitioner reported his pain level at 9/10. His pain complaints and abnormal posturing were not explained by the radiographic findings or the surgery that was performed. Dr. Wehner opined that the petitioner had reached maximum medical improvement for any work injury and could return to work with a 25-pound lifting restriction. She also agreed that he should be weaned off narcotic pain medications due to the high predilection for addiction.

Petitioner followed-up at Rush Oak Park on January 19, 2009, February 17, 2009 and March 24, 2009 but the Arbitrator notes the reports are not entirely legible. Petitioner also followed up at Rush Oak Park on August 3, 2009 and October 6, 2009 with complaints of neck and back pain.

On January 7, 2010 petitioner received a Partially Favorable decision from the Social Security Administration for disability benefits. (PX 40)

On August 26, 2010 the petitioner called Dr. McGinness' office and stated that he needed an order for an MRI.

On September 2, 2010 an MRI of lumbar spine suggested the mild diffuse disc protrusions at the L5-S1 and L4-L5 were stable. There was spinal stenosis at L3-L4, milder at L2-L3 with no significant change since earlier examination. An MRI of cervical spine showed a disc protrusion with spinal stenosis and C3-C4, C5-C6, and C6-C7. There was relative spinal stenosis at C4-C5 and a tiny benign cyst within the central spine canal at the T4 level.

The petitioner was seen by Dr. Edward Goldberg on September 8, 2010 after a significant gap in treatment with the doctor, for complaints involving his neck and right arm. (Rx. 6, pg 55) The petitioner complained of central neck pain radiating down the top of the right shoulder and the lateral aspect of his upper arm into his forearm as well as the third and fourth digits. He reported that he had been constantly in pain for the last three weeks. Dr. Goldberg noted he had some prior treatment relating to a C4-C5 disc herniation in the past and had been treated with epidural steroid injections. The doctor reviewed the MRI of September 2, 2010 and felt he had multi-level cervical spondylosis causing radiculopathy and cord stenosis. As he exhibited a clinical picture of myeloradiculopathy, Dr. Goldberg recommended an anterior cervical discectomy and fusion at C3-C4 and C4-C5. Dr. Goldberg noted that they discussed the natural course and history of his myelopathy.

IME-Dr. Lami

On January 5, 2011 petitioner attended an IME with Dr. Lami to address the proposed cervical surgery. (RX 2, Dep Ex. 2) After a review of petitioner's medical history, Dr. Lami opined petitioner had subjective neck pain and right anterior shoulder pain with degenerative changes seen on the MRI. Dr. Lami opined that the cervical issues were not related to the work accident and opined that he did not need cervical surgery. Petitioner only needed a home exercise program. Regarding the cervical spine, Dr. Lami opined petitioner needed no work restrictions. Regarding the lumbar spine, Dr. Lami noted the invalid FCE and opined that a lifting restriction of 25-30 pounds would be reasonable. Petitioner was at MMI.

On February 28, 2011, petitioner met with Dr. Riley for a tender lymph node. Petitioner was assessed with lymphadenopathy and Dr. Riley noted petitioner did not complete his antibiotics as prescribed. Of note, petitioner mentioned back pain and stated his pain was 10 out of 10 but Dr. Riley opined he did not show evidence of this.

On October 19, 2011 Dr. McGinness prescribed petitioner Norco. This was again prescribed along with Tagamet on February 28, 2012. Another prescription of Norco was made on May 2, 2012. More medication refill requests were made on August 1, 2012; November 15, 2012; January 15, 2013; and February 18, 2013.

The petitioner saw Dr. McGinnis on March 14, 2013 complaining of back pain, chronic neck pain and depression. He now complained of facial and dental pain and an ache in his left forearm. He also had back pain and cramping in his left leg. He complained of depression which they noted they had treated him for in 2008 with Cymbalta. The doctor prescribed Fentanyl patches, Viagra and Cymbalta. Petitioner was living in Atlanta but was in town this week for an IME.

Second IME- Dr. Lami

On March 15, 2013, petitioner attended another IME, with Dr. Lami who opined petitioner's current symptoms were unrelated and out of proportion to the report injury on April 17, 2006. (RX 2, Dep Ex. 3) Dr. Lami opined petitioner was at MMI for the sprain he sustained on April 17, 2006. Dr. Lami also opined any complex regional pain syndrome was not related to his work injury and neither would be the proposed neck surgery. Dr. Lami could not support that petitioner was totally disabled because of the invalid FCE and psychosocial factors at play. He opined a lifting restriction of 25-30 pounds again would be reasonable. No further treatment was recommended.

On March 18, 2013, Dr. Goldberg authored a letter to petitioner's attorney, Mr. Gallagher. (RX 6, pg 53) Petitioner complained of posterior neck pain that radiated into the right shoulder, cramping in all four extremities, low back pain, and bilateral lower extremity paraesthesias. Dr. Goldberg suggested a possible assessment of cervical myelopathy and recommended another cervical MRI. Additionally, he recommended another lumbar MRI to determine if there was an adjacent level problem.

On May 22, 2013, Dr. McGinness prescribed Norco and Tagamet again. Norco was again prescribed on July 10, 2013. The petitioner requested medication refills on: August 15, 2013; August 28, 2013; September 27, 2013; November 8, 2013; December 2, 2013; January 9, 2014; February 3, 2014; and February 26, 2014.

Third IME- Dr. Lami

Dr. Lami issued a report on August 15, 2013. (RX 2, Dep Ex. 4) He opined he could not support surgery for myelopathy to be related to any of the work accidents. That would be a chronic compression of the spinal cord and no sign of same was found by Dr. Goldberg in 2010. A cervical MRI would be reasonable if Dr. Goldberg truly found myelopathic symptoms at this time. The requested lumbar MRI was not reasonable as petitioner showed a solid lumbar fusion without any neurologic deficit and only subjective pain. Additionally, Dr. Lami opined petitioner's spinal fusion was unrelated to the work accidents and his work restrictions were due to that. His work restrictions were not causally related to any of the work accidents.

Dr. Goldberg authored a March 7, 2014 letter responding to the petitioner's attorney's request for a summary of treatment. (Rx 6, pg 49) Dr. Goldberg opined petitioner's work accidents aggravated his degenerative disease of the lumbar spine and that the lumbar spine surgery and therapy were appropriate to relieve petitioner of the effects of his work accident. Dr. Goldberg did not comment on petitioner's right shoulder complaints and deferred to Dr. Palmer's and Dr. Nicholson's opinions.

On March 7, 2014 the petitioner returned to Dr. McGinnis for assessment of back pain, cervical radiculopathy, depression, migraines, gastroesophageal reflux disease, palpitations, erectile dysfunction, prostatitis and fatigue.

On July 3, 2014 petitioner presented to SIU Center for Family Medicine and met with Dr. Khattak. An x-ray of the lumbar spine was stable from previous imaging. After examination, Dr. Khattak diagnosed petitioner with chronic lower back pain that was likely secondary to arthritis. Petitioner refused physical therapy. Dr. Khattak advised petitioner to treat with exercise, stretches, heating pads, and Meloxicam. (Px. 11)

On August 4, 2014 petitioner was initially evaluated for physical therapy at Koke Mill. His diagnoses included lumbago, back pain, and neck pain. Therapy was planned for 1-3 times a week for twelve weeks. Petitioner attended physical therapy which included aqua therapy. Petitioner underwent occupational therapy at Memorial Rehabilitation Services at Koke Mill from August 6, 2014 through November 3, 2014. (PX 3).

Petitioner saw Dr. Khattak on September 4, 2014 and complained of low back pain and neck pain. Examination showed tenderness to palpation over the C4-5 area and lower lumbar area. Petitioner had full range of motion and full strength. He ambulated with a cane. Dr. Khattak ordered MRIs of the cervical and lumbar spine and provided an orthopedic referral. (Px. 11)

On September 19, 2014, petitioner presented to Memorial Medical Center for an MRI of his cervical and lumbar spine. The cervical spine MRI revealed multilevel degenerative changes with mild central canal stenosis at C5-C6 and C6-C7 and multilevel moderate to severe neural foraminal encroachment. The lumbar spine MRI revealed multilevel degenerative most severe at L2-L3 and L3-L4 with severe central canal stenosis. There was also multilevel moderate to severe neural foraminal encroachment. (Px 11)

Petitioner presented to Dr. Venkat Ganapathy on September 24, 2014 with complaints of neck and back pain. (PX 12) The assessment was cervical myelopathy at C6-C7, posterolateral disc herniation at the right C4-C5 disc space, multi-level degenerative disc disease at the cervical spine and central stenosis, lateral recess and foraminal stenosis at L2-L3 and L3-L4 as well as multi-level degenerative disc disease and facet hypertrophy in the lumbar spine. The recommendations were an anterior cervical decompression and fusion and a subsequent posterior lumbar decompression and fusion. Petitioner was directed to obtain a lumbar spine CT due to a question of pars fractures at L2-L3 and L3-L4 and an EMG of the upper extremities for possible carpal tunnel syndrome on the left.

An EMG performed by Dr. Trudeau found right C5 and C7 radiculopathy which was moderately severe, but which was characterized as an older or chronic finding. There were also moderately severe bilateral median neuropathies at the wrist, moderately severe on the left and mild on the right. There was no current evidence of cervical radiculopathy, brachioplexopathy, or mononeuritis multiplex. (PX 21)

The CT of the lumbar spine performed on September 26, 2014 showed the prior fusion from L4-S1. (Px. 11) It was noted that unless there were prior CTs to demonstrate stable position, the short fixation screws which were threaded into the posterior aspect of each pedicular screw were displaced. (Dr. Goldberg later testified the loose screws were not causing any symptoms.)

On November 8, 2014, petitioner underwent an MRI of the cervical spine, which revealed: (1) minimal change since the earlier examination; (2) spinal stenosis was stable at C3-C4, C5-C6, and C6-C7; (3) left neural foraminal stenosis stable at C5-C6 and milder neural foraminal narrowing on the right at C5-C6 and bilaterally at C4-C5 as well as narrowing related to uncovertebral joint degenerative change; (4) osseous and disc degenerative changes; and (5) straightening of the cervical spine.

The petitioner was seen in follow up by Dr. Ganapathy on November 18, 2014. (PX 12) The doctor noted the petitioner had a difficult problem with long term opioid use, multiple sources of pain with axial as well as radicular pain. He also had myofascial pain which was non-dermatomal and pressure point pain. X-rays of the cervical spine showed mild degenerative disc disease from C4-C5 to C6-C7 with no change in alignment to suggest instability. The doctor noted he may still have radiculopathy, but it was difficult to assess in this setting as there were multiple other pain generators. The doctor also bolded the statement that, “I am not convinced that he has myelopathy as today’s exam was not in keeping with the exam finding from last visit.” Dr. Ganapathy felt they needed to understand which of the discs were causing the problems. He therefore recommended a C5 root block injection and a bilateral C7 selective root block injection, performed at separate times, to determine which of these was the offending level.

The petitioner was seen by Dr. Paul S. Smucker on November 21, 2014 on referral from Dr. Ganapathy to perform the root block injection. (PX 3, pg 4) The doctor noted that his “symptoms of pain and paresthesias were not consistent during the time of my discussion with him”. The neurologic exam showed no upper or lower extremity atrophy and balance and coordination were normal. Lower extremity neural tension signs were negative bilaterally. His lumbar range of motion was limited, but there was no focal mechanical reproducible pain. Cervical range of motion was normal. Shoulder impingement was inconsistently positive on the left. Motor strength testing featured break away weakness through the proximal and distal bilateral upper and lower extremities. Straight leg raising was negative bilaterally, as was Tinel’s at the carpal and cubital tunnels. The doctor reviewed the cervical radiographs which showed multi-level mild spondylosis but well preserved intervertebral disc space heights throughout the cervical spine. The cervical MRI from September 19, 2014 showed mild degenerative disc disease at multiple levels. There was moderate to severe neuroforaminal narrowing on the right at C4-5 and bilaterally at C5-C6. There was no severe significant canal stenosis at any level. Lumbar X-rays showed post-operative changes with hardware fusion at L4-L5 and L5-S1. The lumbar MRI of July 3, 2014 showed multi-level degenerative disc disease with facet arthropathy. These combined to create severe canal stenosis at L2-L3 and L3-L4. There was bilateral neuroforaminal narrowing at L2-L3 and L3-L4 as well.

Dr. Smucker noted the petitioner had non-physiologic findings with diffuse inconsistent breakaway weakness on exam. There was diffuse muscular tenderness consistent with myofascial pain syndrome. There was mild to moderate cervical degenerative disc disease with mild central stenosis at C5-C6 and C6-C7. The petitioner was status post L4-S1 fusion with multi-level neuroforaminal stenosis. There was a possible element of neurogenic claudication, although this was difficult to discern through the diffuse complaints he had to offer.

The doctor did not see evidence on his overall presentation including physical exam of cervical myelopathy. Dr. Smucker did not believe that the requested diagnostic cervical selective nerve root blocks would be valid in this individual given the widespread inconsistency of exam and described symptoms. Included with the records of Dr. Smucker is a note in which the petitioner called the office on December 8, 2014 to discuss the November 21, 2014 visit with Dr. Smucker. (PX 3, pg 8) He was frustrated that Dr. Smucker changed the procedure plan suggested by Dr. Ganapathy. The petitioner was advised that the dictation by Dr. Smucker would not be changed, as it was the doctor's medical opinion after the evaluation. The petitioner also requested no records were to be released without his prior approval. A right C5 selective nerve root block was performed on January 22, 2015 and a left C7 selective nerve root block was performed January 23, 2015. A final injection/nerve root block at the right C7 was performed February 11, 2015.

Dr. McGinness saw the petitioner on June 19, 2015. Petitioner stated that he had been seen by a neurosurgeon and was told surgery would not get rid of his pain, therefore he was not planning to undergo surgery.

The petitioner returned to Dr. Goldberg on September 9, 2015, with ongoing cervical and lumbar complaints. Dr. Goldberg recommended MRIs of the cervical and lumbar spine, as well as a functional capacity evaluation. As the petitioner continued to be myelopathic, Dr. Goldberg continued to recommend cervical surgery.

The MRI of the cervical spine, performed on September 11, 2015, re-demonstrated degenerative changes causing mild spinal canal stenosis at C3-C4, C4-C5, and C5-C6, with mild to moderate stenosis at C6-C7. There was severe right foraminal stenosis at C4-C5, which was more pronounced than the prior study. The lumbar MRI was read as showing moderate canal stenosis with massive hypertrophy causing lateral recess and neural foraminal stenosis at L2-L3 and L3-L4. Following review of the MRIs on October 2, 2015, Dr. Goldberg felt that the petitioner was now having an adjacent level breakdown due to the prior lumbar fusion. He therefore recommended decompression at L2 through L4 with laminectomy and/or possible fusion to address the low back pain. In addition, Dr. Goldberg continued to recommend the cervical fusion from C3 through C7. Mr. Loving, however, did not want to consider surgical treatment at this time, and instead the doctor recommended pain management. The petitioner advised Dr. Goldberg that he would be spending the winter in Savannah, Georgia, with his brother. The doctor provided him with a referral to take to Georgia to obtain pain management physician there as well. The recommendation included epidural steroid injections and chronic pain management.

The medical records document physical therapy performed at Saint Joseph's/Candler Health System in Savannah, Georgia from October 6, 2015 through November 19, 2015. (PX 18) The notes of November 2, 2015 indicate the petitioner washed, waxed and detailed his car this weekend. On October 21, 2015, the petitioner reported feeling well and "I feel like I could play football." At the time of discharge, the petitioner reported a significant amount of improvement and was excited that he was feeling better in time for the holidays. He made excellent rehab progress meeting all short and long term goals with the exception of hip extension range of motion.

Petitioner returned for 12 sessions of aquatic/physical therapy at St. Joseph's/Candler in Savannah from March 17, 2016 to April 28, 2016. (PX 18)

Dr. McGinness treated petitioner on September 21, 2016 for continued all over pain. He reported new pain and popping in the right shoulder for two weeks. At the time of the appointment, petitioner ambulated without a cane, but requested a form for a disability card for transportation. Dr. McGinness updated petitioner's diagnosis to include acute right shoulder pain.

Petitioner followed-up with Dr. McGinness on November 3, 2016 with complaints of worsening neck and back pain since August. Petitioner reported pain down the arm to the hand and down the leg and around the groin. Physical therapy was not helping his pain. Dr. McGinness provided petitioner with a prescription of Oxycodone and Lidoderm patches and referred petitioner to the pain clinic for treatment.

Petitioner was seen by Dr. Matthew Jaycox on January 19, 2017 for pain in the low right back and pain in the upper and lower extremities. He was assessed with cervical radiculopathy, degenerative disc disease, myelopathy and facet arthropathy in the cervical spine. He was to be scheduled for cervical epidural steroid injections at C7 through T1. If no relief, they would refer him for surgery.

On January 26, 2017, Dr. Dennis Gumbrecht treated petitioner at the Rush University Medical Center Department of Anesthesia Pain Service. Petitioner reported pain in the cervical spine, specifically midline pain that radiated into the bilateral upper extremities to the fingers. A cervical epidural steroid injection was performed.

Petitioner was seen by Dr. McGinness on January 26, 2017 and reported continued neck and back pain and stated that his right leg buckled several times a week. A left trigger finger diagnosis was also noted. Dr. McGinness refilled petitioner's pain medications.

Dr. Gumbrecht performed a cervical epidural steroid injection on March 9, 2017. A second cervical epidural steroid injection was performed on May 11, 2017.

Petitioner presented to Dr. McGinness on January 16, 2018 and reported pain in his back, neck and right knee.

Petitioner presented to Dr. McGinness on May 8, 2018 and reported continued neck and back pain and that he did not feel the lumbar surgery improved his function enough so that he would contemplate neck surgery. Petitioner reported he had as much lumbar pain as he had prior to surgery.

On October 18, 2018, petitioner returned to Dr. McGinness for back and neck pain and reported he was taking long lasting hydrocodone only when his pain is at a 10/10. Mood was noted as okay on an anti-depressant. Petitioner reported he was going to the gym. According to this note the history of a fall was on June 21, 2018. The assessment was lumbar radiculopathy, depression and cervical radiculopathy. The plan was a refill of hydrocodone.

Petitioner started a new course of physical therapy on January 24, 2019 at NovaCare on referral by Dr. McGinness with a diagnosis of lumbar radiculopathy and cervical radiculopathy. Petitioner reported the pain started in 2006 when he felt pain in his low back and neck when carrying and pushing many bags and containers at work which weighed over 100 pounds. Petitioner attended 11 sessions through March 4, 2019.

The petitioner was seen again by Dr. Jaycox on March 19, 2019 for pain in the right shoulder up into his head and back pain with shooting pain down his right leg and migraines. It was noted the petitioner had returned after an 18 month absence. He was living in Savannah, Georgia and had since returned to Illinois with a return of his neck and arm pain with radiation at the right upper extremity as well as occasional low back pain into the right leg.

The petitioner underwent cervical epidural steroid injections on March 21, 2019 and April 25, 2019 at C7-T1. The petitioner was seen on May 30, 2019 in follow up and reported feeling approximately 75% better with increased activity levels. It was noted he gets out of the house to walk and exercise three to four times per week.

Petitioner was seen at Rush Oak Park Physical Therapy for a spine evaluation on October 9, 2019. It was recommended he continue physical therapy twice a week for six to eight weeks. The physical therapy progress note from October 28, 2019 indicated significant self-limiting tendencies, and noted "observed movements and behaviors inconsistent with subjective reports." The notes of November 4, 2019 again indicate the self-limiting tendencies and inconsistent observed movements and behaviors which were inconsistent with subjective reports. He also performed all activities in a slow and deliberate manner. By November 6, 2019, he had improved neck symptoms and wished to focus on the low back pain.

The petitioner was seen by Dr. Jaycox on December 18, 2019 for a follow up of upper back and neck pain. His pain had been 7/10 and worse on the right side with radiation into the arm. He also described weakness in the grip on the right side. The petitioner underwent cervical epidural steroid injection on December 31, 2019.

The petitioner presented on March 9, 2020 to the Emergency Department at Rush Oak Park Hospital. He stated he had low back pain which was uncontrollable with Norco. He was given an injection of Toradol. He was given a prescription for physical therapy on discharge.

The petitioner was seen by Dr. Jaycox on May 28, 2020 for follow up after cervical epidural injections performed in December 2019. He felt about 50% better, but had not increased his activity levels. He reported that he gets out to exercise two to three times per week. The pain in the right arm and hands was unchanged and the remaining pain was now in the neck. It was recommended that they perform bilateral cervical facet injections from C3 through C7.

On June 20, 2020, the petitioner underwent bilateral cervical facet joint injections at C2-C3, C3-C4, C4-C5 and C5-C6.

Respondent Records Review- Dr. Mather

An orthopedic surgeon, Dr. Steven Mather, issued a records review report on August 5, 2021. (Rx 3, Dep Exh 2) The petitioner was a status post L4-L5-S1 fusion with unrelated lumbar spinal stenosis at L2-L3 and L3-L4. Dr. Mather found the lumbar stenosis was not work related. Dr. Mather found the petitioner sustained disc herniations at L4-L5 and L5-S1, but the appropriate surgery would have been a simple discectomy, and it is unclear why the patient underwent a fusion as this did not meet the standard criteria for such a procedure. There was no evidence of instability, advanced, degenerative disc disease or any condition that would require a fusion.

Dr. Mather also found the cervical spine showed typical degenerative changes/osteophytes which were also unrelated to any work injury. The C3-C4 disc herniation was first noted on the September 5, 2017 MRI. While the petitioner may have sustained an aggravation of the right C4-C5 osteophyte/stenosis, this would've resolved by April 3, 2007 when his exam had returned to normal and he was released to return to work by Dr. Fetzer. Further, Dr. Fetzer had noted he had multiple positive Waddell findings at the time of his discharge from care, and he had no signs of any ongoing neurologic compression as his neurologic exam had completely returned to normal. Dr. Mather noted there were demonstrated inconsistencies and nonorganic pain findings when presenting to his treating physician, Dr. Fetzer and Dr. Nicholson. This indicated many of his symptoms were simply subjective in nature and not supported by clinical physical examination. Patients with multiple positive Wadell signs almost always have psychogenic sources of pain rather than objective organic sources of pain, and he felt this case was no exception. He also noted the patient provided maximum effort and exaggerating his complaints. (Rx 3, Dep Exh 2)

Petitioner presented to U Chicago Medicine Advent Health Hinsdale November 8, 2022 for progressive worsening of his low back pain with increased lower back pain becoming progressively worse over the last few days. Dr. Song in neurosurgery was consulted. An MRI showed severe central stenosis at L2-L3 and L3-L4 which was thought to be causing his complaints. The petitioner was admitted and Dr. Song performed L2-L4 PSF surgery. (PX 2, p. 10). On November 15, 2022, x-rays of the lumbar spine showed the hardware in the lower lumbar spine to be in proper position. At the time of the November 22, 2022 discharge, post-operative back pain had improved but was still present.

On December 6, 2022, petitioner presented to Dr. Song for his first post-operative visit. The numbness, tingling and weakness in his anterior thighs and ankle were unchanged. Petitioner was overall happy and reported his chronic low back pain had essentially resolved. Petitioner was discharged on December 7, 2022. (PX 2, p. 4). (PX 3)

At the next follow up on December 20, 2022. He reported his strength was improving in his bilateral lower extremities. Petitioner reported numbness in his right thigh and complained of a strong burning sensation in his calves and shins bilaterally. Dr. Song recommended he continue physical therapy and opined his neuropathic complaints may take time to improve.

Petitioner presented for his third post-operative visit on February 7, 2023. Petitioner opined his leg symptoms were 90% resolved and the right leg symptoms were 63% resolved. A diagnosis was made of spinal stenosis of the lumbar region.

On February 14, 2023, petitioner returned to Dr. Song to review his legal case and the request sent by his attorney. Dr. Song could not make comment until it passed through the Adventist legal team. Dr. Song opined petitioner had adjacent segment disease related to prior lumbar fusion which was “apparently” causally related to his work injury in 2006 and 2014. Petitioner also complained of neck pain and severe right arm pain that radiated down the arm to the hand and was complicated by petitioner’s carpal tunnel surgery. X-rays of the cervical spine were ordered for a diagnosis of cervical radiculopathy.

Petitioner underwent an MRI of the cervical spine on February 24, 2023 at UChicago Medicine. The study showed hypertrophic degenerative changes with moderate spinal stenoses at C3-4, C4-5, C5-6 and C6-7 levels and moderate to severe foraminal narrowing on the left at C3-4, bilaterally at C4-5, C5-6 and C6-7 levels and on the left at the C7-T11 level.

Petitioner returned to Dr. Song to discuss imaging results on March 7, 2023. He continued to complain of neck pain with numbness, tingling and weakness into the right deltoid and into his arm. The numbness in his fingers had resolved after his bilateral carpal tunnel surgery. Dr. Song was uncertain whether petitioner would have any relief with surgery but if petitioner wished to proceed, Dr. Song would consider a C4-5 and C5-6 ACDF. Dr. Song noted it was hard to determine if his findings on his cervical spine were normal degenerative changes or related to his work injury that happened 17 years ago. An assessment was made of spinal stenosis of the lumbar region and cervical radiculopathy and petitioner was instructed to return to the office as needed.

IME- Dr. Mather

Dr. Mather performed an independent medical evaluation on March 28, 2024 (RX 3, Dep Exh 3) Dr. Mather opined that the recent fusion surgery was due to normal degenerative changes and that as it had been 16 years since the previous surgery therefore, in his opinion, the need for same was unrelated to that original fusion done L4-L5-S1.” (Rx 3, dep exh 3) The petitioner also had positive Waddell’s signs. Upon examination, the petitioner had no tenderness to lumbar spine, but with any simulated axial rotation, he would wince and yell out loudly and nearly collapsed to the floor. However, he had was found to have no real pain with actual axial compression of the spine. The doctor also found him to have diffuse non-dermatomal numbness in the right lower extremity.

Deposition Testimony

Testimony of Dr. Goldberg- treating surgeon

Dr. Edward Goldberg testified on **April 11, 2016** regarding the 2006 discectomy and fusion. (Px 41, pg 11) The doctor testified after review of the MRI he felt Petitioner had some disk degeneration of both L4-5, L5-S1 with an annular tear at both levels. He also felt that he had a central herniation at L4-5. (Px41, pg. 10) On 9/19/06 Dr. Goldberg performed the following: a discectomy at L4-5 for the herniation and then an instrumented fusion at L4-5 and L5-S1 with pedicle screw instrumentation and iliac crest bone graft. (Px41, pg 13-14) As of 8/18/06, the doctor had petitioner off of work and following surgery as well through 3/7/07 when he was released with permanent restrictions. (Px41, pg 11 & 29) As of 12/6/06, Petitioner was enrolled in physical therapy and was reporting some low back pain and stiffness to Dr. Goldberg, but denied any radicular or leg pain. (Px41, pg 19) The doctor found him to be neurologically intact, and the fusion to be healing nicely at both this visit and the January 2007 visit, following x-rays performed. (Id at 24)

Regarding the history reported to him, Dr. Goldberg testified petitioner initially injured his low back on 11/4/05 when he lifted and developed acute right sided low back pain and then pain into the anterior thigh on right side. Then petitioner suffered a reinjury on 4/17/06 again “after lifting and twisting”. (Px41, pg9) The only information Dr. Goldberg had as to how the petitioner was injured working on a ramp was that he was lifting. (PX 41, pg 16) At no time from August 18, 2006 to January 7, 2007 did the petitioner mention any other than his back and at no time did the petitioner have any complaints about his cervical pain. (PX 41, pg 24-25) When asked if it was possible to have cervical pain that was masked by shoulder pain, the doctor said it was unlikely as they were very independent body parts. (PX 41, pg 25-26)

On the 3/7/07 last visit following the fusion, Dr. Goldberg wrote that Petitioner testified to finishing work conditioning and since then had increasing neck pain and reported some low back pain. He denied radicular pain, he had good lumbar motion but limited painful range of motion in his cervical spine. (Px41, pg 28) Regarding work capabilities, Petitioner was now capable of lifting 40 pounds occasionally from floor to waist, overhead 20 pounds, frequent basis lift 20 pounds floor to waist and 10 pounds overhead; when reviewing the work conditioning note it indicated petitioner was required to lift 70 pounds for his original work position. (Px41, pg 28) At this point in time, 3/7/07, Dr. Goldberg testified he was at MMI for the lumbar spine and could go back to work within the work restrictions as well as follow up with Dr. Fetzer for the cervical spine she was treating him for. (Id. at 29)

Dr. Goldberg testified the petitioner injured both the cervical and lumbar spine at work. (PX 41, pg 52-53) He was aware of only the November 4, 2005 and April 17, 2006 accidents. (PX 41, pg 58) When asked about whether his current conditions were related to the work accident, Dr. Goldberg seemed to equivocate and stated only that he had an injury was seen by his partners, had some temporary improvement and it had not progressed. (PX 41, pg 54) **Dr. Goldberg placed the petitioner at maximum medical improvement and released him to return to work with restrictions consistent with the work hardening reports on March 7, 2007. (PX 41, pg 62)**

He did not see him again until September 8, 2010 when he saw him for cervical complaints. Petitioner reported neck pain radiating to the top of the right shoulder and that the pain was constant for past 3 weeks. He reviewed an MRI and given the findings on his exam, discussed surgery. Specifically, the doctor found he had disk herniations at C3-4 and C4-5 and smaller ones at C5-6 and C6-7, and that the C3-4 and C4-5 herniations were causing some impingement on the spinal cord. (PX 41, pg 32-34) Dr. Goldberg discussed possibility of cervical spine surgery due to the change in symptoms and herniations on MRI but the petitioner did not wish to proceed with surgery. (PX 41, pg 34 and 52)

Regarding his history with petitioner, Dr. Goldberg testified that for the initial treatment starting in August 2006, he was primarily treating petitioner's back however he did previously review the cervical spine MRI in November 2006. (Px41, pg 35) The doctor opined that the prior MRI showed there were disk herniations at C3-4 and C4-5; at C3-4 it was central, at C4-5 it was central to the right; and there was a smaller herniation at C5-6 and C6-7. (Id.) Regarding prior cervical treatment in 2006, the doctor testified that Dr. Fetzer had done an epidural which provided good relief and that second epidural was not done since there was good relief. (Id.) From March 2007 through September 2010, Dr. Goldberg was not aware whether petitioner was working and he did not comment on petitioner's ability to work. (Px41, pg 36).

As of the 3/18/13 visit, that was the last examination of petitioner where he reported posterior neck pain, cramping in all four extremities from neck into right shoulder, low back pain and bilateral lower extremity paresthesia's; he had been seeing Dr. McGinness and taking hydrocodone, Cymbalta for depression and using Fentanyl patch; not been working; reported unsteadiness with ambulation; he had limited lumbar range in motion, cervical range was 50 percent normal; x-rays of lumbar spine showed healed fusion but a locking nut at L4 appeared to disengage from screw but incidental finding; cervical x-ray showed disk narrowing particularly at C5-6." (Px41, pg 37-39) Dr. Goldberg testified that he was concerned petitioner had some cervical cord involvement called myelopathy, recommended new MRI of lumbar spine to assess whether was any adjacent, meaning next level pathology, because when the doctor treated petitioner for the lumbar spine in 2006-2007, his radicular pain had resolved and now petitioner was having bilateral lower extremity new complaints. (Px41, pg, 39) As of the 3/18/13 visit, Petitioner had not been working. (Px41, pg.41)

Dr. Goldberg testified that in his March 2014 report (requested by Petitioner's lawyers), he noted that Dr. Palmer reflected in her notes, neck, right shoulder and back pain and that as of April 2006 Dr. Palmer gave work restrictions. (Px41, pg 42-43) He understood that Dr. Palmer was treating petitioner's cervical and right shoulder complaints prior to his involvement with petitioner in August 2006. (Id.) He testified that in his report where he wrote "I do believe that his lumbar condition is due to the work accident as well as the cervical condition based upon my review of these records", refers to Dr. Palmer and Dr. Fetzer's records from his office. (Px41, pg43-44). Specifically, he testified that Dr. Palmer thought it was a shoulder injury from March 2006, refers patient to Dr. Nicholson for injection with no improvement then refers to Dr. Fetzer who does a C5 selective nerve root block which improves neck pain such that the doctor recommended work conditioning. (Id.) Dr. Goldberg testified that he formulated the opinion that

both the lumbar and cervical conditions were related to work based on the record review mentioned above. (Id.)

On the December 2014 visit, the doctor found 5 out of 5 strength in upper and lower extremities but unsteady gait which could be due to spinal cord compression, which petitioner was using a cane; petitioner had abnormal Hoffman's signs; and he recommended cervical surgery again. (Px41, pg 45-46). The doctor opines at this visit that the cervical and lumbar conditions are due to the work accident and encouraged treatment and discussed signs and symptoms of myelopathy, or spinal cord compression. (Id. at 46) At the September 2015 visit, Petitioner presented with lumbar and cervical complaints for which the doctor recommended a MRI. (Id. at 47) Dr. Goldberg testified that there was significant stenosis at C4-5, C5-6 and C6-7; lumbar MRI showed no ongoing compression from L4 to S1 where original surgery was but "there was some moderate spinal stenosis at L2-3 and L3-4...in other words, adjacent level problems." (Px41, pg.48). Surgery was once again recommended but never scheduled. (Id.)

The last visit was on October 2, 2015 where cervical surgery was recommended but not approved, and petitioner was referred to pain management and he was not working, on disability. (Px41, pg. 50) Dr. Goldberg testified that he reviewed the new cervical and lumbar MRIs as of September 2015 and he felt there was significant stenosis at C4-5 and C5-6 and C6-7; he felt the lumbar spine showed no going compression L5-S1 where the original surgery was but did note at L2-3 and L3-4 there was some moderate spinal stenosis centrally and in the lateral recesses, in other words adjacent level problems. (Px41, pg 48) The doctor testified when he saw petitioner last he did not wish to proceed with cervical surgery. (Px41, pg52)

Dr. Goldberg testified that regarding the lumbar spine petitioner had two injuries in November 2005 and he continued to work then exacerbation in April 2006. (Px41, pg. 52-53) Specifically, petitioner had low back right leg radicular type symptoms that the doctor felt was due to the work accident and then regarding the cervical spine, his opinions were predicated upon notes from Drs. Palmer and Fetzer. (Id.) He testified that the records do reflect that petitioner did injure his shoulder and neck and that his treatment for back and neck since November 2005 was reasonable, necessary and related to the work accidents. (Id.) Further, Dr. Goldberg testified the subjective complaints consistent with objective findings as well (Id.) However, the doctor stated that "it's not until a few years later where he's getting bilateral leg pain now and there's new pathology at other levels"; regarding cervical complaints, "he had neck towards right shoulder originally, over the course of time it appeared to progress into some early myelopathic findings." (Px41, pg 54) He thought petitioner's symptoms were what MRIs showed. (Id.)

Regarding causation for the back and neck and whether Petitioner's present condition of ill being is caused in whole or in part by any of the four work related accidents, the doctor testified the lumbar yes in whole part because "unfortunately he developed adjacent level problems." (Px41, pg. 54) Regarding the neck, he testified "all I can state is he did have an injury, he was treated by some of my partners, had some temporary improvement its not progressed." (Id.)

On cross examination, Dr. Goldberg testified he did not review any medical records from prior to the work accidents and he did not have any information regarding the 3/10/06 or 12/23/05 work accidents. (Px41, pg. 57-58) He opined the lumbar spine injury appeared to be caused initially on 11/4/05 and an exacerbation on 4/17/06. (Id.) Regarding the 3/10/06 accident, all Dr. Goldberg had was Dr. Palmer's notes which included that patient works as luggage handler and he has pain in the right anterior aspect of his right shoulder from accident on 3/10/06. (Px41, pg. 58) Regarding Dr. Nicholson, Dr. Goldberg doesn't know why he did not review his records but testified he does know that Dr. Nicholson did not feel petitioner's complaints were related to the shoulder. (Id. at 59). Dr. Goldberg acknowledged that Dr. Nicholson found pain complaints to be out of proportion to physical findings regarding the shoulder. (Id. at 60). Dr. Goldberg had not seen the FCE results at the time he released petitioner with restrictions as the FCE was after; but he did note that work conditioning showed some concerns about invalidity. (Px41, pg. 62). He then saw petitioner three years later and then again on 9/8/10. (Id.)

In the 6 year period between March 7, 2007 and March 18, 2013, the petitioner was seen by the doctor, only on September 8, 2010. (PX 41, pg 32,36,37) The doctor testified that he did not have any information regarding his symptoms or treatment during those periods, other than petitioner reporting he saw Dr McGinness who was prescribing Norco and Darvocet. (PX 41, pg 65 & 67) Dr. Goldberg also did not have any information regarding the automobile accident which occurred in 2008 and testified petitioner did not report the auto accident to him when he saw him in September 2010. (PX 41, pg 66) The doctor agreed an automobile accident could cause or aggravate his cervical and lumbar conditions. (Id.) The doctor testified that the cervical MRI from 2006 showed abutting the cord at C3-4 and C4-5, resulting in stenosis. (Id.)

The doctor acknowledged he saw petitioner on 3/18/13 at the request of his attorney and he was not aware of any treatment petitioner had from September 2010 through March 2013. (Px41, pg. 67). Dr. Goldberg did not review any 2008 records regarding the automobile accident and could not say to what extent that accident or injury aggravated petitioner's cervical or lumbar conditions. (Px41, pg 70) The doctor did not review records from Dr. Smucker, did review some records from Dr. Ganapathy, but was not aware the doctors noted that petitioner did not have findings consistent with cervical myelopathy in November 2014; however this did not alter his opinions because when Dr. Goldberg examined petitioner, he did "find some hyperreflexia, some Hoffman's, consistent with some myelopathy but myelopathy as we stated can wax and wane." (Px41, pg 71) He further testified he did not think the dislodged locking nut had any bearing on petitioner's clinical symptoms and are in the soft tissue nowhere near spinal canal/nerves; and that he had good decompression of the levels of the fusion. (Id. at 72) .

Testimony of Dr. Lami- Respondent IME

The deposition of Dr. Lami, the respondent's IME examiner, was completed on **January 18, 2017**. (RX 2) Dr. Lami is a board-certified orthopedic spine surgeon. (Rx 2, pg 5) Dr. Lami testified that the petitioner's condition of ill being in the cervical spine was not causally related to the work accident of April 17, 2006, or to any of the other work accidents. (Rx 2, Pg 9-10)

Dr. Lami explained that he personally reviewed the MRI findings from November 9, 2006, which failed to show myelopathy, traumatic findings or other significant pathology, but did show: some bulging of the disc with no compression at C4-5; at C5-6 a central disc protrusion which was degenerative in nature, C6-7 protruding disc without any significant compression of the cord. (Rx. 2, Pg. 8-9) In addition, on examination, the cervical spine exam was negative for any significant abnormalities or signs of injury. Based on the doctor's exam of March 15, 2013, he was unable to support any need for cervical surgery related to the April 17, 2016 Work accident. (Rx. 2 Pg. 14)

The petitioner described to Dr. Lami that at the time of the April 17, 2006 accident he felt a crack in his lower back. The notes from the emergency room showed no cervical spine issues or did the records of the initial providers. It wasn't until later in the medical records, where there was a suggestion of right shoulder pain which developed overtime into cervical spine type issues. (Rx 2 Pg. 10) In addition, doctor opined the MRI from 2006 showed no significant pathology only degenerative changes. (Rx 2, Pg 10) Regarding work restrictions, Dr. Lami opined that given the two level lumbar fusion, he recommended maximum lifting from 25 to 30 pounds. (Rx2, pg 11) Dr. Lami also agreed with the treating physicians that he was at MMI on 4/3/07. (Id.) The doctor opined that the need for any cervical surgery would not be related to the 4/17/06 work accident because he did not feel petitioner suffered a cervical spine injury on 4/17/06. (Rx2, pg14) The doctor did not find evidence of myelopathy on the MRIs or on examination of petitioner but did agree with Dr. Goldberg that it can be a progressive condition. (Rx2, pg 15) On cross examination, the doctor acknowledged that a neck injury can have pain in the arm and that sometimes cervical injuries causing pain in the arm can be misdiagnosed as a shoulder injury, "if it is evaluated by an appropriate doctor, its not likely". (Rx2, pg 23) When asked if the shoulder symptoms could have masked the neck injury in the case of Mr. Loving, Dr. Lami testified that it could not. (Rx 2, Pg. 32-34) If the petitioner had a neck injury which resulted in myelopathy; this would be traumatic and would be obvious at the time of the injury. This did not occur in Mr. Loving's case. On redirect, Dr. Lami was asked about Dr. Fetzer's December 2006 report where petitioner stated he was moving luggage at his job, moving forward with arms extended and he felt a pop in his right shoulder. (Rx2, pg 35) The doctor opined this is not something that would cause an injury in your neck. (Id.)

Testimony of Dr. Wehner- Respondent IME

Dr. Julie Wehner is a board-certified orthopedic spine surgeon who testified on **February 17, 2017**. who performed an IME on February 9, 2007 and January 7, 2009. (RX 1) On exam, Dr. Wehner found was no clonus or positive Hoffman's or Babinski signs to support a diagnosis of cervical myelopathy. (Rx 1, Pg. 10) The doctor opined that after review of the medical records and her first examination of petitioner, she gave a diagnosis of low back pain and that he was status post-fusion for degenerative disk disease at L4-5 and L5-S1 (Rx1, pg 8) Regarding the cervical spine, the doctor did not see anything on the MRI that warranted surgery and that the MRI findings did not match clinical findings for level of pain petitioner was demonstrating. (Id.) Dr. Wehner opined Petitioner did not need cervical surgery because petitioner has degenerative findings at C4-5, C5-6 and C6-7, they were not causing cord or nerve root impingement and because "the level of his pain complaints on clinical exam did not correlate with this mild degree of finding." (Rx1, pg. 9) The doctor did not find that petitioner had myelopathy but that he should complete post operative therapy. (Rx1, pg.10)

The doctor testified that the two-level lumbar fusion performed by Dr. Goldberg in 2006 was not appropriate and that the surgery performed was unlikely to provide a good outcome for petitioner, for the MRI findings that were present. (Rx 1, Pg. 12, 30) She indicated that the patient had symptom magnification and pain complaints which were out of proportion to the diagnostic findings at the 2009 exam. (Rx 1, pg 14-15) As such, she felt that he did not have a good prognosis and surgery was unlikely to provide a good outcome. (Rx 1, Pg. 9,10-12) In addition, Dr. Wehner testified that the petitioner exhibited signs of symptom magnification. (Id.) Further the doctor reviewed the 2008 lumbar spine MRI and diagnosed petitioner with chronic pain syndrome following the 2009 IME. (Rx1, pg.15) Specifically, she explained petitioner has ongoing pain that's usually longer than six months duration and that pain complaints were much higher than one would expect after this type of surgery, petitioner was two years out from surgery, high doses of pain medications that are not medically appropriate at that point, normal neurological exam, symptom magnification behaviors and a MRI that did not show any problems with actual surgery performed, (Id.) Regarding the narcotic usage, the doctor testified that is was not medically appropriate and that petitioner was taking Doxepin- anti depressant, Abilify, and Cymbalta which were different mood stabilizing drugs. (Rx1, pg.16) Then petitioner was on Hydrocodone- narcotic, Fexofenadine- narcotic, Fentanyl – very strong narcotic pain medication, Celebrex- anti-inflammatory, then he had patches; petitioner also was on Topmax probably for headaches (Id.) Dr. Wehner opined that it is strongly discouraged that people use this type of doses of narcotics and mixing all different classes of medications. (Id.)

Dr. Wehner as of the last IME recommended Petitioner go back to work with no lifting more than 25 pounds and that he did not need any further medical treatment for his back and that he should be weaned off his narcotic pain medications. (Rx1, pg. 17) The doctor did not believe that the petitioner had any condition of ill-being with respect to the cervical or lumbar spine that was related to the work accident other than a lumbar strain. (Rx 1, Pg. 18,19) Further the doctor found petitioner did not need further treatment for the neck. She testified that his pain levels did not correlate to the radiographic findings. (Rx 1, Pg. 19) She noted there were no acute findings on the first lumbar MRI and that Petitioner had pre-existing degenerative changes of the lumbar spine (Rx. 1 Pg. 18) Despite having a invalid FCE, Dr. Wehner acknowledged petitioner still required the 25 pound permanent restriction because he underwent surgical intervention, and based on the type of surgery done and his age, some people might need restrictions to get back to work in some capacity. (Rx1, pg. 20)

The petitioner had a cervical injection which was a diagnostic tool to ascertain if pain complaints were stemming from the cervical spine or shoulder. (Rx. 1, Pg 33, 37) Dr. Wehner testified that as he did not improve with the injection, this would signify that there was not a problem stemming from the cervical spine. (Rx 1, Pg. 37) As of the date of the deposition, the doctor had not seen petitioner since January 2009. (Id.)

Testimony of Dr. McGinnis- Treating physician

The deposition of Dr. Catherine McGinnis was completed on **December 2, 2016**. (PX 42) Dr. McGinnis testified that she is board certified in family medicine not orthopedic medicine and does not perform any surgeries. (PX 42, Pg 6) Further, she testified she referred petitioner to various other doctors for his back and shoulder/neck. (Px42, pg. 86)

It is Dr. McGinnis' opinion that the petitioner's neck and back pain was causally related to the injuries sustained at work. (Px 42, pg 83) The doctor testified that Petitioner saw her office for low back pain after a work injury on 4/17/06 and petitioner stated he was loading luggage on the plane when he felt a crackle in his right lower back. (Px 42, pg 15) Her assessment at that time was muscle sprain and she refilled his pain medications. (Id.) However, when cross-examined, the doctor testified she had no information regarding any accidental injuries other than the injury to his arm throwing luggage which he reported at the visit on April 13, 2006. (Px 42, pg 99) She specifically denied having any information regarding the accident on November 4, 2005 or the injury on December 23, 2005. (pg. 100)

Dr. McGinness testified that at the 12/20/07 visit Petitioner had severe low back pain and back muscle spasms and needed an x-ray for his finger. (Px42 pg. 26) She treated him for erectile dysfunction and "wrote a letter for work that he was not able to do his job. (Id.) Specifically, the letter she wrote was for "back pain relating to the herniated disc, not being able to participate in his retraining classes at this time because his narcotic medication put him to sleep and because his back pain requires him to get up and walk around frequently." (Px42 pg. 27) Dr. McGinness testified she wrote this letter "based upon his complaints". (Id.)

The Arbitrator notes that the doctor appears to have mentioned neck pain for the first time in her records, in her testimony, following receipt of a letter from pain doctor, Dr. Amin, around March 2008. (Px42, pg 29) When asked about keeping Petitioner off of work, she testified that both the specialists and herself kept petitioner off of work during this period of time prior to March, 10, 2008. (Px42 pg. 30) The doctor testified that Petitioner "now developed pain in the neck radiating down the left arm and right arm" as of 7/1/08 visit she had with him. (Px42, pg. 33)

On the 6/5/09 visit, Dr. McGinness notes that Petitioner would no longer be employed by United and that he understood United would not take back an employee with duty restrictions and that he would never be able to return to unrestricted duty. (Px42, pg 42). Dr. McGinness testified to numerous refill phone call notes for pain medications for the back, migraines, depression and stomach issues from August 2012 through March 2014, where petitioner was not seen in the office (Px42, pg 56) There was only one visit during this time, in March 2013, that the doctor appears to have seen/examined Petitioner. (Id.) The Arbitrator notes that this corresponds with the time period that Petitioner testified to be living out of state, as documented by Dr. McGinness as well.

Dr. McGinness opined that Petitioner's problems to his neck and back are the direct result of his work injuries and that his treatment received was reasonable and necessary. (Px42, pg82) She testified that his subjective complaints were always consistent with her objective findings, specifically with his neurologic exam, physical exam and MRI clearly show targets. (Px42, pg. 83)

When asked why she opined that Petitioner's present condition of ill being as it relates to both the back and neck (as of the deposition date of 12/2/16) was caused in part or by any of the four work related incidents, Dr. McGinness testified: "This --this is a man who'd been seeing us for decades and prior to his injuries he was not what you would call a frequent flier, he was in--- he did have occasional musculoskeletal complaints s a results of hard, physical labor prior to these injuries but you would not see him for months at a time, he was never drug seeking, he would occasionally need a statement for work, and then he had the injuries and he had pain ever since." (Px42, pg. 83-84)

When asked about work restrictions, the doctor testified she believed he was never able to return to work after April 2006, and that she thinks they tried to send him back with restrictions but Petitioner was not able to. (Px42 pg. 84) Dr. McGinness, also opined that Petitioner was permanently and totally disabled and the basis for the opinion was "He has limited strength. He can't get his arms above his head. Baggage handlers have to be able to lift a suitcase that if it doesn't have a heavy tag on it, it weighs 100 pounds and stack it into awkward positions; they may be in a squat, they may be on their knees. The nature of his job is not something you can do with weakness in both hand and both legs due to nerve compression." (Px42, pg84-85)

On cross examination, the doctor acknowledged she did not have all the Midwest Orthopedic records and that she was not aware or did not see that Dr. Fetzer released petitioner to return to work full time and full duty on 4/3/07 given the results of the FCE, positive Waddell's findings, and multiple nonorganic signs. (Px42 pg 87) The doctor also testified that she didn't know Dr. Palmer also reviewed the records and on 4/11/07 released petitioner to return to work in accordance with recommendations from Dr. Fetzer and Dr. Goldberg. (Id.) The doctor was also not aware that Dr. Goldberg, the orthopedic surgeon he was referred to for his back, placed him at MMI and released him to return to work lifting 40 pounds occasionally on 3/7/07. (Px 42, pg88)

Dr. McGinness testified she disagreed with Petitioner's orthopedic treating doctors, Dr. Fetzer, Dr. Palmer, Dr. Goldberg and Dr. Nicholson, who believed Petitioner could return to work full duty or with a 40pound lifting restriction in 2007. (Px42, pg88) She stated she disagreed because of the nature of his job and that he cannot do it with nerve compression. (Px42, pg89) Dr. McGinness opined that even if the orthopedic doctors released him to work with the 40 pound restriction, Petitioner could not return to work in some capacity. (Px42, pg 89) She opined she was in a better position than the orthopedic doctors to make that determination because she looks at Petitioner's total body and level of function and Petitioner could not work.(Id.) On cross exam, the doctor further admitted she was not aware of the inconsistencies in the work conditioning reports by the physical therapists, or in the examinations by Dr. Nicholson and Dr. Fetzer. (Px42 90) Despite not knowing about the above or the invalid FCE, Dr. McGinness testified that her opinions regarding work ability and restrictions remain the same because "given the nature of his job and abnormal MRIs and abnormal nerve conduction studies it is my belief that this man is never able to return to work." (Px42, pg 90)

Dr. McGinness opined that the right shoulder complaints were related to the neck after “looking at how it was evolving over time. But the nerve- but his MRI of his neck demonstrates things that certainly cause shoulder pain.” (Px 42, 90) The doctor discussed in her direct testimony that she “certainly did enough letters” regarding his work status; however, when it was pointed out on cross examination that there are only two letters authorizing petitioner off work at any time, she suggested that off-work notes were instead being written by his orthopedic physicians. (Px. 42 pg 91) The doctor testified migraines preexisted the work accident. (Px42, 97)

The doctor testified that she continued to refill her patient’s medication with phone calls while the petitioner was living in Georgia and she did not see any records from Georgia during this period. After 2009, the petitioner saw Dr. McGinnis for annual medical visits on October 6, 2009, August 17, 2010, June 16, 2011, July 25, 2012, March 14, 2013, March 7, 2014, and September 11, 2015. While he did at some appointments complain of neck and back pain, he was seen for medication refills, swollen glands, abdominal pain and gastrointestinal issues.

Dr. McGinnis testified that prior to the work accidents, she had seen him for back pain on November 4, 2002. (PX 42, pg 101) She saw him May 17, 2004 for neck , muscle spasms and back pain (PX 42, pg 103), and upper back pain June 28, 2004 (PX 42, pg 104), back and hip pain on November 25, 2004 PX 42, pg 104).

Dr. McGinness also admitted on cross examination that she was not aware of Petitioner’s automobile accident in August 2008. She also did not review the medical records from the ER for this automobile accident. (Px42, pg 104-105).

Testimony of Dr. Song- treating surgeon

Dr. Song is a board-certified neurosurgeon. (Px. 45, pg 6) The doctor initially saw the petitioner as an inpatient at Hinsdale Hospital on **November 15, 2022**. He performed a laminectomy from L2 to L4 with fusion. (Px 45, pg. 9) **When asked about whether the prior low back surgery, had any effect on his need for a low back surgery in 2022, the doctor stated, “I don’t have a strong opinion on that. As I said, I could opine on what could have caused the patient’s most recent problems. But whether or not the previous fusion was involved, I can only say possibly.”** (Px 45, pg 13) **When asked to specify his opinion as to what caused his most recent problems, the doctor stated, “well, the differential, as we said, could have been the previous surgery. It could have been any other injury he had in the intervening 15 years or just normal degenerative changes.”** (Px. 45, pg 13) Dr. Song testified he was unaware of the auto accident in 2008. (Px 45, pg 13-14, 24)

On cross examination, Dr. Song did confirm that an automobile accident could be a competent cause of an injury to the low back. (Px. 45, pg 24). The doctor was asked about his report of February 14, 2023, which stated that his lumbar fusion was “apparently causally related” to the adjacent segment disease from his prior lumbar fusion (Px 45, pg. 18), however when asked about that statement on cross examination, the doctor stated that information “must have been from a direct interview with the patient.” (Px 45, pg. 27)

The doctor described adjacent segment disease as “this is a condition where people...had a prior fusion...so over time the remaining segments that were not operated on theoretically can develop more – you know, have to do more work to get the same range of motion. So if they do more work, theoretically, they can wear out quicker.” (Px45, pg.17) Dr. Song testified that he performed a laminectomy from L2 to L4 associated with a posterior lumbar fusion and that he last saw Petitioner on March 7, 2023. (Px45, pg. 19-20) The doctor did not address petitioner’s ability to work in his notes and testified he would defer to Dr. Goldberg or whoever originally gave petitioner the work-related restrictions. (Px45, pg.20)

On cross examination, Dr. Song testified he did not think he had any information specifically written in his notes about what petitioner alleges occurred at work in 2005 or 2006. (Px45, pg. 23) He had not reviewed any prior medical records and testified his opinions regarding a work-related injury or whether it caused any condition of ill being with the neck and back were based on what the petitioner told him about the causal relationship and not from any independent information. (Px 45, pg. 23-24) The doctor had no independent knowledge of the alleged work related injuries or the petitioner’s medical treatment prior to coming under his care. (Px 45, Pg 23-24) Dr. Song did not have any opinion as to whether there was any injury to the cervical spine as a result of any work related accident in 2005 or 2006. (Px 45, pg. 24.)

Dr. Song testified that did not review any medical records regarding an automobile accident Petitioner had in 2008 and that an automobile accident could be a competent cause of injury to the lower back. (Px45, pg 24) In reviewing the medical records from the petitioner’s admissions to the hospital in November 2022, the doctor testified the diagnosis would be low back pain and findings would have been lumbar stenosis and a lumbar degenerative spondylosis. (Px 45, pg. 25) The doctor explained that stenosis is narrowing of the spinal canal or neural foramen can be a degenerative condition but could also be narrowed for any reason. Degenerative spondylosis is arthritis. (Px 45, pg. 26) Following the surgery, the petitioner did well and the doctor’s note of December 6, 2022 stated the petitioner was happy and his chronic low back pain had essentially resolved. (Px 45, pg. 26) On February 7, 2023, the petitioner reported that his left leg symptoms were 80 to 90% resolved and his right leg symptoms were 63% resolved page (px45, pg. 26–27). **Dr. Song testified that he had not issued any work restrictions and would defer to the 25 lb. restriction issued by Dr. Goldberg in 2007.**

Dr. Song was asked about the statement made that the prior lumbar fusion was “apparently causally related” to his work injury in 2006 and also 2014. The doctor explained he did not review any records so the opinion of “ “apparently causally related” must have been from a direct interview with petitioner. (Px45, pg. 27) The doctor also testified regarding petitioner having right arm symptoms and possible right C5-C6 radiculopathy that was complicated by bilateral carpal tunnel surgery he also had. (Px45, pg28)

Dr. Song testified that if the prior lumbar fusion was related to a work accident or injury, and the doctor diagnosed petitioner with adjacent segment disease and that led to the most recent surgery, then the surgery does appear to be causally related to a work injury. (Px45, pg. 30). Even if the prior fusion was not related to a work injury, the doctor testified that “the current issue or most recent issues are still related at least partially to the prior lumbar fusion.” (Id.)

Dr. Song testified that he did not review any of the medical since the prior fusion, did not review Dr. Goldberg's records or prior operative report and has not issued any work restrictions at any time. (Px45, pg.31) The doctor was asked "so, hypothetically, if Dr. Goldberg has stated that the reason why he did the fusion in the first place was a work-related injury, my hypothetical is correct, then. Your causal connection opinion is correct where you say it's causally related because I'm fixing an adjacent segment disease that was caused by a work-related fusion. The doctor answered "I think... As I said before, I believe it is a factor. But, again, is it a major factor? I'm not sure if that's significant. It is a factor, but with so much time in between, it's hard to say how big of a role that played." (Px 45, pg. 32-33)

Testimony of Dr. Mather- Respondent IME

Dr. Steven Mather is a board-certified orthopedic surgeon who testified on **September 5, 2024**. (Rx 3, Pg. 5) Dr. Mather opined that based on the diagnostic films he reviewed, the petitioner had a right L4-L5 and L5-S1 disc herniations. For this condition, if conservative treatment failed, the standard recommended by the American Board of Orthopedic Surgery would be to perform a discectomy. (Rx 3, Pg. 8) He testified fusions are only used to stabilize something or if the patient had an unusual history of chronic back pain for many years which continued and then ruptured the disc. (Rx 3, Pg. 8) **Dr. Mather testified that with respect to the cervical spine, the petitioner sustained only a cervical soft tissue strain or a temporary aggravation of Petitioner's right C4-C5 stenosis which had resolved itself at least by April when his symptoms resolved.** (Id.) The MRI showed only normal degenerative changes of the cervical spine. (Rx 3, Pg. 7-8)

Dr. Mather testified that he found the petitioner to have positive Waddell findings. (Rx 3, Pg. 9) These maneuvers are not supposed to provoke pain and are done to determine if there are any inconsistencies, symptom magnification or functional pain that cannot be medically explained. (Rx 3, Pg.10). Dr. Mather testified that many of the work restrictions were imposed purely based on what the patient said they could do, however, this would be suspect when a patient has a positive Waddell findings as the patient is magnifying their symptoms. (Rx 3, Pg. 13) Dr. Mather also pointed out that the petitioner would go to IMEs and show up with a cane, but then when he was seeing his regular treating doctors, he would not have the cane. He felt this was a clear example of the patient grossly magnifying symptoms. **Despite this, Dr. Mather agreed as a result of the first fusion surgery, the petitioner should have a 25 pound lifting restriction with bending no more than eight times per hour based on the lumbar fusion performed.** (Rx 3, Pg. 13) **In accordance with petitioner's treating physicians at the time, Dr. Mather agreed the petitioner was at maximum medical improvement for the lumbar spine in March 7, 2007 and for the cervical spine on April 3, 2007.** (Rx 3, Pg. 12) The doctor also testified that cervical was non occupational because his own treating physicians placed him at MMI back in 2007 as he didn't really have any significant clinical findings. (Rx3, pg18)

Dr. Mather testified the fusion performed by Dr. Song in 2022 was not related to the work accident and was instead just normal age appropriate or age-related degeneration. (Rx 3, Pg. 19) **In support of this, he pointed out that three years after the original fusion, the patient was already showing stenosis two levels away which strongly indicates it was present to some degree prior to the fusion and progressed in a typical fashion for type of**

degeneration. (Rx 3, Pg. 19) Dr. Mather did agree that as a result of the initial lumbar fusion in 2007, the petitioner required permanent 25 pound lifting restrictions with bending and twisting only eight times per hour. This restriction would preclude his returning to work as a ramp serviceman.

Dr. Steven Mather testified with respect to the cervical spine, the petitioner suffered only a cervical strain or aggravation of the pre-existing stenosis at C4-C5. The petitioner was at maximum medical improvement by April 3, 2007. He did not agree that cervical surgery would be appropriate as there were no indications of myelopathy or any neurological impingement stemming from the cervical pathology at C4-C5. Specifically, he found that even though petitioner has a C3-4 herniation, Petitioner does not have myelopathy or C4 radiculopathy because Petitioner did not have certain positive findings and that the herniations cause tingling as opposed to real pain. (Rx3, pg. 11)

The petitioner was at maximum medical improvement for the lumbar spine as of March 7, 2007 consistent with his treating physicians who initially placed him at MMI. He does not believe petitioner required any further treatment after that date for the lumbar spine. He testified that the fusion surgery performed by Dr. Song in 2022 was due to ongoing degenerative pathology and stenosis noted previously on the MRI done in 2010.

On cross examination, Dr. Mather agreed that petitioner would not be able to return back to work as a baggage handler after a two level fusion and the weightlifting requirements for a baggage handler was at least 50 pounds. (Rx3, pf 26)

David Patsavas- Vocational Rehabilitation counselor

The deposition of David Patsavas, the petitioner's vocational expert, was taken on September 9, 2022. (PX 43) Mr. Patsavas testified he prepared a report in 2019 with medical records reviewed, the petitioner's employment history and his opinion is that there is no stable labor market for Mr. Loving. (Px 43, pg 20-22) He testified that Petitioner could not return as a baggage handler nor could he have returned to any kind of employment as of the time of his assessment, because of petitioner's "lack of transferrable skills, required medication levels, and physical limitations. (Px43, pg21-22). Mr. Patsavas did not perform a labor market survey or do any vocational testing, nor did he perform any computer testing. (Px 43, pg 24-25). When asked what functional restrictions he used in determining there was no stable labor market for Mr. Loving, he appeared to have difficulty answering the question. (Px 43, pg 28-29). He indicated that one of Mr. Loving's physicians indicated he was permanently and totally disabled; he incorrectly suggested another indicated that he should have sedentary restrictions, while he suggested the invalid FCE found he should have a 25-pound restriction. When asked which of these restrictions he used, he could not clearly answer the question and appeared to use various restrictions of light category restrictions and also sedentary restrictions (Px 43, pg 29). He testified that Mr. Loving has not, at any time, looked for alternate employment or provided job search logs. (Px 43, pg 28). In meeting with the petitioner, Mr. Loving also did not express any desire to find employment. (Px 43, pg 28).

Mr. Patsavas' report indicated that the petitioner had a police record. When questioned, Mr. Patsavas did not have any further information regarding that issue. He testified that having a

criminal record could impact types of jobs the petitioner might be able to perform but he did not ask the petitioner to ascertain the impact on any vocational prospects. (Px 43, pg 26-27). When asked what jobs he considered for the petitioner, Mr. Patsavas answered, "none." (Px 43, pg 30).

Testimony of Joe Belmonte- Vocational Rehabilitation counselor

Joseph Belmonte was retained by Respondent to provide vocational services to the petitioner in 2007 following his discharge from care by the physicians at Midwest Orthopedics at Rush. (RX 4.) Mr. Belmonte testified on **November 11, 2022**. Dr. Goldberg the treating surgeon had provided restrictions of 40 lbs. floor to waist, frequent lift of 20 lbs floor to waist, frequent lift of 15 lbs waist to shoulder, occasional lift of 20 lbs. overhead and frequent lift of 10 lbs. overhead. (Rx 4, pg. 51) Mr. Belmonte testified that the petitioner was eligible for employment in a stable labor market at that time within his restrictions. (RX4, Pg. 35) The anticipated likely wage range was \$10 to \$14.50/hour (Rx. 4, Pg. 16)

Following the initial interview and in accordance with the petitioner's restrictions and employment history, a number of different positions were identified which it was felt the petitioner could likely perform. (PX 44, Pg. 15) These included truck dispatcher, aircraft dispatcher, assembler, newspaper circulation clerk and security guard supervisor. (Rx. 4, Pg. 15-16) After administering various tests to identify the petitioner's strengths and weaknesses, additional potential employment opportunities were identified which were a match with the petitioner's abilities. These included charge account clerk, shipping order clerk, route delivery clerk, nutritional aide, electronics utility worker, security gate guard, stock control clerk, information clerk, expeditor, service order expeditor. (RX 4, Pg 23-24)

In addition, Mr. Belmonte testified regarding concerns which were raised as to the petitioner's compliance, interest and motivation in finding work. Mr. Belmonte issued correspondence to Mr. Loving on December 21, 2007 addressing the lack of compliance in the vocational process. (Rx 4, Pg. 29) The concerns centered around three issues. The first involved issues of cooperation, timeliness, attendance, absences and early departures. In addition, there were inappropriate verbal and written comments in response to guidance given to him in good faith by the Vocamotive staff. Finally, there was inappropriate identification of job targets such as Hollywood script writer, congressman or alderman coupled with no apparent effort to identify meaningful job targets consistent with his work history and educational level. (Rx 4, pg 30) Mr. Belmonte requested that Mr. Loving verify whether he was actually willing to cooperate with the job search process and provide an answer by December 26, 2007. (Rx 4, Dep Exh 3)

Mr. Belmonte testified he told the petitioner that "it was my professional opinion that he was not motivated to participate in the service, getting a job was not a priority and that he wasn't cooperating and that I felt that he should be discharged from the service." (Rx 4, Pg. 30) They were willing to give him another chance, however, he Mr. Belmonte laid out that he needed to be realistic in understanding job targets. Mr. Belmonte informed petitioner that he was clearly employable in jobs such as order picking, security, cashier, entry level customer service, mailroom clerk and other jobs. (Rx 4, pg 31)

Mr. Belmonte admitted that during his work with the petitioner, a report was issued prematurely commenting on petitioner's honesty and Mr. Belmonte issued an apology to the petitioner and his attorney on December 21, 2007. (Rx 4 pg 33) They included raw notes which should have been edited down and reviewed by Mr. Belmonte, though through administrative error that did not happen in this case. (Rx 4 pg 33-34)

The records introduced regarding the vocational placement indicate multiple issues raised by Mr. Loving in connection with his efforts. They include that "Mr. Loving stated that he had decided that he wanted to relocate to California and become a Script Writer" (Rx 4, Dep Exh 2) At one point Mr. Loving indicated that he left his last employer as the business was closed. He was questioned on this as United Airlines had not closed, to which he responded, "You told me to answer the questions; I didn't know you wanted the truth." The petitioner is noted not to have completed job search leads or applied to the jobs he was directed to apply for. (Rx 4, Dep exh 2).

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim *O'Dette v. Industrial Comm'n*, 79 Ill. 2d 249, 253 (1980) including that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 63 (1989) It is well established that the Act is a humane law of remedial nature and is to be liberally construed to effect the purpose of the Act - that the burdens of caring for the casualties of industry should be borne by industry and not by the individuals whose misfortunes arise out of the industry, nor by the public. *Shell Oil v. Industrial Comm'n*, 2 Ill.2nd 590, 603 (1954).

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). 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 demeanor of the witness and any external inconsistencies with his/her testimony. Where a claimant's testimony is inconsistent with his/her 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). The Arbitrator, as the trier of fact in this case, has the responsibility to observe the witnesses testify, judge their credibility, and determine how much weight to afford their testimony and the other evidence presented. *Walker v. Chicago Housing Authority*, 2015 IL App (1st) 133788, ¶ 47.

In the case at hand, the Arbitrator observed Petitioner during the hearing and finds him to be only a partially credible witness and his overall testimony is not entirely reliable or credible. He was also a poor historian. The Arbitrator notes Petitioner denied prior low back injuries despite evidence of multiple prior doctor visits for the back pain. Petitioner clearly had some prior back complaints however his work accident on 4/17/06 created a significant change and worsening of Petitioner's lumbar spine. The Arbitrator also finds it important that Petitioner's own treating physicians, including multiple physicians at various medical institutions throughout the years, note

petitioner to have subjective complaints that do not match objective findings or noted symptom magnification.

The Arbitrator further notes that Petitioner is seen on 2020 surveillance video in evidence (Rx8 a, b), volunteering or working with his church, carrying items of unknown weights including clothing, a suitcase and construction cones. The petitioner testified these items and his conduct on surveillance are nonetheless within Dr. Goldberg's permanent restrictions from 2007. The Arbitrator tends to agree that the items are likely within the weight restrictions for carrying/lifting, but notes that this also shows Petitioner is somewhat more active than he testified and likely capable of working within those same restrictions despite testifying that he never attempted to find work within said restrictions. The Arbitrator does not find it reasonable based on the facts of the case and medical evidence, that Petitioner never attempted to find work within the permanent restrictions he was given by Dr. Goldberg in 2007.

Petitioner is and was likely able to do more than be completely off work following his examinations and release from care by Dr. Goldberg and Dr. Fetzer in March and April 2007. However, Petitioner testified that he relied on his PCP, Dr. McGinness, not his orthopedic surgeon and specialists, that he is completely off of work and unable to work. The Arbitrator does not afford the findings and opinions of Dr. McGinness much weight as they are not supported by the record as a whole in this matter. The Arbitrator also notes that despite testifying that he was under doctor's care and/or relying on Dr. McGinness regarding his ability to work from the first date of accident through present, the Arbitrator notes there are also numerous gaps in treatment with Dr. McGinness as elaborated on below: October 2009- August 2010, September 2010- October 2011, October 2011- March 2013 (other than prescription refills with Dr. McGinness), October 2015- March 2016, April 2016-September 2016, May 2017-January 2018, only three visits total in 2018 with Dr. McGinness, May 2019- October 2019 and June 2020 through November 2022. The Arbitrator does note that Petitioner did move a handful of times during this time period which could possibly explain some gaps in care but not all.

Further, the Arbitrator notes Petitioner claims lumbar spine, cervical spine and right shoulder injuries as it relates to his work injuries. The Arbitrator finds petitioner to be credible enough regarding the work accidents and injuries initially sustained, however the Arbitrator has not been convinced that Petitioner's ongoing and current cervical spine, lumbar spine and or right shoulder/arm complaints and progressively worsened conditions, are causally related to the original accidents at work. Despite petitioner's testimony, the Arbitrator finds it to be significant regarding causation, that there was an intervening 2008 rear end motor vehicle collision that occurred, injuring petitioner's low back and neck among other injuries, as well as a large 15 year gap from Dr. Goldberg's issuance of permanent restrictions and Petitioner's necessitating a second lumbar fusion surgery with Dr. Song. It is clear from the medical evidence that petitioner's cervical spine and lumbar spine were injured in the motor vehicle collision requiring medical care. The Arbitrator finds it important that Petitioner's own PCP Dr. McGinness also determined petitioner was injured to the extent following this collision, to be completely taken off a work within a week after that collision.

Regarding the medical witnesses and experts in this case, the Arbitrator finds that overall, the treating physicians, Section 12 examiners and vocational rehabilitation counselors, except for Dr. McGinness, are credible witnesses, however, only finds the opinions of Dr. Goldberg and Drs. Palmer and Fetzer regarding the lumbar spine and cervical spine, Dr. Mather regarding the lumbar spine in part, as well as Mr. Belmonte regarding work capabilities, to be persuasive in making her findings and award as further explained below. The Arbitrator is not persuaded by the opinions of Dr. McGinness, Dr. Song, Dr. Wehner, Dr. Lami and Mr. Patsavas. See below for further discussion.

Issue F, whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds as follows:

To obtain compensation under the Act, a claimant must prove that some act or phase of his employment was a causative factor in his ensuing injuries. It is not necessary to prove that the employment was the sole causative factor or even that it was the principal causative factor, but only that it was a causative factor. *Tolbert v. Ill. Workers' Comp. Comm'n*, 2014 IL App (4th) 130523WC, ¶ 1, 11 N.E.3d 453. "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 Com.*, 93 Ill. 2d 59, 63 442 N.E.2d 908 (1982). Proof of the state of health of an employee prior to and down to the time of the injury, and the change immediately following the injury and continuing thereafter, is competent as tending to establish that the impaired condition was due to the injury. *Kress Corp. v. Industrial Commission*, 190 Ill. App. 3rd 72, 82 (1989).

Therefore, based on a chain of events analysis the evidence shows a causal relationship between the 3/10/06 incident at work and the cervical spine and right shoulder injuries only. Further, based on a chain of events analysis the evidence shows a causal relationship between the 4/17/06 incident at work and the lumbar spine injury that necessitated a fusion surgery and permanent restrictions. The Arbitrator further notes that Petitioner sustained minor lumbar spine injuries at work for Respondent on 11/4/05 and 12/23/05 as well. Petitioner was working full duty without restrictions for Respondent until his first work accident on 11/4/05. Following the 4th accident of 4/17/06, his lumbar spine condition significantly worsened requiring him to seek medical care, be taken off work etc. Regarding the cervical spine, there are clearly some degenerative changes noted on the MRI as well as on the lumbar MRI, however, Petitioner appears to have injured his cervical spine or aggravated it at a minimum, per the Midwest Orthopedic doctors, following the 3/10/06 work accident. Overall, the Arbitrator concludes Petitioner sustained work-related injuries to the lumbar spine and cervical spine but does not find petitioner's current condition of ill-being for both injuries to be causally related. Petitioner reached MMI for all work-related injuries on 4/3/07, per Drs. Goldberg, Fetzer and later Mather.

For the case at hand, Petitioner clearly had prior back pain and some visits with doctors or chiropractors before his four work accidents occurred. The Arbitrator acknowledges that the 2006 lumbar and cervical MRI findings after his work accidents also show some degenerative findings as well but it is still clear to the Arbitrator that the last two work accidents at a minimum, aggravated and worsened Petitioner's cervical and lumbar spine to the point that he required extensive medical treatment for the lumbar spine and needed to be taken off work by his doctors. Even though petitioner was not entirely credible on this issue at trial, medical evidence supports there was some prior back medical history for Petitioner. However, Petitioner was nonetheless working full duty without restrictions for Respondent at the time of first work accident of 11/4/05, and there is no evidence to the contrary. Petitioner also returned to work three times for Respondent before his final work accident on 4/17/06.

The Arbitrator notes that there are questions regarding how the first three accidents occurred. In each case, the accident as testified to by the petitioner does not entirely correlate with the medical history in the contemporaneous medical records.

The petitioner testified that on November 4, 2005, he was hooking up containers for the luggage which weighed about 1,700 pounds. As he was going to clamp the container on the tug he was driving, he slipped on the ice, tried to catch himself and hurt his back (Tr. 24). The medical records from that date at UIC Medical Center at O'Hare indicated instead that he reported lifting heavy bags on his knees in the pit when he twisted the wrong way with a heavy bag. (PX 20)

For the December 23, 2005 accident, the petitioner testified he was hooking up containers to a tug when he injured his back, legs, and hips (Tr. 28). The medical records from December 23, 2005 at UIC at O'Hare instead reflect the petitioner reported continued pain with lifting since the prior injury and acute increase in low back pain and radiation into left thigh when lifting a heavy bag this afternoon. (PX 20).

On March 10, 2006, the petitioner testified that as he was taking luggage out of the containers, he felt something pop in his neck, arm and right shoulder (pp. 29-30). The medical records reflect the petitioner was seen at Celar Chiropractic on March 14, 2006 reporting a new injury while lifting up and tossing a heavy bag. He reported pain in his right shoulder at that time and a shoulder MRI was ordered shortly thereafter.

The foregoing accident issues notwithstanding, the petitioner did not lose any time from work and sought more minimal treatment until the fourth alleged accident in April. On April 17, 2006, the petitioner was in the belly of a plane lifting luggage when he felt a crackle in his low back. He collapsed and was taken by Chicago Fire Department Ambulance to Resurrection Medical Center. The arbitrator finds that the first two accidents of November 4, 2005 and December 23, 2005 involved lumbar strains and the March 10, 2006 accident involved a right shoulder strain and aggravation of cervical spine injury. The injuries from these accidents were superseded by the April 17, 2006 accident.

In reviewing the medical records, they are replete with concerns about symptom magnification and the petitioner falsifying his presentation to his examining physicians. From the first visit with Dr. Nicholson on August 1, 2006, there were concerns about the petitioner's symptom magnification, as his presentation was out of proportion to his physical findings or the pathology seen on the MRI. (Rx 6, pg 87) Dr. Fetzner also noted that on exam he reported he could not actively raise his right arm above his head, however, he then did raise it to approximately 110 degrees of abduction. She outright expressed concern that the petitioner's symptoms were exaggerated. (Rx 6, pg 22)

The work conditioning notes also reflect "the client's refusal to perform resistive activities due to subjective complaints of pain without correlating clinical objective findings." (RX 6, pg 215) He required verbal cues and supervision to remain on task. The therapist went so far as to call this an "invalid" performance in work conditioning. The petitioner was given verbal warnings for non-compliance after receiving specific instructions in the proper conduct for participation. After continuing to demonstrate improper techniques, the therapist noted that "One would expect a client with a high level of low back pain to perform this activity with proper body mechanics to minimize the stress in the low back and to maximize the efficiency of the lift." (RX 6, pg. 216) It was at that point that an FCE with emphasis on validity was recommended. When the FCE was then performed, it was invalid due to submaximal effort from the petitioner. He in fact failed 18 out of 25 objective validity criteria (PX 24). Additionally, he had four out of five positive Waddell's signs for non-organic signs of low back pain. They specifically found that, "Mr. Loving is employable at this time." (PX 24).

This pattern of falsifying his presentation to his examining physicians was also pointed out in the records petitioner submitted related to the decision from the Social Security Administration. (PX 40). The report states,

"As can be seen from the records in this matter, the claimant has severe complaints with respect to his neck and back pain. The record shows that the claimant underwent surgery in September, 2006. All indications in the records show that although the claimant has continued to have severe complaints following the surgery, the objective findings have been minimal. During the physical examinations noted above subsequent to the surgery, it has been noted that the claimant has limitation of motion in the cervical and lumbar spine and the only signs supporting a diagnosis of radiculopathy have been some mild loss of sensation in the right thigh. The claimant has severe complaints which have been out of proportion to the objective evidence. The record is clear that the claimant does not have any limitations in the use of his arms or hands. The restrictions noted by Dr. McGinness are not supported by the record as a whole in this matter. As noted above, there are no treating notes of record to support the severe limitations noted by Dr. McGinness. As a result, the undersigned cannot afford the opinions of Dr. McGinness significant weight. The claimant's overall testimony in this matter was not fully credible. He has alleged very severe symptoms and limitations. He has stated that he has such severe back and neck pain that he cannot stand, walk or sit. However, it is noteworthy that he has not followed through with any epidural steroid injections and has apparently stopped trying any type of physical therapy. The functional capacity evaluation performed on the claimant on March 26, 2007 (Exhibit 16F) shows that claimant was attempting to portray himself much more limited than he actually was." (PX 40, p. 7 of 11).

The Social Security Administration found that while he would have some residual limitations, these would not prevent him from performing sedentary work. They note that with sedentary work there were 1,800 jobs available in the Chicago Metropolitan area for assembly, 1,200 jobs for hand packager, and 1,000 jobs for inspector. The report further indicates,

“The claimant is not persuasive. He said he cannot sit or stand for more than a few seconds and was up and down at the hearing. However, when it was noted he had to sit in the car for more than a few seconds when he goes to appointments and to get to the hearing, the claimant claimed that at every stoplight he opens the car door and stretches his legs out the door. This is rather hard to believe. It is noted that the claimant stated he has not driven since his back surgery in September, 2006. While it was pointed out that he was driving when he was involved in the motor vehicle accident in August, 2008 (Exhibit 11F), the claimant asserted that that was the only time he has driven since surgery. He claimed that his son was driving him to the doctor and got lost, so he had to take over the driving and then got into the motor vehicle accident. Other inconsistencies include the claimant testifying he cannot handle finances, he has done no cooking in the past two years and doing dishes, but information in Exhibits 4E and 8E suggest otherwise.” (PX 40, pg. 7 of 11)

The report further notes that while the claimant stated he had been using a cane for two years, an exam on November 13, 2007 indicated the petitioner did not have a cane and his gait was within normal limits.

The Arbitrator notes that a finding from the Social Security Disability Administration has no precedence. The Arbitrator does take note of the fact that inconsistencies were found, and that the trier of fact found the petitioner not credible with respect to his presentation and the testimony presented. This is consistent with the inconsistencies found in petitioner’s treatment at Midwest Orthopaedics at Rush and the functional capacity evaluation, among other records.

Later medical records also suggest that petitioner is not being forthright. The PT records from Saint Joseph’s/Candler Health System in Georgia include that petitioner washed, waxed and detailed his car over the weekend and then a week later he reported feeling well and “I feel like I could play football.” These comments were made in October 2015, the same month that Dr. Goldberg saw him and recommended cervical surgery. The Rush Oak Park Physical Therapy notes also repeatedly indicate significant self-limiting tendencies, and noted “observed movements and behaviors inconsistent with subjective reports” on October 28, 2019. Also on November 4, 2019, they again indicate the self-limiting tendencies and inconsistent observed movements and behaviors which were inconsistent with subjective reports.

All of these issues raise concerns regarding the petitioner’s presentation. Notwithstanding those concerns, the Arbitrator still finds that the petitioner suffered an injury to his low back on April 17, 2006 which necessitated a lumbar fusion. Dr. Goldberg who evaluated the petitioner on August 18, 2006 opined that the petitioner sustained a disc herniation and aggravated his degenerative disc disease with the work-related accident.

While Dr. Wehner could not substantiate any injury other than a sprain and Dr. Mather opined that a discectomy would have been more appropriate in light of the pathology on the MRI, the Arbitrator still agrees it was reasonable for the petitioner to follow the surgical recommendation of Dr. Goldberg. Dr. Goldberg was persuasive and credible in his testimony regarding his diagnosis of Petitioner's lumbar spine and the fusion surgery that was needed. Following the surgery, the petitioner had a favorable result to surgery. Despite the petitioner's testimony as to a "failed fusion", there is no evidence in the record to substantiate such a diagnosis. Instead, the records show he had an uncomplicated postoperative course and described successful resolution of his symptoms. Dr. Goldberg authorized the petitioner to return to work lifting 40 pounds occasionally from floor to waist, 25 pounds waist to shoulder, and overhead 20 pounds occasionally and placed the petitioner at MMI on March 7, 2007. (Rx. 6, pg 61) Regarding the cervical spine, Dr. Fetzer released to return to work full time and full duty on April 3, 2007 following the invalid FCE (Rx 6, pg 8)

Upon follow up questions by the arbitrator at trial, Petitioner testified that he felt a crackle and pain in the neck with the injury of April 17, 2006. This, however, is not supported by the medical records. Based on the Ambulance records and when the petitioner was seen at Resurrection Medical Center on April 17, 2006, he reported only low back pain. (PX 7). The history given was that he bent over to pick up a luggage bag and felt something pull in his back. A pain diagram also indicates pain only in the low back. The Chicago Fire Department ambulance records specifically note he had no neck or upper back pain. The petitioner described he felt something in his lower back go crunch after he bent over and lifted a piece of luggage (PX 7). Contrary to what the petitioner advised the Arbitrator, there was no injury to the neck or upper back reported at the time of the April 17, 2006 work accident. That said, based on the medical records and testimony by Dr. Goldberg, the Arbitrator finds that Petitioner did sustain a cervical injury and aggravation of his neck condition on the 3/10/06 accident date.

The Arbitrator notes that the petitioner also suffered an auto accident in August of 2008 which resulted in increased neck and back pain. He treated at Loyola ER, then with West Suburban Medical through early 2009.

In August 2010, Petitioner called Dr. McGinnis to request a cervical MRI and then went to see Dr. Goldberg, who he hadn't seen since his discharge from care in 2007. He reported that he had been constantly in pain for the last three weeks. It is unclear what caused this exacerbation. Dr. Goldberg recommended surgery but the petitioner did not want to proceed. Dr. Lami then performed an IME and opined that he did not need cervical surgery.

The basis for the surgery recommendation was concern for myelopathy. The petitioner's tests for myelopathy at his exams, however were inconsistent. Dr. Ganapathy on November 18, 2014 noted myofascial pain which was non-dermatomal and stated, "I am not convinced that he has myelopathy as today's exam was not in keeping with the exam finding from last visit." He referred the petitioner to Dr. Smucker for a possible diagnostic injection, but Dr. Smucker found his "symptoms of pain and paraesthesias were not consistent during the time of my discussion with him".

The neurologic exam showed no upper or lower extremity atrophy and balance and coordination were normal. Lower extremity neural tension signs were negative bilaterally. His lumbar range of motion was limited, but there was no focal mechanical reproducible pain. Cervical range of motion was also normal. Shoulder impingement was inconsistently positive on the left. Motor strength testing featured break away weakness through the proximal and distal bilateral upper and lower extremities. Dr. Smucker was concerned about the non-physiologic findings with diffuse inconsistent breakaway weakness on exam. The doctor did not see evidence of any cervical myelopathy, as such, he did not believe that the requested diagnostic cervical selective nerve root blocks would be valid in an individual with widespread inconsistencies on exam and in described symptoms.

Dr. Lami testified that the petitioner's condition of ill being in the cervical spine was not causally related to the work accident of April 17, 2006, or to any of the other work accidents. Dr. Mather testified that with respect to the cervical spine, the petitioner sustained only a cervical soft tissue strain or a temporary aggravation of Petitioner's right C4-C5 stenosis which had resolved itself at least by April when his symptoms resolved. Dr. Goldberg testified the petitioner injured both the cervical and lumbar spine at work, however, when asked about whether his current conditions were related to the work accident, Dr. Goldberg seemed to equivocate and could not affirmatively answer the question. He also was not aware of the automobile accident in 2008. Dr. Song also offered no opinion on whether the petitioner's condition of ill-being with respect to his cervical spine was causally related to the employment.

Overall, the Arbitrator finds that Petitioner sustained a cervical injury and right shoulder injury on 3/10/06 and a lumbar spine injury on 4/17/06. The petitioner also sustained more minor back injuries on 11/4/05 and 12/23/05. Regarding causation for Petitioner's current condition of ill being, the Arbitrator overall relies on the opinions and findings of both Dr. Goldberg in part and Dr. Mather, in part, in finding that: 1) Petitioner sustained work related lumbar spine and cervical spine injuries 2) Petitioner required lumbar fusion surgery and related care as provided by Midwest Orthopedics at Rush to his neck and back and 3) Petitioner was at MMI for his cervical spine in April 2007 and for the lumbar spine, March 2007 4) Petitioner required permanent restrictions and could not return to his prior job as a ramp agent for Respondent. The Arbitrator finds it reasonable that Dr. Wehner and Dr. Lami agree with the permanent restrictions of 25 pounds regarding the lumbar spine due to the fusion, but does not otherwise find their opinions to be persuasive. The Arbitrator does not find Dr. McGinness to be credible and is not persuaded by Dr. Song.

The Arbitrator relies on Dr. Goldberg's opinion when he gives causation for both the neck and back injuries as of the time he testified in 2016, however the Arbitrator does not agree that Petitioner's ongoing lumbar and cervical spine conditions as of 2016 are still related to the 2005 and 2006 work accidents. Unlike the IME physicians, Dr. Goldberg finds Petitioner did sustain a work-related cervical spine injury. However, there are no further treatment dates, opinions obtained or discussion with Dr. Goldberg regarding petitioner's conditions after his 2016 deposition. At this time, petitioner had still not had the 2022 second fusion, nor was Dr. Goldberg privy to the various IME opinions, deposition testimony and overall treatment records from 2016 to present. There are also no strong or persuasive opinions for causation of petitioner's current conditions after this deposition. The Arbitrator is also not persuaded

regarding Petitioner's current condition by Dr. Song who did not have all the records or a clear and complete picture of Petitioner's medical history. Dr. Song also deferred to Dr. Goldberg regarding work restrictions. Dr. Goldberg the treating surgeon, previously had provided restrictions of 40 lbs. floor to waist, frequent lift of 20 lbs floor to waist, frequent lift of 15 lbs waist to shoulder, occasional lift of 20 lbs. overhead and frequent lift of 10 lbs. overhead.

Regarding the lumbar surgery: while Dr. Mather's opinions are somewhat persuasive, the arbitrator more so relies on Dr. Goldberg's opinions which are convincing regarding the lumbar spine and the need for the fusion surgery he performed in 2006 and that was successful in helping petitioner's right leg complaints. The Arbitrator also finds it important that Dr. Goldberg testified that when Petitioner originally saw him regarding the lumbar spine, he has right leg symptoms improve after surgery, and it is not until a few years later where petitioner is getting bilateral leg pain and new pathology at other levels. Regarding the cervical, Petitioner had neck towards the right shoulder originally, over the course of time it appeared to progress into some early myelopathic findings. (Px41, pg54) It is clear per Dr. Goldberg that there was a change in petitioner's lumbar spine and cervical spine over the years, from the 2007 release from care with permanent restrictions and the 2010, 2013 and 2015 visits (last visit) with Dr. Goldberg.

It is noted that Dr. Goldberg last saw Petitioner in October 2015. Regarding causation for the back and neck and whether Petitioner's present condition of ill being is caused in whole or in part by any of the four work related accidents, the doctor testified the lumbar yes in whole part because "unfortunately he developed adjacent level problems." (Px41, pg. 54) Regarding the neck, he testified "all I can state is he did have an injury, he was treated by some of my partners, had some temporary improvement its not progressed." (Id.) The Arbitrator notes that the doctor found some adjacent level issues, however he also found that there was a stable lumbar fusion and he did not recommend further lumbar surgery. It important to note that the doctor did not change petitioner's work status or provide any additional opinions that changed the prior permanent restrictions he imposed in March 2007 for the lumbar spine.

In addition, regarding the neck, Dr. Goldberg did not find the condition to be worsening in 2015 but continued to recommend cervical surgery that petitioner declined and was also not approved. Dr. Goldberg as the treating surgeon was in the best position to opine as to Petitioner's conditions in 2006 and 2007, regarding the lumbar spine as well as cervical spine for finding a work related injury. He personally saw petitioner and examined him multiple times. He took numerous MRIs and reviewed many of them. He relied on his own medical records and those of his colleagues at Midwest Orthopedics. He was involved early on with petitioner's care and treatment and saw him from 2006 through 2015 (on and off). He testified that his opinions on the cervical spine was predicated on his review of Drs.' Palmer and Fetzer notes as well. Specifically, he testified that his colleagues thought petitioner had a shoulder condition and records reflect that petitioner injured his right shoulder and neck as well. The Arbitrator finds it important and persuasive that the doctor's objective findings matched petitioner's subjective complaints during his treatment of him, despite other treating physicians and IME doctors finding symptom magnification. There was clearly symptom magnification documented by numerous treating physicians per the extensive medical records in this case but it appears that with Dr. Goldberg, Petitioner was more credible with his pain complaints. All of the IME doctors

also documented symptom magnification and/or unexplained subjective complaints which goes towards credibility of Petitioner.

Regarding his history with petitioner, Dr. Goldberg testified that for the initial treatment starting in August 2006, he was primarily treating petitioner's back however he did previously review the cervical spine MRI in November 2006. (Px41, pg 35) The doctor opined that the prior 2006 MRI showed there were disk herniations at C3-4 and C4-5; at C3-4 it was central, at C4-5 it was central to the right; and there was a smaller herniation at C5-6 and C6-7. (Id.) It is therefore appears to the arbitrator that Petitioner sustained a right shoulder and neck injuries as described above by Dr. Goldberg, in the 3/10/06 injury. Importantly, Petitioner, per Dr. Goldberg had herniations on his cervical MRI as of November 2006.

It was reasonable for Dr. Goldberg to give permanent restrictions in this case Dr. Goldberg provided restrictions following work hardening of 40 lbs. floor to waist, frequent lift of 20 lbs floor to waist, frequent lift of 15 lbs waist to shoulder, occasional lift of 20 lbs. overhead and frequent lift of 10 lbs. overhead. Despite not agreeing with Dr. Goldberg in performing a fusion surgery, Dr. Mather agreed as a result of the first fusion surgery, the petitioner should have a 25 pound lifting restriction with bending no more than eight times per hour based on the lumbar fusion performed. (Rx 3, Pg. 13) This is reasonable to the Arbitrator. In accordance with petitioner's treating physicians at the time, Dr. Mather agreed the petitioner was at maximum medical improvement for the lumbar spine in March 7, 2007 and for the cervical spine on April 3, 2007. (Rx 3, Pg. 12)

Dr. Mather testified that with respect to the cervical spine, the petitioner sustained only a cervical soft tissue strain or a temporary aggravation of Petitioner's right C4-C5 stenosis which had resolved itself at least by April when his symptoms resolved. (Id.) The Arbitrator is persuaded by this opinion based on his testimony and the record as a whole. Dr. Mather, like the other IME doctors in this case, testified that he found the petitioner to have positive Waddell findings. (Rx 3, Pg. 9) These maneuvers are not supposed to provoke pain and are done to determine if there are any inconsistencies, symptom magnification or functional pain that cannot be medically explained. (Rx 3, Pg.10). Dr. Mather also pointed out that the petitioner would go to IMEs and show up with a cane, but then when he was seeing his regular treating doctors, he would not have the cane. He felt this was a clear example of the patient grossly magnifying symptoms. Dr. Mather further opined that petitioner was at maximum medical improvement for the lumbar spine as of March 7, 2007 consistent with his treating physicians who initially placed him at MMI. He does not believe petitioner required any further treatment after that date for the lumbar spine. The Arbitrator agrees. He testified that the fusion surgery performed by Dr. Song in 2022 was due to ongoing degenerative pathology and stenosis noted previously on the MRI done in 2010. The arbitrator finds this opinion to be persuasive. On cross examination, Dr. Mather agreed that petitioner would not be able to return back to work as a baggage handler after a two level fusion and the weightlifting requirements for a baggage handler was at least 50 pounds. (Rx3, pf 26)

The Arbitrator finds that Dr. McGinness is not entirely credible and is not more credentialed than the board-certified surgeons, both neuro and orthopedic who testified in this case. Petitioner testified that the doctor kept him off of work and he relied on her for his work status, appearing to disregard Dr. Goldberg's permanent restrictions. Further, Dr. McGinness was not aware that Petitioner had been released from Midwest Orthopedic surgeons and doctors with permanent restrictions. Despite being later informed, the doctor testified she was still more qualified to opine on restrictions for petitioner. This is not reasonable to the Arbitrator, that a primary care physician would possibly disregard work conditioning and/or FCE testing results and permanent restrictions imposed by the medical group Dr. McGinness apparently referred petitioner to because she is not a specialist or orthopedist.

The Arbitrator also finds it important to note that there were large gaps in care with Dr. Goldberg where petitioner treated with various other doctors and it appears petitioner never informed Dr. Goldberg or his other doctors of the MVC in August 2008 where he injured his neck and back, and also complained of chest pain. Dr. Mather is the sole doctor to have reviewed all of the treating records and was aware of the various medical opinions and additional treatment after the 2016 Dr. Goldberg deposition, as well as the 2008 MVC. While the Arbitrator finds causation for the injuries, that causation cuts off in 2007 when Petitioner is released from care. The lumbar fusion performed by Dr. Goldberg as well as all of Petitioner's care and treatment through April 2007 would also be causally related to the work injuries he sustained.

The Arbitrator agrees that petitioner's cervical spine and lumbar spine injuries to an extent, would be related to the work accidents. However, petitioner's current condition of ill-being for both injuries would cut off as of Dr. Goldberg's 2007 release from care. Regarding the myelopathy diagnosis, the Arbitrator notes Dr. Goldberg's findings and that the doctor testified it is a diagnosis that can wax and wane but the arbitrator is not persuaded this is work related due to numerous other doctors (treater and IME alike) not finding the same at any other examination over the years and because of the gaps in medical care among the numerous treating doctors . Therefore, the petitioner more than likely, at a minimum, aggravated both his neck and low back based on some of the generative findings shown on MRI scans and treating records, in these work accidents. In summary, his ongoing issues for many years after the 2007 release from care by Midwest Orthopedics at Rush, would not be related to his work accidents with Respondent.

The Arbitrator finds based off the extensive medical over 20 years, 8 depositions, the record as a whole that Petitioner sustained a neck injury and right shoulder injury in the 3/10/16 work accident and injured his low back in the 4/17/06 accident, in addition to injuring his lumbar spine in both 2005 work accidents as well. Despite his testimony at trial that he injured his neck on 4/17/06, the Arbitrator agrees with the IME doctors that the medical does not support that the cervical spine injury occurred on the 4/17/06 date. Regardless, like Dr. Mather opines, Petitioner sustained a cervical injury that would have resolved by the April 2007 release from care by his treating doctors.

Psychological

Petitioner introduced records of Dr. Gierl into evidence. (PX 14) The Arbitrator notes these are handwritten and difficult to decipher. Dr. Gierl issued a report dated February 18, 2019 to the Veterans Administration noting he had been seeing the petitioner since March 7, 2014 for severe depression. He noted that on or about August 16, 2017, the petitioner reported PTSD symptoms and reported trauma and abuse to the doctor from when he was in military training. The petitioner described suffering physical, verbal and emotional abuse to the doctor. He states this has been verified as he was discharged from the military after this abuse came to light. He reported this was still causing nightmares, flashbacks and severe emotional distress. It was his recommendation he receive his medication through the Veterans Administration due to PTSD symptoms which are the result of trauma and abuse experienced during military training. (PX 14).

In addition, when he was seen for treatment of the auto accident at West Suburban Medical Center on September 26, 2008, the Arbitrator notes he reported depression since the auto accident. (Px 28) The petitioner did not appear to testify to any ongoing psychological condition and the medical introduced supports an alternate cause of any psychological condition. Accordingly, the Arbitrator finds that there is insufficient evidence to support that any condition of ill-being with respect to petitioner's psychological condition is related to the work injuries.

Issue K, whether Petitioner is entitled to temporary total disability benefits, the Arbitrator finds as follows:

A claimant is temporarily totally disabled from the time an injury incapacitates him from work until such time as he is as far recovered or restored as the permanent character of his injury will permit. *Westin Hotel v. Indus. Comm'n*, 372 Ill.App.3d 527, 542 (1st Dist. 2007). In determining whether a claimant remains entitled to receiving TTD benefits, the primary consideration is whether the claimant's condition has stabilized and whether she is capable of a return to the workforce. *Interstate Scaffolding, Inc. v. Illinois Workers' Comp. Comm'n*, 236 Ill.2d 132, 148 (2010). Once an injured employee's physical condition stabilizes, she is no longer eligible for TTD benefits. *Archer Daniels Midland Co. v. Indus. Comm'n*, 138 Ill.2d 107, 118 (1990). To be entitled to TTD benefits, it is the claimant's burden to prove not only that he did not work but also that he was unable to work. *Holocker v. Illinois Workers' Compensation Comm'n*, 2017 IL App (3d) 16036WC, P35 (3rd Dist., 2017). The fundamental purpose of the Act is to provide injured workers with financial protection until they can return to the work force. *Id.* When determining whether an employee is entitled to TTD benefits, the test is whether the employee remains temporarily totally disable as a result of a work-related injury and whether the employee is capable of returning to the work force. *Id.* The touchstone for determining whether claimant is entitled to TTD is whether the claimant's conditions had stabilized to the extent that they are able to reenter the workforce. *Id.* at P40.

The Arbitrator finds based on the facts as discussed above, that the petitioner reached MMI for the lumbar spine on March 3, 2007 as was found by Dr. Goldberg his treating surgeon and MMI full duty for the cervical spine on April 3, 2007 per Dr. Fetzer.

The petitioner was released to return to work with permanent restrictions per Dr. Goldberg. As he was authorized off work from April 17, 2006 until he is placed at MMI, the petitioner is owed TTD benefits from April 17, 2006 to April 3, 2007, or 50 2/7 weeks at a TTD rate of \$723.85/week.

After April 17, 2006, work restrictions were imposed by Dr. Goldberg which precluded his return to work in his prior capacity as a ramp serviceman. Vocational rehabilitation was provided by the respondent through Vocamotive. Despite the personnel issues that eventually occurred with Vocamotive with Petitioner, the Arbitrator finds that Petitioner did not appear to actively cooperate in that process and terminated vocational services on December 21, 2007. The petitioner testified and the record confirms that he did not at any time look for alternate employment within his restrictions. While the petitioner testified that he was kept off work by Dr. McGinness, there are not medical records which support this and this is contrary to all of the other doctors involved in his case. It appears there was no opinion provided that the petitioner could not return to work or was permanently disabled until Dr. McGinness testified on December 2, 2016. Dr. McGinness addressed work restrictions at her deposition on December 2, 2016 and in only two work restriction notes which are dated May 2, 2006 and November 5, 2007 (PX 19, pg 242 and 243). The doctor testified that the petitioner's treating orthopedic physicians were instead responsible for addressing his work status. His treating orthopedists all returned him to work in some capacity. The Arbitrator did not find Dr. McGinness to be a credible or persuasive witness.

Accordingly, maintenance benefits are awarded from April 4, 2007 to December 21, 2007 when petitioner terminated vocational rehabilitation and quit any effort to look for alternate employment within his restrictions. Respondent is given a TTD credit for the \$71,350.62 in benefits paid prior to trial.

Issue L, the nature and extent of the injury, the Arbitrator finds as follows:

As Petitioner's accidents occurred before September 1, 2011, adherence to Section 8.1b(b) of the Act is not required for establishing permanent partial disability but it is helpful to the Arbitrator in analyzing the permanency of the injury Petitioner sustained. In determining PPD benefits, Section 8.1b(b) of the Act directs the Commission to consider: "(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." 820 ILCS 305/8.1b(b); *Con-Way Freight, Inc. v. Illinois Workers' Compensation Comm'n*, 2016 IL App (1st) 152576WC, ¶ 22, 67 N.E.3d 959. "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b). "None of the factors set forth in section 8.1b is to be the sole determinant of the claimant's disability." *Corn Belt Energy Corp. v. Illinois Workers' Compensation Comm'n*, 2016 IL App (3d) 150311WC, ¶ 49.

As the claimant's disability is not limited in nature that he is obviously unemployable, and as there is no medical evidence to support a claim of permanent total disability, the burden is upon the petitioner to establish the unavailability of employment to a person in his circumstances. *Valley Mould & Iron Co. v. Industrial Comm'n*, 84 Ill. 2d 538, 546-47 (1981).

An employee is totally and permanently disabled when he is unable to make some contribution to industry sufficient to justify payment of wages to him. *A.M.T.C. of Illinois v. Ind. Comm'n*, 77 Ill.2d 482, 487(1979). It is the petitioner's burden to establish that he falls into the 'odd lot' category either by showing that evidence of a diligent but unsuccessful attempt to find work, or by showing that because of his age, skills, training, experience and education that he cannot find regular employment. The Petitioner here has not presented sufficient evidence of either. He has not looked for any work and the restrictions are not so limiting to establish that there is no employment available to him. The Arbitrator was not persuaded by the opinions of Mr. Patsavas for reasons previously explained.

The petitioner's request for a permanent total disability award pursuant to Section 8(f) of the Act is not supported by the evidence. Overall, the long timeline of petitioner's injuries and treatment appear to show Petitioner sustained a serious and permanent lumbar spine injury that required lumbar spine fusion surgery. He also suffered right shoulder injury that was misdiagnosed and/or developed into a cervical spine injury. The Arbitrator finds that Petitioner should have attempted to work within the permanent restrictions his surgeon Dr. Goldberg provided, as he was found at MMI by his treating physicians by April 2007. Despite this, Petitioner admitted during testimony, he never attempted to find work. Dr. Mather, one of Respondent's IME, also agreed that Petitioner required lumbar surgery (disagreed with a fusion) and permanent restrictions and could not return to his old job. Dr. Lami and Dr. Wehner, also agreed with the permanent restrictions Dr. Goldberg gave in 2007. Dr. Song, petitioner's most recent neurosurgeon/treater never gave work restrictions and also testified that he would defer to Dr. Goldberg's restrictions. The Arbitrator finds Petitioner to have suffered a significant low back injury that permanently injured him to the point he could never return to work as a ramp agent for Respondent, as he was given permanent restrictions. This is and was a loss of trade injury as of 2007. However, the Arbitrator is not convinced Petitioner is permanently and totally disabled after review of the numerous medical evidentiary records over the last 20 years, eight depositions and other professional vocational opinions provided. See further analysis below regarding permanency.

The restrictions imposed by Dr. Goldberg were restrictions to lifting 40 pounds occasionally from floor to waist, 25 pounds waist to shoulder, and overhead 20 pounds occasionally. Even if the petitioner was limited to lifting 25 lbs as suggested by the invalid FCE, the IME doctors and Dr. Song, the restrictions were not so onerous as to make the petitioner not employable. Following petitioner's discharge with restrictions, the respondent provided vocational services through Vocamotive. He was not, however, cooperative with the process. Mr. Belmonte identified jobs for the petitioner within his restrictions which included truck dispatcher, aircraft dispatcher, assembler, newspaper circulation clerk, security guard supervisor, order picking, security, cashier, entry level customer service, mailroom clerk and other jobs. As a lead ramp agent, the petitioner was responsible for making sure the plane goes out on time and everything was on the plane that was supposed to be loaded. Accordingly, the petitioner was equipped to perform supervisory duties.

Rather than undertake a good faith effort to participate, the petitioner appeared to make excuses, stated he wanted to relocate to California, and proposed that he be a Senator or Hollywood script writer. He reported he couldn't complete his job search assignments as he had to have Christmas lights installed.

Petitioner refused to participate in any job search activities on days that he was not at Vocamotive. Rather than applying for job leads provided to him, he apparently left inappropriate commentary on his computer. This further demonstrates that Mr. Loving was not taking the job search seriously. The Arbitrator notes there was testimony regarding petitioner's pain levels and effect of pain medications on him at Vocamotive. Some of his testimony regarding these issues was mentioned in the treating records and some of petitioner's poor performance at vocational rehabilitation would be explained by his pain medications/ sleepiness but not all. Since 2007, it is clear from the record that the petitioner has not at any time undertaken a job search of any kind.

The Arbitrator finds the report Mr. Patsavas undertook in 2019 insufficient to prove petitioner is not employable. It appears that the report was not prepared in effort to find the petitioner alternate employment. Mr. Loving also did not express any desire to find employment to Mr. Patsavas. Nor was Mr. Patsavas able to identify any jobs he considered for Mr. Loving. Mr. Patsavas did not conduct an interest inventory to assess what areas of employment may be appropriate for the petitioner. He did not evaluate whether the petitioner was a candidate for a retraining program or any classes which would improve his employment prospects. No explanation was provided as to why the petitioner could not work in one of the employment sectors identified by Mr. Belmonte as within the petitioner's restrictions per his treating surgeon, Dr. Goldberg. In short, Mr. Patsavas, the vocational expert hired by the petitioner's attorney, did not do any testing or evaluation of the petitioner other than meeting briefly with the petitioner to review his work restrictions, employment history and transferable skills.

Although Mr. Patsavas knew the petitioner had a criminal record and that this could impact what types of jobs he could perform, he did not request information from the petitioner at his intake evaluation as to the extent of that criminal record. Mr. Patsavas should have done more to properly assess petitioner's prospective job options and make further efforts to determine whether petitioner was employable or to assist petitioner in finding employment himself. His limited or more abbreviated report undermines the persuasiveness of his report to the Arbitrator.

The Respondent paid maintenance benefits and offered pay for vocational rehabilitation, including a job search. The petitioner terminated those services, has never requested any other vocational assistance and has not shown any interest in finding work. Accordingly, the petitioner has not proven an entitlement to permanent total disability benefits under Section 8(f).

The Arbitrator instead turns to an assessment of the petitioner's permanent partial disability. 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 ramp serviceman at the time of the accident and that he is not able to return to work in his prior capacity as a result of said injury and permanent restrictiond. The Arbitrator notes that this was a low skilled position, but because it is no longer available to the petitioner, the Arbitrator gives significant weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 46 years old at the time of the accident. Because he is now 65 years old and at retirement age, 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 that the petitioner has permanent restrictions of 25 lbs lifting as a result of the work accident and injury to his lumbar spine. That said, such a restrictions likely would not have impeded Mr. Loving from many potential occupations should he have had the desire to return to work from 2007 to present. Based on the opinions of the vocational expert Joseph Belmonte in 2007, the petitioner could have returned to work with earnings between \$10 and \$14.50/hour. The Arbitrator therefore gives greater 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 no records of any treatment after the discharge from Dr. Song on March 7, 2023, were introduced into evidence. In addition, Petitioner testified that he had not had treatment since that time. At that time, the petitioner complained of neck pain but there are no recorded complaints for his low back. There is little documentation of current lumbar spine disability in the medical records, however Petitioner was still precluded from returning to work as of March 2007 due to his serious lumbar injury. Despite not finding petitioner's current conditions of ill-being for the lumbar spine and cervical spine related to his work injuries, the Arbitrator relies on Dr. Goldberg assigning permanent restrictions which prevented Petitioner from returning to work for Respondent as a ramp agent as of his release from care. These restrictions were not disputed by Dr. Mather. IME doctors Dr. Lami and Dr. Wehner, also agreed with the imposition of permanent restrictions due to the lumbar fusion surgery performed. The Arbitrator therefore gives more 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 55% loss of use of the person as a whole pursuant to §8(d)2 of the Act. Respondent shall pay Petitioner permanent partial disability benefits of \$651.46/week for 275 weeks, because the injuries sustained caused 55% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

For the reasons stated above, Petitioner is entitled to an award of benefits under The Illinois Workers' Compensation Act consistent with the findings herein.

It is so ordered:



Jacqueline C. Hickey
Arbitrator

3/3/25
Date

March 4, 2025

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	23WC004067
Case Name	Brandon Yates v. Liberty Tire Recycling, LLC
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	25IWCC0503
Number of Pages of Decision	14
Decision Issued By	Raychel Wesley, Commissioner

Petitioner Attorney	
Respondent Attorney	Daniel Farroll

DATE FILED: 12/19/2025

/s/ Raychel Wesley, Commissioner

Signature

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)
☐ Modify	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRANDON YATES,
 Petitioner,

vs.

NO: 23 WC 04067

LIBERTY TIRE RECYCLING, LLC,
 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, causal connection, medical expenses, prospective medical, and 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 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 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 13, 2023, 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.

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 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 bond requirement in §19(f)(2) of the Act is only applicable when the Commission has entered an award for the payment of money. Therefore, no bond is set by the Commission. 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.

December 19, 2025

RAW/wde

/s/ Raychel A. Wesley

D: 11/5/25

/s/ Carolyn M. Doherty

43

/s/ Frank J. Soto

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	23WC004067
Case Name	Brandon Yates v. Liberty Tire Recycling, LLC
Consolidated Cases	
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	11
Decision Issued By	Linda Cantrell, Arbitrator

Petitioner Attorney	John Winterscheidt
Respondent Attorney	Richard Day

DATE FILED: 9/13/2023

THE INTEREST RATE FOR THE WEEK OF SEPTEMBER 12, 2023 5.30%

/s/ Linda Cantrell, Arbitrator

Signature

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)

Brandon Yates

Employee/Petitioner

v.

Liberty Tire Recycling, LLC

Employer/Respondent

Case # **23** WC **004067**

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 **Linda J. Cantrell**, Arbitrator of the Commission, in the city of **Collinsville**, on **July 28, 2023**. 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, **01/11/23**, 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 **\$38,771.20**; the average weekly wage was **\$745.60**.

On the date of accident, Petitioner was **38** years of age, *single* with **7** dependent children.

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

Respondent shall be given a credit of **\$2,000.00** for TTD, **\$0** for TPD, **\$0** for maintenance, and **\$2,684.00** for other benefits, for a total credit of **\$4,684.00**.

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

ORDER

Based on the Arbitrator's finding that Petitioner did not sustain accidental injuries that arose out of and in the course of his employment with Respondent, the disputed issues of causal connection, medical expenses, temporary total disability benefits, and prospective medical care 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.



SEPTEMBER 13, 2023

Arbitrator Linda J. Cantrell

STATE OF ILLINOIS)
) SS
 COUNTY OF MADISON)

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

BRANDON YATES,	)	
	)	
Employee/Petitioner,	)	
	)	
v.	)	Case No.: 23-WC-004067
	)	
LIBERTY TIRE RECYCLING, LLC,	)	
	)	
Employer/Respondent.	)	

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Collinsville on July 28, 2023 pursuant to Section 19(b) of the Act. On 2/9/23, Petitioner filed an Application for Adjustment of Claim alleging injuries to his right foot and body as a whole as a result of tripping on steps on 1/10/23. (AX2) Petitioner amended the Application for Adjustment of Claim at arbitration to reflect a date of accident of 1/11/23 without objection.

The issues in dispute are accident, causal connection, medical expenses, temporary total disability benefits, and prospective medical care.

TESTIMONY

Petitioner was 38 years old, single, with seven dependent children at the time of the alleged accident. Petitioner began working for Respondent in August 2021 as a temporary employee and began full-time employment in January 2022. Respondent makes goods out of recycled tires. Petitioner testified that the plant receives ground rubber of different sizes that is moved around the plant by an overhead auger or mixer. The auger is located on the paver line. He testified it is important to keep the augers from clogging because it costs Respondent a lot of money when production stops. Petitioner is a Line Lead and it is his job to keep the augers running. He wears tennis shoes while working. He worked Monday through Thursday from 4:00 p.m. to 3:00 a.m.

Petitioner testified that he never experienced problems with his right foot while working for Respondent prior to 1/11/23. He testified that on 1/11/23 they were having issues with the auger overflowing and he had to run to the machine to get it in working order. He tripped up the stairs to the auger and injured his right foot. He testified that the stairs are corrugated metal and they lead up to the auger platform. He tripped on the second step from the bottom.

Petitioner viewed security videos entered into evidence. He testified that the videos depict the stairs to the auger but not the stairs he injured his foot on. He agreed that the auger he ran to on 1/11/23 is shown in the videos, specifically the blue oblong tub depicted in RX3. He stated that the video marked RX3 shows the platform of Mixer 2 and the bottom of the video is where the stairs led up to the platform but they are not depicted in the video. Petitioner testified that the steps leading up to Mixer 2 in RX3 were not the steps he injured his foot on but agreed that all of the yellow steps are the same throughout the plant. He stated the steps are not like a ladder but similar to steps in your home.

Petitioner testified that when he tripped on the second step from the bottom his foot went down, and his shin hit and scraped the step above. He continued to climb the stairs to perform his job duties.

Petitioner testified that his accident occurred at the end of his shift. He went home and his foot did not improve. Petitioner reported the accident to his supervisor Carl Parker on 2/7/23. He sought treatment on 2/7/23 at the Alton Memorial Hospital emergency room. He reported the work accident and was provided with medication and a surgical boot to wear. Petitioner was placed off work. Petitioner underwent surgery on 4/26/23 by Dr. Huels at Alton Podiatry. On 6/23/23, Dr. Huels recommended that Petitioner purchase motion control shoes, but Petitioner stated he could not afford them. Petitioner last saw Dr. Huels on 7/21/23 and was prescribed medication and continued off work. He is scheduled to follow up with him again on 8/22/23.

Petitioner testified he has not received temporary total disability benefits. He has paid some medical bills in order to continue treating with Dr. Huels. Petitioner testified he has daily sharp pain and joint discomfort in his right foot and takes a lot of pain medication. His foot is stiff in the morning and it swells. He uses a cane due to back pain caused by his foot injury. He walks with a limp and cannot walk further than a couple of meters. He is slow climbing stairs. He can only move his big toe a little. He takes three pain medications prescribed by Dr. Huels.

On cross-examination, Petitioner testified he spoke to his supervisor Mr. Parker about his accident prior to 2/7/23. He believes it was the day after his accident as Mr. Parker was not working that night. He agreed that the accident information contained in RX1 is based on information he provided to Respondent. He testified that the form was incorrect that he finished working that day at 12:28 a.m. He testified that the time of injury between 9:00 p.m. to 11:00 p.m. was also incorrect and he reported the injury occurred at the end of his shift. Petitioner testified that he has never saw the Employee Injury Reporting form prior to the day of arbitration. Petitioner never signed the form. The form is dated "February 96, 2023". The date the injury was reported to a supervisor is listed as 2/8/23, and he testified he reported it to Mr. Clark on 2/7/23. The date of hire is listed as 3/1/22 which he stated was also incorrect because he was hired as a full-time employee in January 2022. Petitioner testified that it is not his telephone number listed on the report. He agreed that the description of accident was correct that he fell up steps on the paver line and he was running to access the mixer stairs.

Petitioner identified his timecards entered into evidence as RX5. It showed he worked 4:00 p.m. to 12:28 a.m. on 1/10/23 and 12:58 a.m. to 3:20 p.m. on 1/11/23. He testified that he

typically took his break around 12:30 a.m. and his accident occurred around 3:00 a.m. on 1/11/23.

Petitioner testified that he had difficulty walking immediately after the accident and he walked with a limp. He agreed he continued working his regular job duties after his accident and worked 33 hours the week of 1/10/23, 50 hours the week of 1/16/23, 43.5 hours the week of 1/23/23, and 43.5 hours the week of 1/31/23. He agreed he worked just over 10 hours on 2/6/23. He testified he had pain and swelling while working and had a limp. He took a vacation day on 2/7/23 which was scheduled weeks in advance. He went to the emergency room around 2:20 p.m. on 2/7/23. He denied taking pain medication prior to 2/7/23.

He denied having an ingrown toenail that Dr. Huels treated. He agreed that Dr. Huels scraped a callus off the bottom of his big toe which he had prior to his work accident. He understood his surgery was to remove crushed bone and he was not aware of a bone spur. He was not aware if Respondent offered light duty to injured employees and he did not ask.

Petitioner identified himself depicted in the security video marked RX2 (starting at 17:18). He was wearing a stocking cap, yellow jacket, and gray sweatpants. He identified pavers in the video and molds that have planks coming out of them that go along a conveyor. He testified that the stairs that go up and over the platform are like the stairs he injured himself on on 1/11/23. The video shows Petitioner getting into and driving a forklift at 11:16 p.m. on 1/10/23 which was prior to his injury.

Carl Parker testified on behalf of Respondent. Mr. Parker is the Production Manager at Respondent's IMC Outdoor Living facility, which is a division of Liberty Tire, LLC. In January 2023, Mr. Parker worked second shift part of the month. Petitioner worked directly under him as they did not have a production supervisor at that time. He testified that work injuries are to be reported to him immediately. He testified that Petitioner did not report a work injury to him or mention any pain in his right foot until early February. Mr. Parker testified that Petitioner came to work limping and he asked Petitioner what was wrong. Petitioner replied he had gout and did not mention a work accident. Mr. Parker testified he had an opportunity to observe Petitioner working prior to early February and he did not have a limp or appear to be in pain.

Mr. Parker testified that he first became aware Petitioner claimed a work injury when he saw him sitting in the HR manager's office around 2/8/23. Mr. Parker spoke to Petitioner at that meeting and said, "I thought you said you had gout." Petitioner did not respond. Mr. Parker testified that Petitioner has not worked since that meeting. He testified that Respondent offers light duty work.

Mr. Parker testified that the HR manager provides him with Petitioner's work status reports. He is not aware of any of Petitioner's physicians releasing him with light duty restrictions. Mr. Parker testified that Petitioner is a good worker and he promoted him. He testified that he did not work the evening of 1/10/23 or early morning of 1/11/23. He testified that he was probably working first shift at the time of Petitioner's alleged accident.

MEDICAL HISTORY/SECURITY VIDEOS

On 2/7/23, Petitioner presented to the emergency room at Alton Memorial Hospital for a chief complaint of toe pain. (PX1) He provided a history of injuring his right great toe approximately three weeks ago when he was running up a staircase at work. It was noted that Petitioner slipping going up stairs and hit his toe and it has been hurting since. He denied taking any pain medication prior to presenting to the hospital. Petitioner requested a refill of Amitriptyline which he stated he gets from “some doctor” but was unsure of the name and he denied having a primary care physician. Physical examination revealed mild tenderness ecchymosis to the right great toe at the MTP joint. He was observed to ambulate with a steady gait and was able to move all toes on the right foot. Petitioner could plantar flex and dorsiflex his right foot against resistance with a negative Thompson’s test. X-rays revealed an acute tiny avulsion fracture of the 1st proximal phalanx with associated mild soft tissue injury and mild degenerative osteoarthropathy in the first MTP joint. Petitioner was diagnosed with a closed, nondisplaced fracture of the right great toe. His toes were taped, and he was placed in a post-operative boot. He was placed off work through 2/9/23 and referred to Alton Podiatry Clinic.

On 2/9/23, Petitioner was examined by Dr. Michael Huels at Alton Podiatry Clinic. (PX2) Petitioner reported tripping upstairs and bending his big toe in a plantar flexor redirection approximately three weeks ago. He reported that since his injury he has had swelling in his big toe and walked with his toes pointed outward. Dr. Huels agreed the x-rays showed a small avulsion fracture over the proximal phalanx base of the right great toe. Examination revealed a significant incurvated medial border of the right great toe and a significant callus under the middle of Petitioner’s right great toe. Dr. Huels noted a swollen first metatarsophalangeal joint with no signs or symptoms of gout, etc.

Dr. Huels diagnosed an avulsion fracture of the proximal phalanx dorsum of the right foot, tendinitis of the right foot, onychogryphosis of the medial border of the right great toe, and intractable plantar keratosis of the interphalangeal joint of the right great toe. Dr. Huels debrided the ingrown toenail and the callus to viable tissue. He recommended that Petitioner continue wearing the surgical boot and placed him off work for two weeks. He prescribed Diclofenac gel three times per day. He recommended over-the-counter anti-inflammatories for pain management and icing.

On 2/22/23, Petitioner followed-up with Dr. Huels and reported 45-50% improvement, but his big toe was “locking up”. X-rays revealed an osteophyte over the first metatarsal and proximal phalanx base of the right foot, which Dr. Huels found to be consistent with the small avulsion/chip fracture. He continued Petitioner off work for two weeks and advised him to wear stiff soled shoes and to engage in range-of-motion exercises. Dr. Huels stated that if Petitioner failed to improve, he would surgically excise the osteophyte.

On 3/8/23, Petitioner reported continued “locking” of the first metatarsalphalangeal joint. Clinical examination revealed decreased range of motion of the first MPJ and extensor tendon. Dr. Huels continued Petitioner off work for another two weeks.

On 3/22/23, Petitioner presented to Dr. Huels and reported his big toe swelled quite a bit all of the time and it prevented him from walking appropriately. Dr. Huels noted swelling and limited range of motion of the MPJ and pain along the extensor tendon. X-rays were consistent with a small osteophyte over the dorsal aspect of the distal phalanx and a bone spur on the first metatarsal head. Dr. Huels recommended surgery to excise the osteophyte and remove the bone spur. Petitioner was continued off work pending surgery on 4/26/23.

On 4/26/23, Dr. Huels performed an excision of an osteophyte on the proximal phalanx of Petitioner's right great toe. (PX3) Intraoperatively, Dr. Huels observed a large dorsal spur over the first metatarsal head and a large osteophyte over the dorsal aspect of the proximal phalanx base. He did not note Petitioner's avulsion fracture.

On 4/28/23, Petitioner followed up with Dr. Huels who described the procedure as a Valente bunionectomy of the right foot. Petitioner was in significant discomfort despite taking Tramadol. X-rays revealed good reduction of the dorsal spur over the first metatarsal head and base of the proximal phalanx. He advised Petitioner to increase physical therapy as much as possible. He noted that utilization of a cane would be necessary for everyday living due to increased pain.

On 5/22/23, Dr. Huels noted Petitioner was doing well but was concerned with swelling. Dr. Huels noted Petitioner had normal healing post-cheilectomy (bone spur removal) and bunionectomy. Petitioner had some edema around the first MPJ but good range of motion. He was scheduled to return to work on 6/26/23.

On 6/22/23, Petitioner reported he was still walking with a cane and had increased pain that made him walk sideways after being on his feet 4 to 5 hours. Dr. Huels noted slight swelling at the first MPJ and guarded range of motion of the right foot. He believed that Petitioner's symptoms were consistent two months post-Valente bunionectomy. He did not appreciate any signs or symptoms of RSD or infection. Dr. Huels recommended motion control or rocker soled shoes and to stop wearing the surgical boot. If Petitioner failed to improve, he would refer him to physical therapy. Petitioner's return to work date was extended to the end of July.

Petitioner last saw Dr. Huels on 7/21/23 and reported ongoing discomfort around the first MPJ. Dr. Huels noted pain upon palpation and swelling around the joint. He noted breaking out under the foot consistent with a fungal infection. Petitioner had not purchased the recommended shoes. Dr. Huels advised Petitioner to buy stiffer soled shoes and to apply Voltaren gel for inflammation. He prescribed Tramadol and Lamisil and recommended therapy and icing. Dr. Huels continued Petitioner off work.

Security videos were entered into evidence that were taken on 1/10/23 and 1/11/23. (RX2, 3, 4, and 6) RX2, 3, and 4 contain nine security videos of Respondent's facility on 1/10/23, prior to Petitioner's alleged work accident. Petitioner is depicted walking without difficulty or limp on the concrete floor of the plant, driving a forklift, operating a machine while standing and sitting, and dumping totes.

RX6 depicts security video of Respondent's facility on 1/11/23 from 2:38 a.m. to 3:14 a.m. Petitioner walks into view at 3:07.48 and sits down on a chair at a desk. He performs paperwork for 5 to 6 minutes. At 3:13.08, Petitioner stands up at the desk and retrieves items from a locker and walks over to a trash can to dispose of cups that were on the desk. He then walks with another employee across the plant floor until he is out of view at 3:14.24.

CONCLUSIONS OF LAW

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). "In the course of employment" refers to the time, place, and circumstances surrounding the injury. *Id.* That is to say, for an injury to be compensable, it generally must occur within the time and space boundaries of the employment.

An injury "arises out of" one's employment if its origin is in a risk connected with or incidental to the employment. *Id.* A risk is incidental to the employment "...when it belongs to or is connected with what the employee has to do in fulfilling his or her job duties. 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. *McAllister v. Ill. Workers' Comp. Comm'n*, 2020 IL 124848. Illinois courts recognize the following three categories of risks: "1) risks distinctly associated with the employment; 2) risks personal to the employee; and 3) neutral risks which have no particular employment or personal characteristics." *Id.* A risk is distinctly associated with the employment if the employee was "performing (1) acts he or she was instructed to perform by the employer, (2) acts that he or she had a common law or statutory duty to perform, or (3) acts that the employee might reasonably be expected to perform incident to his or her assigned duties." *Id.*

The Arbitrator finds that Petitioner did not meet his burden of proof by a preponderance of the credible evidence that he sustained accidental injuries on 1/11/23 that arose out of and in the course of his employment with Respondent. Petitioner testified that on 1/11/23 they were having issues with the auger overflowing and he had to run to the machine to get it in working order. He tripped up the stairs to the auger and injured his right foot. Petitioner testified that the incident occurred around 3:00 a.m. at the end of his work shift. The only security video entered into evidence that was recorded on 1/11/23 depicted Paver D. Petitioner did not testify as to which mixer he was running to when he injured his foot and Petitioner's accident report does not specify. There were ten security videos entered into evidence that depicted only two machines which were labelled Pavers "D" and "G". Petitioner testified that the steps leading up to Mixer 2 in RX3 were not the steps he injured his foot on which was labelled Paver "G". Therefore, one can assume Petitioner injured himself on Paver "D" which is the machine depicted in the video on RX6 taken on 1/11/23. Petitioner is not seen walking up the stairs to Paver "D" between 2:38 a.m. to 3:14 a.m. on 1/11/23.

Even assuming Petitioner was working on a machine that was not depicted in the video taken on 1/11/23, his physical demeanor depicted in RX6 from 3:07 a.m. until 3:14 a.m. is not consistent with his testimony. He testified that his injury occurred around 3:00 a.m. Petitioner walked into view of the camera at 3:07 without difficulty or a limp. He sat at a desk performing paperwork until 3:13, at which time he stood up, retrieved items from a locker, and walked over to a trash can to dispose of cups that were on the desk. He then walked with another employee across the plant floor until he is out of view at 3:14.24. The Arbitrator assumes Petitioner was leaving for the day as the video depicts other employees walking toward the same area of the plant with their possessions at approximately 3:00 a.m., and Petitioner's timecard shows he clocked out at 3:20 a.m. Further, Petitioner testified that his shift was 4:00 p.m. to 3:00 a.m. Petitioner is seen walking without difficulty or a limp at 3:14 a.m. on 1/11/23, approximately 15 minutes after he claims to have injured his right great toe/foot.

Petitioner continued to work his full job duties through 2/6/23, working approximately 11 hours per shift. He worked 50 hours the week after his accident and over 40 hours in the weeks thereafter. He agreed that he worked 10 hours on 2/6/23 and took a pre-approved vacation day on 2/7/23. Petitioner testified that vacation days had to be scheduled weeks in advance. It was not until his day off that he went to the emergency room on 2/7/23 and sought medical treatment.

Petitioner testified that he had difficulty walking after the accident and he walked with a limp. Petitioner's supervisor Carl Parker testified that Petitioner never reported his injury to him or mentioned any pain in his right foot until early February. Mr. Parker switched to second shift at some point in January 2023 and had an opportunity to observe Petitioner working prior to early February. He testified that Petitioner did not have a limp or appear to be in pain. Mr. Parker testified that in early February, Petitioner came to work limping and he asked him what was wrong. He testified that Petitioner told him he had gout. Petitioner agreed that he did not report his work injury until 2/7/23, the day he went to the emergency room and almost one month after the accident. Petitioner was off work on 2/7/23 and the accident report states Petitioner reported the accident to his supervisor on 2/8/23. The first time Mr. Parker learned Petitioner was reporting a work injury was when he overheard Petitioner speaking with the HR manager on 2/8/23. When Mr. Parker confronted Petitioner about what he had previously informed him about having gout, Petitioner had no response. The Arbitrator finds no inherent bias to Mr. Parker's testimony, and in fact, Mr. Parker testified Petitioner was a good worker and he had previously promoted him.

When Petitioner presented to the emergency room on 2/7/23 he reported he injured his right great toe approximately three weeks ago when he was running up a staircase at work. He was observed to ambulate with a steady gait and was able to move all of the toes on his right foot. There is no dispute that Petitioner was diagnosed with an acute tiny avulsion fracture of the right great toe. He began treating with Dr. Huels on 2/9/23 who diagnosed an avulsion fracture of the right great toe, tendinitis of the right foot, onychogryphosis (toenail disorder) of the right great toe, and a callus on the bottom of his right great toe. Dr. Huels debrided the ingrown toenail and the callus to viable tissue. Petitioner denied having an ingrown toenail treated by Dr. Huels.

On 4/26/23, Dr. Huels performed an excision of an osteophyte on the proximal phalanx of Petitioner's right great toe. (PX3) Intraoperatively, Dr. Huels observed a large dorsal spur over the first metatarsal head and a large osteophyte over the dorsal aspect of the proximal phalanx base. He did not note Petitioner's avulsion fracture. His subsequent treating records indicate the surgery performed was a Valente bunionectomy and cheilectomy (bone spur removal). Petitioner testified he understood the surgery was to remove crushed bone. In June 2023, Dr. Huels believed Petitioner's symptoms were consistent two months post-Valente bunionectomy.

Based on the evidence, the Arbitrator finds that Petitioner did not sustain an accident that arose out of and in the course of his employment with Respondent.

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

Based on the Arbitrator's finding that Petitioner did not sustain an accident that arose out of and in the course of his employment with Respondent, the Arbitrator finds this issue moot.

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 prospective medical care?

Based on the Arbitrator's finding that Petitioner did not sustain an accident that arose out of and in the course of his employment with Respondent, the Arbitrator finds these issues moot.

Issue (L): What temporary benefits are in dispute? (TTD)

Based on the Arbitrator's finding that Petitioner did not sustain an accident that arose out of and in the course of his employment with Respondent, the Arbitrator finds this issue moot.



Arbitrator Linda J. Cantrell

DATED:

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC020431
Case Name	Sanjay Modhera v. Cook County Hospital & Health System
Consolidated Cases	17WC025326
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	25IWCC0504
Number of Pages of Decision	31
Decision Issued By	Amylee Simonovich, Commissioner

Petitioner Attorney	Kurt Niermann
Respondent Attorney	G. Steven Murdock

DATE FILED: 12/19/2025

/s/Amylee Simonovich, Commissioner

Signature

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)
☐ Modify	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SANJAY MODHERA,
 Petitioner,

vs.

NO: 17 WC 020431

COOK COUNTY HOSPITAL &
 HEALTH SYSTEM,
 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 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.

The Commission observes Petitioner's personal identity information was unredacted from Petitioner and Respondent's Exhibits. The Commission cautions the parties to adhere to Supreme Court Rule 138. Ill. S. Ct. R. 138 (eff. Jan. 1, 2018).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 24, 2025, 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 bond requirement in Section 19(f)(2) of the Act is only applicable when the Commission has entered an award for the payment of money. Therefore, no bond is set by the Commission. 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.

December 19, 2025

O: 11/25/25

AHS/ps

051

/s/ *Amylee H. Simonovich*
Amylee H. Simonovich

/s/ *Stephen J. Mathis*
Stephen J. Mathis

/s/ *Kathryn A. Doerries*
Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
DECISION SIGNATURE PAGE

Case Number	17WC020431
Case Name	Sanjay Modhera v. Cook County Hospital & Health System
Consolidated Cases	17WC025326;
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	28
Decision Issued By	James Byrnes, Arbitrator

Petitioner Attorney	Kurt Niermann
Respondent Attorney	G. Steven Murdock

DATE FILED: 3/24/2025

/s/ James Byrnes, Arbitrator

Signature

THE INTEREST RATE FOR THE WEEK OF MARCH 18, 2025 4.10%

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**

Sanjay Modhera,

Employee/Petitioner

v.

Cook County Hospital & Health System,

Employer/Respondent

Case # **17** WC **020431**

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 **James Byrnes**, Arbitrator of the Commission, in the city of **Chicago, Illinois**, on **11/12/24** and **12/10/24**. 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 **9/21/2016**, 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.

In the year preceding the injury, Petitioner earned **\$119,999.98**; the average weekly wage was **\$2,307.69**.

On the date of accident, Petitioner was **47** years of age, *married* with **1** dependent child.

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

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

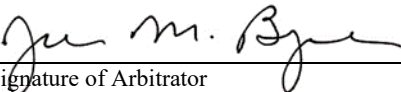
Respondent shall be given a credit of **\$0.00** for TTD, **\$0.00** for TPD, **\$0.00** for maintenance, and **\$0.00** for other benefits, for a total credit of **\$0.00**. Respondent is entitled to a credit of **\$0.00** under Section 8(j) of the Act.

ORDER

Because Petitioner failed to prove by a preponderance of the evidence that he sustained an accident arising out of and in the course of his employment with Respondent on September 21, 2016, the claim for compensation is hereby 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

March 24, 2025

[illegible]

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SANJAY MODHERA,

Petitioner,

v.

COOK COUNTY HOSPITAL &
HEALTH SYSTEM,

Respondent.

MEMORANDUM OF DECISION OF ARBITRATOR

PROCEDURAL HISTORY

This matter proceeded to hearing on November 12, 2024, and on December 10, 2024, in Chicago, Illinois before Arbitrator James Byrnes on Respondent's Request for Hearing. Issues in dispute include accident, notice, causal connection, medical bills, TTD benefits, and nature and extent of the injury. Arbitrator's Exhibit 1 (AX 1). Attorney Kurt Niemann of Porro, Niemann & Petersen, LLC, appeared on behalf of Petitioner. Attorney G. Steven Murdock of IMFK Law, Ltd., appeared on behalf of Respondent.

Petitioner's Exhibits 1, 2, 4, 5, 7, 8, 9, 10, 11, 12 and 14 were admitted into evidence. Petitioner Exhibit 13 was accepted as a rejected exhibit, due to lack of proper foundation for the document. Respondent's Exhibits 1 through 8 were admitted into evidence. After considering the testimony and reviewing the evidence presented, the Arbitrator makes the following findings of fact and conclusions of law.

FINDINGS OF FACT

Job Duties

The Petitioner was employed as a staff pharmacist for Respondent from 2013 through 2016, specifically at the Oak Forest Health Center. (11/12/24 Tr. 12, 72) The pharmacy at the Oak Forest Health Center is the mail order pharmacy for Respondent. (12/10/24 Tr. 7) The mail order pharmacy would fill prescriptions for Cook County residents who had been seen by a Cook County prescriber, within the Cook County Health System. (11/12/24 Tr. 27-28)

Upon receipt of prescription, a pharmacist or pharmacist technician would transcribe the details of the prescription, including the name of the drug, the strength, the directions for use and

the quantity. After that step is complete, the prescription would move to the pre-verification queue, where only a pharmacist (such as Petitioner) would verify that all the information from the prescription was transcribed accurately. The pharmacist would also review for any drug interactions or any duplicate therapy, and potentially call the doctor for clarification. From that point, the prescription was filled either by “robot” (a machine) or manually by a technician and a label was placed on the container. From there it would go to a pharmacist for final verification, to ensure the correct medication was in the bottle and the correct label was on the bottle or box. The technician would then prepare the medication for packing and shipment. (11/12/24 Tr. 28-30)

A pharmacist at the mail order pharmacy can be scheduled to work any number of assignments, but primarily performs the verification function. At the Oak Forest facility, there were about ten pharmacists working verification. Pharmacists would also perform the pre-verification function. (12/10/24 Tr. 8-10) In 2016, there were 22 pharmacists employed at Respondent’s Oak Forest facility. (11/12/24 Tr. 26; 12/10/24 Tr. 32) At the Oak Forest facility, the pharmacists were assigned different duties on a daily basis: one group would be performing pre-verification, another group would be performing verification and a third group fielding patient calls. (12/10/24 Tr. 20)

The Oak Forest facility utilized a machine and conveyor belt system. The technicians would fill the machine with the requisite drugs. The machine would automatically fill the bottle per the prescription and place a label on the bottle, and the bottle would then travel down a conveyor to the verification pharmacist. The pharmacist would take the bottle off the conveyor and visually inspect the bottle to ensure the prescription was properly filled by the machine. If the prescription was filled correctly, the pharmacist would place the bottle back on a conveyor, where it would be transported to the back of the pharmacy for packaging and shipping to the patient. (12/10/24 Tr. 12-13) The conveyor system was for the convenience of the pharmacist, who could then sit during their shift while verifying prescriptions (as opposed to physically transporting the totes of pill bottles to and from the verification station). (*Id.*, p. 13)

A pharmacist at the Oak Forest facility would be responsible for 30 prescriptions per hour, whether working in the pre-verification or verification function. (12/10/24 Tr. 10, 25) Over the course of a seven-hour shift, this would amount to a metric of 210 per pharmacist. (*Id.*, p. 25) In 2015 and 2016, the average number of prescriptions filled by the mail order pharmacy at the Oak Forest facility was somewhere between 2,500 and 3,000. (12/10/24 Tr. 66)

Accident

Testimony of Petitioner, Sanjay Modhera

The Petitioner graduated from Rutgers University in 1993 with a degree of Bachelor of Science in Pharmacy. (PX 1, p. 2; 11/12/24 Tr. 59) He was employed as a pharmacist from 1993 through 2016. (11/12/24 Tr. 60) He worked in a variety of settings in the pharmacy industry, including working in hospital settings, long-term care settings, retail pharmacies, the Veteran’s Administration, and mail order experience with Respondent. (*Id.*) He last worked for Respondent in December of 2016. (*Id.*)

The Petitioner testified his experience as a pharmacist with Respondent was different from his experience with other pharmacies, in a variety of ways. First, he believed the “metrics” used by Respondent, by which a pharmacist’s performance was measured, was “unbearable and overwhelming.” (11/12/24 Tr. 62) In his opinion, the number of prescriptions required to be entered, verified, and checked was overwhelming because it was on an hourly basis, and a monthly report would be generated. A monthly meeting would be held with a supervisor to discuss whether the pharmacist was meeting the requirements per the metrics, and if the pharmacist was not meeting the metrics, he or she would be told they needed to meet the requirements. (*Id.*) This added stress to the pharmacist’s job and made them error-prone and thus less safe for the patients. (*Id.*)

The Petitioner also felt the conveyor system added stress to the job. The medications were coming down on a conveyor belt at such a speed he would be rushing to perform his job. (11/12/24 Tr. 62) In addition, the “robots” would sometimes mix medications and the scanners were not one hundred percent accurate, so the pharmacist would have to stop the conveyor and empty out the prescription bottle to check for accuracy. The Petitioner did not feel Respondent was providing optimum resources to make his job safer and allow the pharmacists to perform with one hundred percent accuracy. (*Id.*, p. 63)

Once the medications had been pre-verified, the bottles would be filled by the “robots,” labeled and sent down the conveyor to the pharmacists. “At that time it’s like a rush, all the pharmacists are just grabbing them, as many as possible putting them on their table trying to meet the metrics because metrics is so much forced onto you that you’re not taking a couple bottles at a time. There’s 10, 15 bottles on that table because the metrics say – I don’t know what the metrics are to be exact anymore, but at the time I believe it was 40 per hour, to enter 40, to verify 40 and to pre-verify, ...” (11/12/24 Tr. 65)

As a pharmacist, he would also have to make sure every medication goes through a phase of drug interactions, and to check for duplications of the same medication or same class of medication that may have been prescribed by two different doctors. In that instance, he would have to intervene by sending an email to the doctors and sometimes they did not respond right away. (11/12/24 Tr. 66) Every one of those interventions takes time and such factors delay the verification of the medications. (*Id.*)

Another delay would be caused by computer issues, such as locking the pharmacist out of the system, requiring the pharmacist to initialize several times to get back into the system. (11/12/24 Tr. 66) The system is very old, over 20 years old, and has never been updated. (*Id.*) If a bottle had another medication mixed in with the correct medication, the Petitioner would have to empty the bottle of its contents and send it back to be refilled with the correct medication or relabeled if necessary. (11/12/24 Tr. 68)

The system of verification and dispensing used by Respondent was different than the system Petitioner used while working at other pharmacies, such as at Walgreen’s or Walmart. (11/12/24 Tr. 69) Such systems were more user-friendly for the pharmacists and prevented two pharmacists from working on the same prescription at the same time, thereby avoiding a waste of time for one of the pharmacists. (*Id.*, pp. 69-70)

According to Petitioner, the Respondent, as well as all retail pharmacies, use metrics to increase the number of prescriptions being filled to increase their profit. (11/12/24 Tr. 71) In his opinion, during his employment from 2013 to 2016, the Cook County system was overburdened and understaffed, and therefore asked its pharmacists to do more, including mandatory overtime in order to meet patient requirements to avoid risking patient care. (*Id.*, pp. 71-72)

The Petitioner testified that his work with Respondent was more overwhelming and stressful than his work with the other pharmacies, and “I never experienced any other problems mentally, as they say. I never had any mental disorders, never was hospitalized at this extent or burnout.” (11/12/24 Tr. 72-73) He did admit, however, that he had previously been hospitalized while working for Walmart. (*Id.*, p. 73) He previously testified that the situation with Respondent was more stressful because, “[t]he metric system and the constant demand of making sure the conveyor belt system allowed you to push prescriptions through without having the ample time to check everything.” (*Id.*, p. 75) His other jobs did not use a conveyor system. (*Id.*)

Regarding the metrics, while the other pharmacies he worked for had metrics in terms of other duties, such as answering the telephone, they did not have, metrics about how many prescriptions a pharmacist must fill per hour, how many must be pre-verified and how many have to be checked. (11/12/24 Tr. 75) In his opinion, Respondent had a more stringent or burdensome metric system, as well as a conveyor belt operation with a “high throughput.” (*Id.*, p. 76)

According to Petitioner, there were about ten pharmacists in his group with Respondent, and they were responsible for filling about 4,000 prescriptions per day, sometimes more with overtime. (11/12/24 Tr. 76)

Petitioner testified that from 1993 through 2013, he had no difficulty finding or retaining a job, or having any issues with job performance. (11/12/24 Tr. 77) After working for Respondent, however, his ability to concentrate, ability to look at the labels and make proper clinical judgments was deteriorating because there was always the rush and the competition that was created due to the metrics and comparison to other pharmacists. (*Id.*) As a result, his mental health began declining in 2015 and 2016. (*Id.*, pp. 76, 78)

The Petitioner sought treatment for his mental health issues at Advocate Good Samaritan Hospital in 2015, including antidepressant and antianxiety medications, as well as ECT (electroconvulsive) treatments. (11/12/24 Tr. 78) He discussed his struggles at work with his supervisor, Charnell Hall, possibly more than once. (*Id.*, p. 79) Approximately three months before another hospitalization in September of 2016, he asked Ms. Hall if he could work in the data entry station only, which would involve typing in medications and interacting with patients, which he enjoyed. (*Id.*, 82-83) He felt this would be less stressful than performing the pre-verification and verification work. (*Id.*) According to Petitioner, Ms. Hall indicated she would work on his request, but it may be difficult because other pharmacists had made similar requests. (*Id.*) He was never given such an assignment prior to his hospitalization in September 2016. (*Id.*)

The Petitioner was admitted to Advocate Good Samaritan Hospital in September of 2016, as a result of taking a large quantity of Clonopin and Amlodipine, which had the effect of causing kidney dysfunction and respiratory depression. (11/12/24 Tr. 85-87) At that time, he was

extremely depressed [with] suicidal ideation, with racing and erratic thoughts. (*Id.*) “I felt extremely hopeless from all the years of experience being in the pharmacy system.” (*Id.*, p. 87) He was hospitalized for almost three months and never returned to work for Respondent after that, or for any other pharmacy after December 2016. (*Id.*, p. 87-88)

The Petitioner does not feel he would be capable of returning to work as a pharmacist. (11/12/24 Tr. 91) He believes that since he last worked as a pharmacist in 2016, the field has gone through many changes such that the goal of profits “overrun the pharmacies,” and they create an environment where pharmacists “are always overburdened.” (*Id.*, p. 92) As a result, pharmacists don’t have time to clinically advise or protect [patient] safety, resulting in many medication errors. (*Id.*) The Petitioner testified as to the many articles and news reports he has read on the subject. (*Id.*, pp. 92-94) In his opinion, the more prescriptions that are filled, the more profits for the pharmacies, to the detriment of patient safety. (*Id.*, p. 94)

Testimony of Shelby Taylor

Shelby Taylor graduated from Howard University in 2010 with a pharmacy degree. (12/10/24 Tr. 6) He worked as an intern and then a pharmacy manager for various Walmart locations until 2015. (*Id.*, p. 7) In 2015, he became a pharmacy manager for Respondent at the Oak Forest Health Center mail order pharmacy. (*Id.*)

Mr. Taylor has been employed with Respondent since October 2015. (11/12/24 Tr. 11) He worked with Petitioner at the Oak Forest Health Center, at which time he was the pharmacy manager and Petitioner was a staff pharmacist. (*Id.*, pp. 11-12) There were 22 staff pharmacists at that location. (*Id.*, p. 12, 26) Prior to his employment with Respondent, he was employed as a pharmacist for Walmart from 2010 to 2015, and before that as an intern for Walgreens and CVS while attending pharmacy school. (*Id.*, pp. 13-14)

As a pharmacy manager for Respondent, he manages staff, creates workflow calendars and schedules, determines where people are working and their rotations, what their primary and secondary duties are and structures the workflow. (12/10/24 Tr. 7-8) While Petitioner was working for Respondent, there were 22 pharmacists and 35 technicians. (*Id.*, p. 8)

At the Oak Forest facility, a pharmacist or technician can perform pre-verification duties, but only a pharmacist can perform the verification duties. (12/10/24 Tr. 8-10) The metric for both pre-verification and verification was to process 30 prescriptions per hour. (*Id.*, p. 10) A pharmacist would also get credit for performing a “DUR” (drug interaction) review, which involves flagging any possible drug interactions and contacting the prescribing doctor to rectify the situation. (*Id.*, p. 11) A pharmacist would also get a point for verifying that the pill bottles were filled correctly. (*Id.*)

It is Mr. Taylor’s understanding that Petitioner left employment with Respondent in 2016 due to mental health issues. (11/12/24 Tr. 19) He only became aware of the issues with Petitioner after he had already stopped working for Respondent. (*Id.*, p. 20)

Mr. Taylor denied that, while he worked at the Oak Forest facility, there were 10 pharmacists responsible for processing 4,000 prescriptions per day. He testified that during his tenure, they never reached 4,000 per day, but actually processed closer to 2,500 to 3,000 per day. (11/12/24 Tr. 26-27, 30)

Mr. Taylor does not believe he ever spoke with Petitioner about the latter's mental health condition and possible relationship to his duties as a pharmacist. He does not know whether Petitioner discussed this issue with Charnell Hall, Petitioner's supervisor. (11/12/24 Tr. 35)

Mr. Taylor is not aware of the production levels required by the other pharmacies where Petitioner worked, or the working conditions at those other employers. (11/12/24 Tr. 36-38) The only time he worked with Petitioner and was familiar with his duties is when they both worked for Respondent at the Oak Forest Health Center. (*Id.*, p. 38)

Mr. Taylor worked at various Walmart locations as a pharmacy manager prior to working for Respondent. (11/12/24 Tr. 41) In his experience, the volume of medications dispensed by those Walmart locations was significantly higher than dispensed by Respondent. (*Id.*, p. 43) The Walmart system for verification differed from that used by Respondent, and in his opinion the duties for a pharmacist with Respondent were about half that of the duties for a Walmart pharmacist. (*Id.*, p. 47) Specifically, a pharmacist at Walmart performs both the pre-verification and verification duties, while a Cook County pharmacist performs one or the other activities per day, but not both. (*Id.*)

He does admit the computer system used by Cook County in 2016 wasn't as up to date as the systems used at Walmart and Walgreens, but more advanced than the system used at CVS. (*Id.*, pp. 47-48) For example, the visuals of the computer system were more aesthetically pleasing than the visuals on the Cook County system, and the Walmart system had multiple checkboxes for the pre-verification system, whereas the Cook County system only used one checkbox to be clicked after the pharmacist had gone through all the requisite steps. (*Id.*, pp. 49-50) In his opinion, that made the Walmart system superior in that it was a safer method of dispensing medications to patients. (*Id.*, p. 50)

Mr. Taylor testified as to the difference in metrics between working for Respondent and working for a retail pharmacy. For Respondent, a pharmacist is responsible for processing 30 prescriptions per hour over the course of a seven-hour shift. (12/10/24 Tr. 21) In a retail setting, a pharmacist is evaluated on different measurements, such as on-time percentage or the customer's wait time, or if the prescription is dropped off, was the prescription filled within a two-hour time frame. (*Id.*, p. 22)

As the pharmacy manager for Respondent, if he found errors in the dispensing of medications, he would speak with the pharmacist in question, and also have a general discussion with the department in general to educate them to avoid such mistakes in the future. (11/12/24 Tr. 51-52) Typically, when a medication error was found, he would perform a root cause analysis to determine whether it was a system error or human error. A pharmacist could be disciplined for an intentional error (e.g., intentionally mixing up medications, doing something to harm a patient or

a co-worker), but a pharmacist would not be disciplined for a system or human error. (*Id.*, pp. 52-53)

In his time as a pharmacy manager for Respondent, Mr. Taylor has never had to discipline a pharmacist for failing to meet performance metrics, although he has had counseling/coaching sessions. (12/10/24 Tr. 22-23) According to Mr. Taylor, most people will have “a day or two here or there where they don’t meet their metrics, and that’s not really a big deal.” (*Id.*, p. 59) It’s only a problem if the pharmacist is consistently not meeting the metrics. (*Id.*)

He never disciplined or had any counseling/coaching sessions with Petitioner, that he can recall. (12/10/24 Tr. 23, 33) He does not recall having any conversations with Petitioner for failing to meet the Respondent’s metrics. (*Id.*, p. 34) To his recollection, Petitioner consistently met his metrics and does not recall ever having a conversation with him regarding a medication error or a failure to meet his metrics. (*Id.*, pp. 59-60) He has no recollection of Petitioner mis-filling prescriptions while working for Respondent. (*Id.*, p. 60)

Mr. Taylor agreed that working in the pharmacy field can be stressful, but based on his experience and the articles he has read, such stress is typically more associated with working in a retail setting, where there is pressure to meet certain metrics and there is not enough staff to handle the volume, in addition to making sure the pharmacist is performing accurately and not making mistakes. (11/12/24 Tr. 54)

Prior Medical Condition

The Petitioner testified that during and after a divorce in 2003, he sought “episodic” psychological treatment for anxiety, but he was not diagnosed with chronic anxiety or depression. (11/12/24 Tr. 143-147). He testified that he sought treatment with a psychiatrist after being terminated by Walmart in 2010. (*Id.*, p. 143-144) According to Petitioner, he had no diagnosis of chronic anxiety or depression prior to 2016. (*Id.*, p. 154)

The Petitioner denied that he told Respondent’s expert examining physician, Dr. Reff, that he had been hospitalized 8 or 10 times since 1996. (11/12/24 Tr. 166) He does recall admission to Advocate Good Samaritan Hospital in 2015 for electroconvulsive (“ECT”) treatment. (*Id.*, p. 166-167) He was first diagnosed with chronic depression in 2015, by Dr. Nazeer. (*Id.*, p. 169) He sought treatment with Dr. Nazeer because he was experiencing a high level of stress, confusion, lack of focus, and memory problems. (*Id.*, p. 170)

At an office visit with Dr. Nazeer on August 7, 2015, the Petitioner reported that “things are not going well at all,” and that he was very depressed and helpless. He reported undergoing a divorce and multiple other family issues. He also reported “passive suicidal thoughts,” that he worries excessively and has very low stress tolerance. (PX 7, p. 230)

The Petitioner was hospitalized at Advocate Good Samaritan Hospital from August 22, 2015, through September 11, 2015, during which he was diagnosed with major depressive disorder, chronic and recurrent. (RX 3A, pp. 1-8) According to the History of Present Illness set forth in those records, Petitioner “has a long psychiatric history dating back to 1996.” (*Id.*, p. 1)

The current episode of illness had been ongoing for about 8 months and was getting progressively worse, with Petitioner reporting very poor concentration, repeated irrational thoughts, difficulty adapting to his environment, increased irritability and decreased functional capacity. He reported that none of his current medications had helped. (*Id.*)

The Petitioner also reported at that time that he had at various times had been diagnosed with PTSD, severe major recurrent depression with anxiety and panic attacks, and possible bipolar disorder, but it was noted the patient was unable to give “any solid history of clinical signs and symptoms of bipolar disorder.” (RX 3A, p. 1)

The Past Psychiatric History section of the Advocate Good Samaritan Hospital records from August 22, 2015, states that the patient reports at least 5 prior psychiatric hospitalizations at Alexian Brothers Medical Center, Northwest Community Hospital, Linden Oaks, Provena Mercy in Aurora and St. Joseph Hospital in Joliet. (RX 3A, p. 2) It is noted his last psychiatric hospitalization was at Provena Mercy in March 2015, and that he has followed up with various psychiatrists on an outpatient basis. (*Id.*) He has most recently been under the care of Dr. Nazeer at the Dreyer Clinic for the past 6 months, who had prescribed various medications (escitalopram, Lamictal, Klonopin, and Lexapro). (*Id.*) The Petitioner provided a list of 17 other medications that he been prescribed since 1996, noting that none of the medications had helped. He denied any prior ECT treatment. (*Id.*)

The Past Personal History provided by Petitioner in those records notes that he works at Cook County Hospital as a pharmacist, noting that it is “a stressful job, with horrible working conditions.” (RX 3A, p. 2) He denied any suicidal or homicidal ideation but did relate a history of 2 prior suicide attempts, once by an overdose of Prozac and the other by an overdose of nitroglycerin tablets. (*Id.*) On September 5, 2015, he reported flashbacks to his childhood, when he was having problems at home due to his father’s gambling in India and how it all affected his family. (PX 7, p. 4994)

The Petitioner was diagnosed with major depressive disorder, recurrent and severe, with anxious distress. (RX 3A, p. 2) After undergoing 9 ECT sessions, the Petitioner was noted to be functioning very well, was not depressed or anxious, and had no suicidal thoughts. (*Id.*, p. 3) He was advised to follow up with his psychiatrist, provided with medications for mood stabilization (Zyprexa) and depression (Fetzima), and advised he could return for maintenance ECT if necessary. (*Id.*, p. 4)

Summary of Medical Records

An ambulance from the Downers Grove Fire Department was dispatched to Petitioner’s home on September 21, 2016. The Petitioner reported taking approximately 100 Xanax pills because he does not enjoy his job, that there is too much pressure and he can no longer handle it, so he decided to overdose on the pills. (PX 7, p. 1410) The Petitioner denied any prior medical history, although his wife advised that he is a pharmacist and has a history of depression. (*Id.*) He was taken to the emergency department of Advocate Good Samaritan Hospital. (*Id.*)

The History of Present Illness report from the emergency department notes the Petitioner's ex-wife reported Petitioner being depressed over the past week and hadn't taken his medications. The Petitioner stated that he tries to help people but he's very hopeless. The Petitioner admitted that he was trying to hurt himself. (PX 7, p. 1418) The Petitioner was diagnosed with polysubstance overdose, depression with suicidal attempt and hypotension, and deemed to be in critical condition. The plan was to admit him to the hospital and consult with a poison control specialist, a toxicology specialist, and a critical care specialist. (*Id.*, pp. 1419-1420)

The Petitioner was admitted to Advocate Good Samaritan Hospital from September 22, 2016, through November 4, 2016. On September 22, 2016, the Petitioner was seen by Dr. Ahsan for consultation, and provided a history of overdosing on various medications (Xanax, trazodone, and amlodipine). He reported not wanting to work due to increasing depression and inability to concentrate and focus, feelings of increased hopelessness, feeling worthless and wanting to kill himself. (PX 7, p. 1497); RX 3B, p. 1) The report notes the patient has a long history of depression and admits to suicidal intent. (*Id.*) The history also refers to Petitioner's prior ECT inpatient treatment a year prior.

Based on the history and his examination of the patient, Dr. Ahsan diagnosed major depressive disorder with suicidal attempt. Dr. Ahsan recommended inpatient psychiatric treatment. (PX 7, p. 1498; RX 3B, p. 2)

The Petitioner was seen for consultation by various specialists, including Dr. Julka of the Renal Service, due to development of acute kidney failure following polysubstance overdose. (PX 7, p. 1501) The past medical history in Dr. Julka's report notes a "long history of depression" for which the Petitioner received ECT and multiple medications. (*Id.*, p. 1502) The patient gave a history of panic reactions and missing exits while driving, which makes him anxious. (*Id.*) He also related that "[h]e does not like the changes in medical system in addition to other things." (*Id.*) Dr. Julka diagnosed acute kidney injury secondary to hypotension and underperfusion, intentional polysubstance overdose, depression, chronic hypertension, and obesity. (*Id.*, p. 1503) A course of treatment was recommended to address the injury to the kidneys. (*Id.*) In addition to acute renal failure, the Petitioner was also diagnosed with acute respiratory failure, anxiety, calcium channel blocker overdose, hypotension, intentional drug overdose, metabolic acidosis, and suicide attempt, during his stay at the hospital. (*Id.*, p. 1506)

During his stay in the hospital, the Petitioner made references to personal problems apart from his work experience, such as "trauma from the money \$250,000.00 his father lost and feels that everything is on his shoulder..." and "I don't think it's a good idea to go back to Delaware, last time I was there my brother choked me." (PX 7, pp. 673-674) On October 14, 2016, he expressed that he "feels like a failure as a man, father, husband..." that there is "no meaning in life, hopelessness, helpless mindset, loss of his faith in God." (*Id.*, p. 665) On November 1, 2016, he did report that he worked as a pharmacist for Cook County and that "his job is stressful." (*Id.*, p. 367)

The Petitioner was discharged from the hospital on November 4, 2016, after undergoing nine ECT sessions; it was noted that he responded well to these treatments, did not report any side effects and his memory was good. (RX 3G, p. 2) At the time of discharge he was doing well, was

not isolated and was functioning well in groups as well as with staff. (*Id.*) His mood was appropriate, and he denied any suicidal or homicidal ideation. He was advised to continue with his medications and to participate in the partial day program. (*Id.*, p. 3)

The Petitioner participated in the Partial Hospital Program at Advocate Good Samaritan Hospital from November 7, 2016, through November 21, 2016. The progress note of November 7, 2016, notes the Petitioner appeared alert, oriented and cooperative. He noted being grateful to be alive and was motivated for treatment. (RX 3H, p. 14) On November 21, 2016, however, Petitioner called to report that he would no longer participate because he felt the program was not helping him. The Petitioner denied being suicidal or homicidal and stated that he had made an appointment with Dr. Ahsan for November 28, 2016. (*Id.*, p. 16)

The records from Advocate Medical Group indicate Petitioner was hospitalized again from December 2, 2016, through December 27, 2016. (PX 2, p. 90) The Petitioner was seen by Dr. Mirza of Advocate Medical Group on December 3, 2016. He reported the ECT sessions did not help him, that he was experiencing auditory hallucinations and suicidal thoughts again, as well as feeling irritated, paranoid, disorganized and losing touch with reality. (PX 2, p. 87) He also reported an extensive psychiatric history, including 9-10 hospitalizations, the first time in 2011, as well as 3 prior suicide attempts. (*Id.*) Dr. Mirza outlined a treatment plan for voluntary admission to the hospital for stabilization and monitoring of medications, and individual and group psychotherapy. (*Id.*, p. 88) The Petitioner was discharged by Dr. Ahsan on December 27, 2016. (*Id.*, p. 90)

The Petitioner sought treatment with Dr. Barbara Belford of Norman Broudy, M.D. & Associates, in Newark, Delaware, on April 4, 2017. On that date, the Petitioner advised that he had a current pharmacy license in Illinois, and that he last worked a year ago. (PX 9, p. 2) He provided a history of his suicide attempt in September 2016 and his subsequent hospitalization and treatment at Advocate Good Samaritan Hospital. He reported taking his medications (Klonopin, Seroquel, Serazone) and denied any suicidal or homicidal ideation. He reported wanting to “clear up his brain/thoughts and to make decisions without doubts.” (*Id.*)

Based on the history and examination by Dr. Belford, Petitioner was diagnosed with major depressive disorder, recurrent episode, and anxiety disorder. (PX 9, p. 3) He was advised to continue treatment with Dr. Joshi and to participate in supportive counseling for decision making and problem solving. (*Id.*, p. 4)

A progress note of May 4, 2017, states that Petitioner felt he “can’t go fast enough; can’t get up in the morning; gets lost during the day; cannot function normally; can’t make sense of complicated things.” (PX 9, p. 9) It also notes that he was “too scared to do pharmacy,” and that he was “applying for Soc. Sec. Disability [but] never finished because want to work but life is too tough.” (*Id.*) The Petitioner was advised to continue with supportive counseling. (*Id.*)

The psychotherapy session with Dr. Belford took place on July 3, 2017, at which time Petitioner reported he would be leaving for Illinois to live with his wife and son. (PX 9, p. 12) He also reported that he “wants to be able to work in a low-level professional setting PT in the future.”

(*Id.*) The diagnoses continued to be major depressive disorder, recurrent, and anxiety disorder. (*Id.*)

The Petitioner returned to Illinois and followed-up with Dr. Ahsan of Advocate Medical Group on November 7, 2017. He related that he had moved to Delaware for a year to be with family but recently moved back to Illinois. He stated that he was still depressed and lethargic, with low energy and memory issues. The doctor noted short term memory impairment, but remote memory intact and recent registration memory intact. The Petitioner was diagnosed with generalized anxiety and major depressive disorder. Dr. Ahsan prescribed medications and psychotherapy. (PX 2, pp. 92-93)

The Petitioner participated in individual therapy with Christopher Rhone, LCPC, from November 14, 2017, through December 28, 2017. At the last session, the Petitioner was exceedingly negative about life and was angry at himself. He was assessed as having panic disorder, major depressive disorder, and hypochondriasis. (PX 2, p. 97)

On November 16, 2017, and November 27, 2017, the Petitioner participated in a neuropsychological examination, conducted by Dr. Nicholas Jasinski of Neuropsychological Services, P.C. The report notes that Petitioner was referred to Dr. Jasinski by his neurologist for assessment of current neuropsychological status due to complaints of memory difficulties and depression. (PX 4, p. 2; RX 8, p. 1)

The Petitioner reported a history of multiple inpatient admissions for treatment of significant depression and anxiety, with the most recent admission taking place in September 2016 after an attempted suicide by overdose of amlodipine and Xanax. (PX 4, p. 2; RX 8, p. 1) He reported significant difficulties at work keeping up with the demands of his pharmacist position due to perceived unreasonable productivity requirements; he reported resigning from his position in December 2016. (*Id.*)

Since that time, Petitioner reported significant depression characterized by low self-esteem low self-efficacy, sadness, helplessness, hopelessness, anhedonia, and amotivation. (PX 4, p. 2; RX 8, p. 1) He reported intense anxiety surrounding his future and reported daily panic attacks for some time. (*Id.*) Regarding cognitive functioning, he reported being absent-minded, forgetting things like passwords or appointments, and getting lost while driving. (*Id.*) He noted these cognitive issues were causing him trouble in his work and led to difficulty managing such things as family finances. (*Id.*)

The results of the cognitive testing indicated Petitioner exhibited variability in aspects of executive function. Specifically, he exhibited variable performance on measures of mental flexibility and ability to inhibit automatic responses, variable performance on visuospatial measures, mild to moderate difficulties on a measure of visuoperception and visuoconstruction. (PX 4, p. 4; RX 8, p. 3) These results were observed in the context of otherwise intact attention, working memory, processing speed, verbal fluency, and verbal reasoning. (*Id.*) The Petitioner presented with complaints of poor memory, but the report notes he performed at expected levels with a strength in verbal memory. (*Id.*)

The report also notes “[i]t is clear from his clinical report and the results of psychological testing that he is in marked clinical distress related to significant life stress, primarily related to his work as a pharmacist.” (PX 4, p. 4; RX 8, p. 3)

Dr. Jasinski notes in his report that the results were difficult to parse out as far as etiology. While the Petitioner’s scores on testing suggested possible frontal and right hemisphere dysfunction, his marked mood symptoms clearly impacted his performance on some of those measures. As such, Dr. Jasinski noted it was difficult to determine the extent to which some of his deficits are due to brain dysfunction or the detrimental effects of his mood on cognitive performance. (PX 4, p. 4; RX 8, p. 3)

For treatment, Dr. Jasinski recommended cognitive-behavioral therapy to address acute panic symptoms and to address chronic depressive symptoms which appear to be recurrent and harmful to day-to-day functioning. (PX 4, pp. 4-5; RX 8, pp. 3-4) He also recommended ongoing evaluation by the neurologist to rule out any organic causes of brain dysfunction, ongoing treatment with his psychiatrist, and a possible follow-up neuropsychological evaluation in 8 to 12 months. (*Id.*, p. 4)

The Petitioner returned to Dr. Ahsan on January 10, 2018. He advised the doctor he was not doing well and was feeling miserable and guilty for not working. He denied any suicidal ideation. The doctor diagnosed generalized anxiety, major depressive disorder, and panic disorder, refilled the Petitioner’s medications and advised him to return in 8 weeks. (PX 2, pp. 98-99)

The Petitioner was hospitalized again at Advocate Good Samaritan Hospital from January 16, 2018, through January 24, 2018. (PX 2, pp. 100-107) At his admission on January 16, 2018, Petitioner reported progressively worsening major depression and anxiety, and “blames a lot on Indian culture stating there are too high of expectations placed on him by society and his family and this is the reason for his depression.” (*Id.*, p. 100) He also reported severe stress in his life, and that the increased stress was changing his personality, and he denied having a good support system at home. (*Id.*) He was diagnosed with major depression with psychosis, anxiety, hypertension, dyslipidemia, and GERD. (*Id.*, p. 102)

The discharge report of January 24, 2018, noted that Petitioner’s medications were changed, that he responded slowly to group and milieu therapy, and was appropriate with staff and peers, and did well in groups. The Petitioner’s discharge diagnosis was bipolar disorder type II and at the time of discharge, he was functioning well. (PX 2, p. 103) He was to follow up with Dr. Ahsan on February 14, 2018, and with therapist Chris Rhone on January 25, 2018. (*Id.*, p. 106)

The Petitioner was hospitalized for a fourth time at Advocate Good Samaritan Hospital on February 21, 2018. He reported worsening depression and suicidal ideation, and that he had not been doing well on Seroquel. (PX 2, p. 109) He was diagnosed with bipolar disorder with worsening depression and suicidal ideation. (*Id.*, p. 110) He was discharged on March 3, 2018. (*Id.*, pp. 112-113)

On March 14, 2019, the Petitioner presented to James R. Meier, LCSW, for a psychosocial evaluation. He reported continuing moderate to severe depression, inability to concentrate,

difficulty thinking, hypersomnia/somnia, restlessness, negativity, and indecisiveness, as well as ruminating on his position in life and feeling like a failure. (PX 2, p. 138) He had difficulty maintaining activities of daily living and completing tasks and reported no motivation or energy. (*Id.*) He also felt his mind racing at times and reported excessive worry and often has symptoms of panic or dread. (*Id.*, p. 139) Based on the history and mental status exam, Petitioner was diagnosed with major depression, recurrent, severe without psychosis, general anxiety, and panic without agoraphobia. (*Id.*, p. 141) He was advised to consider scheduling regular weekly or biweekly appointments. (*Id.*)

The Petitioner presented to Dr. Zhang at Dreyer Clinic on May 1, 2019, to reestablish care at the department of behavioral health. (PX 2, p. 142) It is noted the patient seemed to show cognitive deficit and he was unable to provide detailed information about his past psychiatric treatment. (*Id.*) The history in the report, however, notes that a review of the medical record from Dreyer Medical Clinic showed a history of psychiatric treatment in 2007 at age 32, initially diagnosed with major depressive disorder and prescribed various psychotropic medications. In 2014, the patient started to treat with Dr. Pankov in the department of psychiatry at Dreyer Medical Clinic, diagnosed with major depressive disorder, generalized anxiety disorder, and panic disorder. In March 2015, the Petitioner was admitted to Provena Mercy Medical Center for management of depression with suicidality and admitted to the psychiatric facility for treatment of bipolar disorder type II. In the summer of 2015, the Petitioner began to treat with Dr. Nazeer at Fox Valley, diagnosed with bipolar disorder, panic disorder with agoraphobia and generalized anxiety disorder. The Petitioner treated with Dr. Nazeer for almost two years, was admitted to Advocate Good Samaritan Hospital in 2016 and lost his job as a pharmacist. (*Id.*, pp. 142-143)

The symptoms on May 1, 2019, included feeling “terrible” and depressed, with crying spells, insomnia, difficulty with concentration and memory, and feeling anxious and fearful. He denied having suicidal thoughts or psychotic symptoms. (PX 2, p. 143) Based on the history and mental fitness examination, Dr. Zhang diagnosed bipolar disorder, type II, and severe depression without psychotic features. He modified the Petitioner’s medication regimen and scheduled a follow-up appointment for 2 weeks. (*Id.*, p. 144)

The Petitioner continued to treat with Dr. Zhang throughout 2019. At an appointment with Dr. Zhang on December 13, 2019, the Petitioner reported that “he has been traumatized on numerous occasions over the past 20+ years since he got married the first time in 1996.” He related his father losing money in the stock market which caused a financial crisis for his family, in turn causing Petitioner to become involved in that family financial crisis and eventually leading to the end of his first marriage. In 2001, his wife called the police, and he was charged with domestic violence; they were divorced in 2003. In 2005, while working for Walgreens, he was accused by a customer of touching her daughter, and even though the accusation was baseless he had to hire an attorney. While working at a different pharmacy, he was accused by a female pharmacy tech of inappropriate touching and was terminated. In 2010, he was terminated by a Walmart pharmacy after making three mistakes in one year. He reported his work for the Cook County pharmacy in 2015 was so stressful and demanding, it led to his suicide attempt. (PX 2, pp. 205-206)

The Petitioner attended counseling sessions with James Meier, LCSW, and treatment with Dr. Zhang through the end of 2019 and into 2020. (PX 2, pp. 185-296) The treatment records

showed periods of Petitioner's condition improving and relapsing. At his appointment with Dr. Zhang on May 29, 2020, he reported having fatigue, apathy, and anhedonia, with inattentiveness, being absent-minded and indecisive. (*Id.*, p. 293) He also reported being irritable, angry, and frustrated, and internalizing the anger toward himself because he could not "lash out toward nobody." (*Id.*) His current major stressors included a dysfunctional marriage and traumatic memories about his past, outlined in the report of that date. (*Id.*)

Dr. Zhang diagnosed the Petitioner with symptomatic bipolar disorder, type II, as well as generalized anxiety disorder with OCD and PTSD. He adjusted the Petitioner's medication regimen, and provided treatment recommendations such as emphatic listening, coping mechanisms, restructuring his daily routine, and engage in aerobic exercise to improve physical and mental wellbeing and cognitive functioning. (PX 2, p. 296)

The Petitioner presented for treatment at the emergency department of Linden Oaks Hospital on July 27, 2020. He presented with feelings of panic and insecurity, stating he feels depressed all the time and "feels his prior job as a pharmacist affected him, felt he was not valued and caused anxiety." (PX 8, p. 10) He expressed feelings of guilt with life decisions and fixating on that issue, as well as stress with family and work. He related that he retired in 2016 and went on disability, and lately was having a hard time with memory, was not getting up in the morning and wasn't doing much. (*Id.*) He was seeking treatment to reduce anxiety and insecurities. (*Id.*)

The Petitioner denied any suicidal ideation within the prior 30 days ("I'm blessed every day that I wake up, I'm just inactive and feeling useless"). (PX 8, p. 10) His mental health symptoms included a change in activity level, loss of interest, isolation, feelings of helplessness and worthlessness, impaired concentration, crying, sleep disturbance and increased irritability. (*Id.*, p. 11) He reported waking up from sleep in a state of panic and a 7/10 level of anxiety in the morning, with frequent racing thoughts. (*Id.*)

Based on the history and clinical presentation, the Petitioner was diagnosed with major depressive disorder, recurrent episode, as well as anxiety disorder. (PX 8, p. 17) He was advised to follow up with his outpatient psychiatrist, Dr. Zhang, as well as to call the crisis line or 911 if his condition worsens. (*Id.*)

The next record of treatment is an office visit with Dr. Michael Kinkade of BMG – Central, in Columbia, Missouri, on March 10, 2022. According to the report of that visit, the Petitioner had recently moved to Columbia and wished to establish care with a new primary care physician ("PCP"). (PX 11, pp. 2-3) The Petitioner provided a medical history of, *inter alia*, mood disorder with depressive and anxiety components, controlled on current meds and previously treated by psychiatry in Aurora, Illinois. (*Id.*, p. 3) He was seeking a referral to establish care with psychiatry in Columbia. (*Id.*) The Petitioner was provided with a referral to Dr. Bhaila of Centerpoint, for treatment of depression and anxiety. (*Id.*, p. 6)

The Petitioner was last seen by Dr. Kinkade on August 14, 2023, at which time he was seen for a preventative health visit. The Petitioner was seen for a variety of health issues, and it is noted his mood disorder with depressive and anxiety components was being followed by

psychiatry. The Petitioner did not express any specific issues to Dr. Kinkade regarding his mental health. (PX 11, pp. 57-66)

The Petitioner subsequently came under the care of Dr. Agara Reddy of Serenity Health, LLC, in Columbia, Missouri, from June 8, 2023, through June 4, 2024. (PX 10, pp. 1-49) At the office visit on June 8, 2023, the Petitioner related that he was feeling more anxious and depressed at times, and failing memory which was affecting his ability to function. (*Id.*, p. 4) The report notes the patient was stable on his current medication regime and the treatment plan included counseling and stress reducing activities. (*Id.*)

The last record of treatment with Dr. Reddy was an office visit on June 4, 2024, at which time Petitioner related that he was “struggling with increased depression.” He reported taking all of his medications, but experiencing depression, anxiety and nightmares and flashbacks of things that happened years ago. He reported being hospitalized for psychiatric issues “for a few days,” and recently having difficulty with sleeping and functioning. (PX 10, p. 39) The Petitioner’s medications were adjusted and the Petitioner was referred to cognitive behavior therapy and was scheduled to return in one month. (*Id.*, p. 42) The Petitioner cancelled his appointment on July 2, 2024, advising that he was “doing good” and had “all my meds.” (*Id.*, p. 47)

Expert Reports

Dr. Robert A. Reff – Section 12 Examinations

November 19, 2021

On November 1, 2021, Dr. Robert Reff examined the Petitioner at the request of the Respondent, pursuant to Section 12 of the Act. In addition to interviewing the Petitioner and conducting a mental status examination, Dr. Reff reviewed various documents, including the neuropsychological testing report of Dr. Jasinski, dated November 15 and 27, 2017, and emails sent to Dr. Reff by the Petitioner, concerning the stresses experienced by pharmacists in general and complaints against corporate pharmacies. (RX 1, pp. 148-152) He thereafter drafted a report dated November 19, 2021. (*Id.*, pp. 148-155)

Based on his examination of the Petitioner and review of the documents, Dr. Reff opined that Petitioner had a pre-existing psychiatric history and diagnosed major depression, recurrent, moderate severity, and adjustment disorder with mixed anxiety and depressed mood. (RX 1, p. 152) He also opined that Petitioner’s medical history was more likely than not the cause of his current symptoms, and noted the daily stresses he experienced from work became overwhelming and contributed to the recurrence of his major depression. (*Id.*, pp. 152-153)

Dr. Reff also noted the hallmark of adjustment disorder is that the individual responds in ways that are out of proportion to the severity of the stressor and in response to an identifiable stressor. Once the stressor has been removed, the individual returns to pre-stressor levels. (RX 1, p. 153) In his opinion, Petitioner’s depression was in remission due to his treatment and was no longer experiencing an adjustment disorder with mixed anxiety and depressed mood as he was no longer engaged in the environment that apparently led to his condition. (*Id.*)

Regarding medications, Dr. Reff noted that Petitioner had a pre-existing history of depression and anxiety and had been taking medications for those conditions in the past. As such, in his opinion, the Petitioner's use of psychotropic medication for his psychiatric condition was reasonable, necessary and related to his pre-existing mental health condition. (RX 1, p. 153)

As for whether Petitioner had reached maximum medical improvement or required further medical treatment, Dr. Reff stated that Petitioner suffered a recurrence of his major depression which was contributed to by his work environment, and he had since attained maximum medical improvement as pertains to that contributing factor. He also stated, however, that Petitioner will require ongoing medical management and supportive psychotherapy, perhaps indefinitely, due to the recurrent nature of his pre-existing psychotic condition. (RX 1, p. 154)

Regarding the Petitioner's ability to return to work, Dr. Reff commented that Petitioner did not demonstrate any observable evidence of cognitive limitations but given his response to his most recent work environment, it is unlikely that he would be able or willing to return to a corporate pharmacy. While Dr. Reff did not believe Petitioner was totally impaired in his ability to function as a pharmacist, he did not believe Petitioner would be able to tolerate the deadlines and quota mandates associated with retail or large-scale pharmacy work. In his opinion, Petitioner could likely return to work for a small community hospital setting or private pharmacy. (RX 1, p. 154)

As for permanent disability, Dr. Reff opined that Petitioner is not globally impaired by his psychiatric condition and that his work environment contributed to a temporary aggravation of his pre-existing psychiatric condition. (RX 1, p. 154)

January 4, 2022

Following the issuance of his initial report, Dr. Reff reviewed additional records, including those which outlined psychiatric treatment rendered to Petitioner from August 2015 through May 29, 2020. (RX 1, pp. 156-163) He thereafter drafted an addendum report at the request of Respondent, pursuant to Section 12 of the Act, updating his opinions and conclusions, based on a review of those records as well as his interview and examination of Petitioner on November 1, 2021. (*Id.*, pp. 156-168)

Based on his review of the additional records and prior examination of the Petitioner, Dr. Reff again diagnosed Petitioner with major depression, recurrent, severe, without current psychotic features. (RX 1, p. 164) In his opinion, the Petitioner's depression pre-dated the alleged accident(s) and his condition has waxed and waned over time due to any number of personal stressors (family issues, failed marriages), problems at work, and difficulty sustaining the requirements of his job as a retail pharmacist or hospital system-based pharmacist. (*Id.*, pp. 164-165) He noted that Petitioner "has not always been forthcoming with providing accurate information about his psychiatric history." (*Id.*, p. 165) He also notes the normal course of major depression is that the more times one has an episode, the greater the likelihood of another one for any reason, obvious or not, and the number of episodes suffered by Petitioner portends a poor prognosis for him ever achieving an extended remission or retuning to pre-illness condition. (*Id.*)

Dr. Reff also opined there are several non-work-related factors which contribute to Petitioner's current condition of ill-being, including the length of time he has been ill and the number of depressive episodes he has suffered, family issues regarding resentment toward his deceased father, cultural pressures, and conflicts with his mother, brother, and ex-wife. (RX 1, p. 165) Dr. Reff also notes Petitioner is using litigation "to justify the problems he has had in his occupation," and "[i]f he were to win this lawsuit and affect change in the working conditions of all pharmacists everywhere, he could now see himself as a savior and less so as a failure." (*Id.*)

Regarding maximum medical improvement, Dr. Reff opined that Petitioner's psychiatric condition appeared to be stable, but he was unable to opine with any degree of certainty when this period of reasonable stability occurred. (RX 1, p. 166) Based on Petitioner's history, he felt it impossible to predict how long this period of stability is apt to lapse. (*Id.*) He opined Petitioner will require ongoing medical management and supportive psychotherapy, indefinitely, due to the recurrent nature of his pre-existing psychiatric condition. (*Id.*, p. 167) In his opinion, neither Petitioner's mental health condition nor the treatment thereof is causally related to any alleged work accident. (*Id.*)

As for the Petitioner's ability to return to work, Dr. Reff's opinions remained the same as before: Petitioner does not demonstrate any observable cognitive limitations, but he would not be able to tolerate the deadlines and quota mandates associated with retail or large-scale pharmacy work, and that he would regress were he to return to that environment. (RX 1, p. 167) In his opinion, such restrictions are permanent and related to Petitioner's pre-existing psychiatric condition. (*Id.*)

Regarding permanent disability, it is the opinion of Dr. Reff that Petitioner did not suffer any permanent disability as the result of injuries sustained on either alleged work accident date. (RX 1, p. 167) Any disability, either temporary or permanent, is due to Petitioner's serious mental health condition which pre-dates the alleged work accident dates. (*Id.*) Similarly, while Dr. Reff agrees the treatment rendered to Petitioner to date has been reasonable and required due to the severity and recurrent nature of his serious mental health condition, such treatment is not due to any injuries sustained on the alleged accident dates. (*Id.*, p. 168)

Deposition Testimony

Evidence Deposition of Dr. Robert Reff – April 19, 2022

The parties took the evidence deposition of Dr. Robert Reff on April 19, 2022. Dr. Reff is board-certified in general psychiatry and has been in private practice since 1986, and a solo practitioner since 2005. (RX 1, p. 7) He was retained by Respondent to conduct an independent medical examination of the Petitioner. (*Id.*, p. 8)

Dr. Reff testified consistent with his examination report of November 19, 2021, and his addendum report of January 4, 2022. On direct examination, he testified that at the time he interviewed Petitioner, it was his opinion that Petitioner's condition was a recurrence of psychiatric illness, specifically recurrent major depression, and the stresses that he experienced from work did become overwhelming and was a contributing, but not causative, factor. The cause

of his condition was his underlying illness, but his work environment at the time was a contributor as it overwhelmed him. (RX 1, p. 23)

After a review of Petitioner's extensive medical records, Dr. Reff felt the records described an individual who has a very longstanding psychiatric history with rather significant issues that he has been dealing with for a very long time. (RX 1, p. 26) In his opinion, Petitioner has a preexisting condition that was likely made worse by any type of psychosocial stressor. (*Id.*, p. 27) In addition, Dr. Reff felt that the Petitioner was severely depressed at the time he was last working and that depression likely caused cognitive problems, which very well could have contributed to the stress he was experiencing at work. (*Id.*, p. 28)

Dr. Reff reiterated that in his opinion, the cause of Petitioner's condition was a preexisting serious mental health condition, that being major depression, and it is well-accepted that the more an individual has episodes of depression, the more likely they are to experience further episodes of depression. (RX 1, p. 30)

It is also Dr. Reff's opinion that Petitioner is capable of work, so long as his condition is stable in terms of his depression. He doesn't believe, however, that Petitioner would function well if he were again put into a situation that would require high pressure or high demand. In his opinion, such a work restriction is not related to a work accident but rather to his preexisting mental health condition. (RX 1, pp. 33-34)

When asked about possible secondary gain, Dr. Reff testified that Petitioner has a vested interest in demonstrating that he was victimized and severely injured by his job, and that if he should "win this lawsuit," it would be a way to become the champion of the downtrodden, of which he sees himself as one. (RX 1, pp. 34-35)

On cross-examination, Dr. Reff testified that while Petitioner complained to him about financial distress, he did not complain about losing his career or what he was going to do with the rest of his future because he could not return to his career. Rather, he told Dr. Reff that in his opinion, his time has passed. (RX 1, p. 65)

When asked whether the Petitioner's need for ECT came about because of his work with Respondent, specifically the conveyor belt system utilized by Respondent, Dr. Reff testified that he disagreed with such a conclusion, as Petitioner had a 20-year history of treatment for depression and despite treatment, never had an extended period of remission, and this predated his employment with Respondent. (RX 1, p. 89) He did not dispute, however, that Petitioner's work for Respondent was an aggravating issue. (*Id.*, p. 90)

When asked whether he was aware of Petitioner's job duties for Respondent, Dr. Reff testified that he based his opinions on what he was told by Petitioner, specifically that the work for Respondent was very stressful, more stressful than other jobs he previously worked, and that he didn't like working for corporate pharmacies because they "were all getting to be the same." (RX 1, p. 101) In his opinion, the work for Respondent was one of multiple things in Petitioner's life that likely contributed to his condition and led to the suicide attempt in 2016, but the primary causal factor was not his job so much as it was his underlying mental health issue. (*Id.*, p. 102) Dr.

Reff does not deny that Petitioner's job with Respondent is repeatedly referenced in the medical records as something that's causing him stress between 2015 and 2016. (*Id.*, p. 111)

Petitioner's Current Condition

The Petitioner testified that he does not feel he could return to work as a pharmacist at this time. (11/12/24 Tr. 91) In his opinion, since he left the field in 2016, there have been changes in the industry such that the profit goal predominates and creates an environment where the pharmacists are overburdened. (*Id.*, p. 92) As a result, pharmacists do not have the time to clinically advise patients or protect their safety or prevent medication errors. (*Id.*) The Petitioner draws these conclusions from his own research of various articles and studies. (*Id.*, pp. 92-94; PX 14)

The Petitioner also testified that the idea of returning to the pharmacy field "brings me post-traumatic issues." (*Id.*, p. 99) He has not looked for a job [in pharmacy] "because I know that it is going to bring me to the point of hurting somebody and hurting myself." (11/12/24 Tr. 103)

Petitioner began working on a part-time basis on April 19, 2022, as a front desk attendant at a Super 8 Motel in Columbia, Missouri. (11/12/24 Tr. 103) He worked three days (24 hours) per week in that job, earning \$8.50 per hour, approximately \$16,000.00 per year. (*Id.*, p. 104) In December 2023, he left that job and began working for Quality Inn in Columbia, where he still works. (*Id.*, p. 156) He has also been collecting SSDI benefits since 2019. (*Id.*)

The Petitioner testified he is currently "much more peaceful mentally" so long as he continues to take his medications and stays away from pharmacies. (11/12/24 Tr. 107) He stays away from any discussions that recollects his memories and stays away from his former occupation as a pharmacist, working in a low-stress environment as a front desk attendant. (*Id.*) He feels he has no choice but to continue in that line of employment. (*Id.*, p. 108)

The Petitioner tries to remain physically active and takes multiple medications, including Abilify, Cymbalta, Clonopin, Amlodipine, and Metoprolol. (11/12/24 Tr. 121) He feels his condition is stable at this point. (*Id.*, p. 122)

He does feel that he has "lost his bread and butter" in that he can no longer work as a pharmacist. (11/12/24 Tr. 124) In his opinion, society and the health profession doesn't care for pharmacists because "they are geared more over profits and sales [such] that they're sacrificing their own employees' mental health to get their own goals and bonuses." (*Id.*)

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v. Industrial*

Commission, 47 Ill.2d 144, (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, (1977).

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 demeanor of the witness and any external inconsistencies with his/her testimony. Where a claimant's testimony is inconsistent with his/her 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).

The Arbitrator did not find the Petitioner to be a credible witness regarding his medical and psychiatric history. For example, he testified on direct examination that prior to his working for Respondent, "I never experienced any other problems mentally, as they say. I never had any mental disorders, never was hospitalized at this extent or burnout." (11/12/24 Tr. 72-73) On cross-examination, however, he testified that during and after a divorce in 2003, he sought "episodic" psychological treatment for anxiety, but he was not diagnosed with chronic anxiety or depression. (11/12/24 Tr. 143-147), and that he had no diagnosis of chronic anxiety or depression prior to 2016. (*Id.*, p. 154)

The medical records rebut Petitioner's testimony in this regard. At the time of his August 2015 hospitalization at Advocate Good Samaritan Hospital, the Petitioner relates a history of psychiatric treatment as far back as 1996, including five prior hospitalizations (with the specific hospitals listed in the history). In addition, the Petitioner provided a list of 17 medications that he had been prescribed since 1996.

When seen by Dr. Zhang at Dreyer Clinic on May 1, 2019, the history notes that a review of the medical record from Dreyer Medical Clinic showed a history of psychiatric treatment in 2007 at age 32, initially diagnosed with major depressive disorder and prescribed various psychotropic medications. (PX 2, p. 142) The same history relates that in 2014, the Petitioner was diagnosed by Dr. Pankov at Dreyer Medical Clinic with major depressive disorder, generalized anxiety disorder, and panic disorder. In March 2015, the Petitioner was admitted to Provena Mercy Medical Center for management of depression with suicidality and admitted to the psychiatric facility for treatment of bipolar disorder type II. In the summer of 2015, the Petitioner began to treat with Dr. Nazeer at Fox Valley, diagnosed with bipolar disorder, panic disorder with agoraphobia and generalized anxiety disorder.

Regarding the Petitioner's job duties and responsibilities as a pharmacist for Respondent, the general operations at the mail order pharmacy, and the Petitioner's job performance while working for Respondent, the Arbitrator finds the testimony of Shelby Taylor to be more credible than that of Petitioner.

Regarding 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:

Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d). It is well established that the Petitioner bears the burden of proof by a preponderance of the evidence that his injury arose out of and in the course of his employment. *First Cash Financial Services v. Industrial Commission*, 367 Ill. App.3d 102, 105, 853 N.E. 2d 799, 803 (1st Dist. 2006).

Whether the claimant sustained an accidental injury that arose out of and in the course of his employment is a question of fact. *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 674 (2009). In resolving disputed issues of fact, it is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony and resolve conflicts in the evidence. *Id.* at 675; *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041 (1999); *Swartz v. Industrial Comm'n*, 359 Ill. App. 3d 1083, 1086 (2005).

There is no question that prior to the alleged work accident date of September 21, 2016, the Petitioner suffered from mental health conditions, including recurrent major depression and anxiety. The Petitioner alleges that as a result of the stressful nature of his work for Respondent in 2015 and 2016, his mental health condition deteriorated to the point he attempted to commit suicide on September 21, 2016, by intentional polysubstance overdose.

In Illinois, psychological injuries are compensable under one of two theories, either physical-mental, when the injuries are related to and caused by a physical trauma or injury, or mental-mental, when the injuries are caused by sudden severe emotional shock traceable to a definite time and place and cause even though no physical trauma or injury was sustained. See *Pathfinder Co. v. Industrial Com.*, 62 Ill. 2d 556, 563 (1976); and *City of Springfield v. Industrial Comm'n*, 291 Ill. App. 3d 734, 738, 685 N.E.2d 12, 14, 226 Ill. Dec. 198 (1997). In *Pathfinder*, the supreme court, mindful of the potential for abuse in cases of alleged psychological injury through fabrication, allowed recovery on the basis the nonphysical traumatic events triggering the mental disability were uncommonly gruesome and the disability immediate and sudden. *Pathfinder* does not authorize compensation under the Workers' Compensation Act for anxiety, emotional stress or depression which develop over time in the normal course of an employment relationship. *General Motors Parts Division v. Industrial Comm'n*, 168 Ill. App. 3d 678 (1988); *Chicago Bd. of Education v. Industrial Com.*, 169 Ill. App. 3d 459, 466-467 (1988).

Recovery for non-traumatically-induced mental disability is limited to those employees who can establish that: (1) the mental disorder arose in a situation of greater dimensions than the day-to-day emotional strain and tension which all employees must experience; (2) the conditions exist in reality, from an objective standpoint; and (3) the employment conditions, when compared with the nonemployment conditions, were the major contributing cause of mental disorder. *Northwest Suburban Special Education Organization v. Industrial Comm'n*, 312 Ill. App. 3d 783, 787, 728 N.E.2d 498, 501, 245 Ill. Dec. 416 (2000). Mental disorders which develop

over time in the normal course of the employment relationship do not constitute compensable injuries. *Northwest Suburban Special Education Organization*, 312 Ill. App. 3d 783, 788. *Matlock v. Indus. Comm'n*, 321 Ill. App. 3d 167, 171 (2001).

The Petitioner did not testify as to any physical trauma or injury, and therefore is seeking compensation based on a “mental-mental” theory of recovery. At the outset, the Arbitrator notes Petitioner did not testify as to a single work event which constituted a “sudden severe emotional shock traceable to a definite time and place.” The Petitioner must prove by a preponderance of the evidence that (1) the mental disorder arose in a situation of greater dimensions than the day-to-day emotional strain and tension which all employees must experience; (2) the conditions exist in reality, from an objective standpoint; and (3) the employment conditions, when compared with the nonemployment conditions, were the major contributing cause of mental disorder. For the reasons set forth below, the Arbitrator finds Petitioner failed to satisfy his burden on all three counts.

The Petitioner testified to the stress he experienced while working for Respondent as a pharmacist, which he believed was caused by Respondent’s “metrics” (i.e., the requirement to pre-verify or verify 30 prescriptions per hour), the Respondent’s use of automation in the form of machines to fill prescriptions and a conveyor belt system to send the filled medicine bottles to the pharmacist, and the Respondent’s outdated computer system.

Regarding the metrics, in his opinion, the number of prescriptions required to be entered, verified, and checked per hour was “unbearable and overwhelming” and the pharmacist was required to meet with a supervisor on a monthly basis to discuss whether he or she was meeting the requirements per the metrics, and if the pharmacist was not meeting the metrics, he or she would be told they needed to meet the requirements. This added stress to the pharmacist’s job and made them error-prone and thus less safe for the patients. He also testified that during his tenure, Respondent’s mail-order pharmacy was understaffed, leading to increased burdens for the pharmacists to meet the metrics.

Respondent’s pharmacy manager, Shelby Taylor, who was Petitioner’s supervisor, agreed that the metric for both pre-verification and verification was to process 30 prescriptions per hour. During the time the mail-order pharmacy was in Oak Forest, there were 22 pharmacists and 35 technicians. In his experience working for retail pharmacies, specifically Walmart pharmacies, the volume of medications dispensed by those Walmart locations was significantly higher than dispensed by Respondent. The Walmart system for verification differed from that used by Respondent, and in his opinion the duties for a pharmacist with Respondent were about half that of the duties for a Walmart pharmacist. Specifically, a pharmacist at Walmart performs both the pre-verification and verification duties, while a Cook County pharmacist performs one or the other activities per day, but not both.

Mr. Taylor testified as to the difference in metrics between working for Respondent and working for a retail pharmacy. For Respondent, a pharmacist is responsible for processing 30 prescriptions per hour over the course of a seven-hour shift. In a retail setting, a pharmacist is evaluated on different measurements, such as on-time percentage or the customer’s wait time, or if the prescription is dropped off, was the prescription filled within a two-hour time frame.

Regarding the monthly meetings which Petitioner found to be so stressful, Mr. Taylor testified that a pharmacist working for Respondent would only be disciplined for intentional errors, but not for a system or human error. Rather, he would meet with the pharmacist for coaching or counseling and with the department to educate them to avoid mistakes in the future. In his experience as pharmacy manager for Respondent, he never had to discipline a pharmacist for failing to meet performance metrics; most people will have “a day or two here or there where they don’t meet their metrics, and that’s not really a big deal.” (12/10/24 Tr. 59) It’s only a problem if the pharmacist is consistently not meeting the metrics. (*Id.*)

As for Petitioner, Mr. Taylor never disciplined him or had any counseling/coaching sessions, does not recall having any conversations with Petitioner for failing to meet his metrics and to his recollection, Petitioner consistently met his metrics, and he has no recollection of any medication errors by Petitioner.

Regarding the pill machine and conveyor belt system, Mr. Taylor testified that the purpose was not to push the pharmacists and technicians to work faster and beyond reasonable capabilities, but rather to make the job easier by dispensing with the need for the pharmacists to physically move totes of medications and pill bottles from one location to another.

Regarding the software used by Respondent, Mr. Taylor testified the computer software used in 2016 was not as advanced as some pharmacies (Walmart and Walgreens), but more advanced than other pharmacies (CVS).

Overall, it was Mr. Taylor’s opinion that the stress of working in a retail pharmacy setting was greater than the stress of working at Respondent’s mail order pharmacy. To some degree, the Petitioner’s testimony and research supports this assertion, given his contention the pharmacy industry in general places greater value on profits over the well-being of its pharmacists, which is perhaps a relevant argument regarding the retail pharmacy sector but not a persuasive argument regarding Respondent, which is a government public health entity.

Finally, the medical records make reference to Petitioner suffering from mental illness prior to his suicide attempt in September 2016, a history which Petitioner downplayed during his testimony. The Petitioner cannot deny, however, that he was hospitalized at Advocate Good Samaritan Hospital from August 22, 2015, through September 11, 2015, during which he was diagnosed with major depressive disorder, chronic and recurrent. (RX 3A, pp. 1-8) According to the History of Present Illness set forth in those records, Petitioner “has a long psychiatric history dating back to 1996.” (*Id.*, p. 1)

The Past Psychiatric History section of the Advocate Good Samaritan Hospital records from August 22, 2015, states that the patient reports at least 5 prior psychiatric hospitalizations, the most recent in March 2015, and that he has followed up with various psychiatrists on an outpatient basis. He was under the care of Dr. Nazeer at the Dreyer Clinic for the past 6 months, who had prescribed various medications (escitalopram, Lamictal, Klonopin, and Lexapro). The Petitioner provided a list of 17 other medications that he been prescribed since 1996, noting that none of the medications had helped.

The Past Personal History provided by Petitioner in those records notes that he works at Cook County Hospital as a pharmacist, noting that it is “a stressful job, with horrible working conditions.” (RX 3A, p. 2) He denied any suicidal or homicidal ideation but did relate a history of 2 prior suicide attempts, once by an overdose of Prozac and the other by an overdose of nitroglycerin tablets. (*Id.*)

Even after Petitioner left Respondent’s employment in 2016, he continued to treat for various psychiatric conditions (depression, anxiety, panic disorder, bipolar disorder) on a fairly regular basis, both as an inpatient and outpatient basis, from 2016 through 2024. The histories in those records refer to the stress Petitioner felt he experienced as a pharmacist, but also make reference to issues with prior employers (e.g., fired from Walmart), marriage issues (two marriages ending up in divorce), family issues (anger at deceased father, conflicts with mother and brother), financial issues (father who allegedly squandered a large sum of money and left Petitioner responsible for supporting the family, his inability to return to work as a pharmacist, and possible bankruptcy), and cultural issues (unrealistic expectations he feels are placed upon Indian men).

In the opinion of Dr. Reff, while the Petitioner’s employment as a pharmacist, and the stress Petitioner perceived he was under in that position, was a contributing factor to his psychiatric condition, the work for Respondent was but one of multiple things in Petitioner’s life that likely contributed to his condition and led to the suicide attempt in 2016, but the primary causal factor was not his job so much as it was his underlying mental health issue.

Applying the above to the three factors noted in the *Northwest Suburban Special Education Organization* and *Matlock* cases, the Arbitrator finds Petitioner did not satisfy these factors. First, his mental disorder did not arise in a situation of greater dimensions than the day-to-day emotional strain and tension which all employees must experience. The Arbitrator is persuaded by the testimony of Shelby Taylor that the conditions at the Respondent’s mail-order pharmacy were no worse than the conditions faced by all employees: all employees are subject to performance expectations set by their employer, engage in meetings with their supervisors regarding their performance, and at times face problems caused by mechanical/hardware or computer software issues. In addition, Mr. Taylor testified that while the pharmacy profession can be stressful in a general sense, the stress of working at a retail pharmacy is greater than the stress of working for Respondent in their mail order pharmacy.

Second, the Arbitrator is not persuaded that the alleged working conditions, as described by Petitioner, existed in objective reality. Petitioner describes “overwhelming and unbearable” working conditions, in which the pharmacists were pitted against each other to meet the requisite metrics or face dire consequences. Mr. Taylor, however, testified that he, as the pharmacy manager, understood that his employees would occasionally fail to meet the metrics and “it was not a big deal,” and that the employees were coached or counseled on how to improve performance and reduce mistakes. In fact, neither Petitioner nor Mr. Taylor testified to one instance in which Petitioner was disciplined in any manner for failure to meet the metrics or for medication errors.

Third, the Arbitrator is persuaded by the opinion of Dr. Neff that while the Petitioner’s work experience may have contributed to the deterioration of his mental health condition, the primary cause of his suicide attempt in 2016 was his preexisting, underlying and longstanding

mental illness. The fact that Petitioner continued to require both inpatient and outpatient psychiatric treatment long after he stopped working for Respondent supports the notion that the nonemployment conditions were the major contributing cause of Petitioner's mental disorder.

Overall, the Arbitrator finds Petitioner's mental disorder developed over time, both before, during and after the normal course of his employment relationship with Respondent. Such does not constitute a compensable work injury. See *Northwest Suburban Special Education Organization*, 312 Ill. App. 3d 783, 788 (2000). *Matlock v. Indus. Comm'n*, 321 Ill. App. 3d 167, 171 (2001).

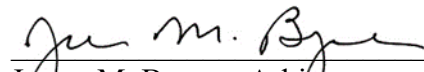
Based on the record as a whole, the Arbitrator finds Petitioner failed to prove by a preponderance of the evidence that he sustained accident arising out of and in the course of his employment with Respondent on September 21, 2016.

Regarding Issues (D) Date of Accident, (E) Notice, (F) Causal Connection, (J) Medical Treatment, (K) Temporary Total Disability, and (L) Nature and Extent of the injury, the Arbitrator finds as follows:

The Arbitrator having found that Petitioner failed to prove that he sustained an accident arising out of and in the course of his employment with Respondent on September 21, 2016, the remaining issues of Date of Accident, Notice, Causal Connection, Medical Treatment, TTD, and Nature and Extent, are moot.

Petitioner's claim for compensation is hereby denied.

IT IS SO ORDERED:


James M. Byrnes, Arbitrator

March 24, 2025

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	22WC011563
Case Name	Lisa Hartline v. State of Illinois - Choate Mental Health Center
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	25IWCC0505
Number of Pages of Decision	22
Decision Issued By	Frank Soto, Commissioner

Petitioner Attorney	Thomas Rich
Respondent Attorney	Shannon Rieckenberg

DATE FILED: 12/22/2025

/s/ Frank Soto, Commissioner

Signature

22 WC 11563

Page 1

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)
☐ Modify	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lisa Hartline,

Petitioner,

vs.

NO: 22 WC 11563

State of Illinois – Choate Mental Health Center,

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, medical expenses, TTD benefits, nature and extent, and prospective 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 May 16, 2025 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.

22 WC 11563

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IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Illinois Workers' Compensation 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.

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

December 22, 2025

O: 12/10/25

FJS/mek

046

/s/ Frank J. Soto

Frank J. Soto

/s/ Carolyn M. Doherty

Carolyn M. Doherty

/s/ Raychel A. Wesley

Raychel A. Wesley

ILLINOIS WORKERS' COMPENSATION COMMISSION
DECISION SIGNATURE PAGE

Case Number	22WC011563
Case Name	Lisa Hartline v. State of Illinois - Choate Mental Health Center
Consolidated Cases	
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	19
Decision Issued By	Bradley Gillespie, Arbitrator

Petitioner Attorney	Thomas C Rich
Respondent Attorney	Shannon Rieckenberg

DATE FILED: 5/16/2025

/s/ Bradley Gillespie, Arbitrator
Signature

INTEREST RATE WEEK OF MAY 13, 2025 4.11%

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



May 16, 2025

/s/ Michele Kowalski

Michele Kowalski, 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
19(b)

Lisa Hartline
 Employee/Petitioner

Case # **22** WC **011563**

v.

Consolidated cases: _____

State of IL / Choate Mental Health Center
 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 **Bradley Gillespie**, Arbitrator of the Commission, in the city of **Mt. Vernon, Illinois**, on **March 20, 2025**. 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, **04/15/2022**, 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 **\$5,271.60**; the average weekly wage was **\$820.03**.

On the date of accident, Petitioner was **45** 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 **\$TTD paid in 18WC023086 – 04/26/2022-08/15/2022** for TTD, **\$N/A** for TPD, **\$N/A** for maintenance, and **\$5 service connect days** for other benefits, for a total credit of **\$TTD paid in 18WC023086 – 04/26/2022-08/15/2022 + 5 service connect days**.

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

ORDER

Respondent shall pay the reasonable and necessary medical services outlined in Petitioner's group exhibit, 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 authorize and pay for the prospective treatment recommended by Dr. Bradley, including, but not limited to, right total knee replacement surgery.

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.

Bradley D. Gillespie

Signature of Arbitrator

MAY 16, 2025

work, and she was stuck in that position. (Tr. pp. 17-18) She testified that with everything going on, it was difficult to say exactly what she did, but she testified that she injured and bruised both of her knees, her right hip, and her lower back. (Tr. p. 17)

She testified she had previous treatment to her right knee which included a right meniscus repair around the year 2000, following which she returned to work. (Tr. pp. 18-19) She testified that she had a meniscus repair of the right knee in June 2021. *Id.* Following her June 2021 surgery, she testified she was released in September 2021 and that her right knee was “very good” and had healed very well. (Tr. pp. 19, 40) She testified that just prior to her April 15, 2022, accident, she was not having symptoms in her right knee. (Tr. p. 19)

Background/Medical Evidence Pre-Accident

Prior to the instant claim, Petitioner filed an Application for Adjustment of Claim with respect to date of accident of February 9, 2018, bearing case number 18 WC23086. (PX 10) Petitioner’s claim for this date of injury was tried at Arbitration pursuant to Petitioner’s 19(b) Petition on October 1, 2019, and an Arbitration decision was rendered on December 27, 2019. *Id.* The decision was appealed to the Commission (20IWCC0630), who filed a decision on October 20, 2020, and remanded to the Arbitrator for further proceedings. *Id.* The findings of the Commission are noted and incorporated by reference herein. The prior decision indicates that Petitioner was working for Respondent on February 9, 2018, when she twisted to her right while her weight was on her left leg, causing a loud pop and immediate severe pain in her left knee. *Id.* Petitioner ultimately underwent left knee surgery with Dr. Lehman on July 16, 2018, in the form of a left knee arthroscopy with partial meniscectomy, debridement of medial femur and trochlea, and articular cartilage reconstruction. (PX 10) On October 10, 2018, during Petitioner’s preoperative course, it was noted that her right knee was bothering her more than her left knee and that she had been compensating and using her right side since her surgery. *Id.* An MRI of Petitioner’s right knee was performed on October 30, 2018, which revealed mild-to-moderate degenerative fraying of the medial meniscus, joint effusion, mild chondromalacia of the patella, and a 9 mm ganglion cyst arising from the posterior tibiofibular joint. *Id.*

The Arbitrator found in favor of Petitioner with respect to her bilateral knees on December 16, 2019. (PX 10) Respondent appealed the decision. *Id.* The Commission adopted the Arbitrator’s findings and conclusions with respect to the left knee medial meniscus tear, but reversed the decision as to Petitioner’s right knee injury and did not find that she suffered an overuse injury to the right knee. *Id.* The Commission noted Dr. Lehman’s testimony that according to the MRI, Petitioner’s symptoms could either be meniscal or arthritic, and they noted that the October 30, 2018, MRI indicated no evidence of a tear in the right knee. *Id.*

On July 20, 2020, Petitioner returned to Dr. Lehman for right knee pain. (PX 4 p. 2) Dr. Lehman noted that an MRI showed her right knee medial meniscus was torn. *Id.* His assessment

was acute pain of the right knee. *Id.* He called in stronger pain medication, as he believed Petitioner needed it while she waited for surgery approval. *Id.*

On March 16, 2021, Petitioner returned to Dr. Lehman for her bilateral knees. (PX 4 p. 4) For the left knee, he recommended anti-inflammatories and HA injections. *Id.* With respect to the right knee, he reviewed her prior MRI, which showed a medial meniscus tear. (PX 4 p. 6) He discussed arthroscopy, meniscus repair and debridement of the patellofemoral joint versus a total knee replacement. *Id.*

On June 7, 2021, Petitioner underwent surgery with Dr. Lehman in the form of a right knee arthroscopic partial medial and lateral meniscectomy, plica synovialis resection, and debridement of the medial femur, patellofemoral articulation, trochlea, patella, lateral tibial plateau, and infrapatellar fat pad. (PX 4; PX 6) Intraoperatively, Dr. Lehman noted that there was a significant breakdown over the medial meniscus, a horizontal cleavage tear, and a significant tear posteriorly. (PX 6 p. 2)

At Petitioner's initial postoperative visit of June 21, 2021, Dr. Lehman noted that he was pleased with Petitioner's progress. (PX 4 p. 16) He recommended a home exercise program, a home stimulation unit, and physical therapy. *Id.* At Petitioner's July 20, 2021, postoperative visit, Dr. Lehman noted that he was pleased with her progress and that there were no complaints or modifying factors. (PX 4 p. 19, 22) He instructed her to work on muscle strengthening. *Id.* That same day, he saw Petitioner for her left knee and noted that she had ongoing discomfort in same. *Id.* he recommended anti-inflammatory medication, home exercise program, and injections. *Id.* Dr. Lehman gave her a hyaluronic acid injection. (PX 4 p. 19)

Petitioner returned to Dr. Lehman on August 5, 2021, with symptoms of left knee pain. (PX 4 p. 25) Hyaluronic acid injections were administered into Petitioner's left knee that day. *Id.*

Petitioner returned to Dr. Lehman on August 19, 2021. (PX 4 pp. 28-29) With respect to the left knee, he noted that she had left knee pain. *Id.* X-rays were taken, which revealed degenerative arthritis of the patellofemoral joint, but well maintained medial joint space. (PX 4 p. 28) Based on her x-ray, he did not feel she was a candidate for a left knee total knee arthroplasty. *Id.* With respect to Petitioner's right knee, Dr. Lehman noted that if Petitioner had a sedentary, no patient contact job he would feel comfortable sending back to work; however, with her current employment, he was not comfortable doing so and wanted Petitioner to continue strengthening her knee. (PX 4 p. 31) Petitioner reported that she was exercising, walking, and biking, and that she took medication the days she was active. *Id.* No other complaints or modifying factors were noted. *Id.*

On September 28, 2021, Petitioner returned to Dr. Lehman for her right knee. (PX 4 p. 34) He noted that her motion and mechanics were good, and he felt she should continue strengthening her knee. *Id.* He was "really pleased" with her postoperative progress and felt that as her knee became stronger, it would feel better. *Id.* He stated, "if things continue to go this well, I will

medically release pt in 3-4 weeks” and indicated that he gave her a tentative mid-October date for same. *Id.* On exam of the right knee, he noted that her joints were calm, there was no fluid, and that her joint line was not tender. (PX 4 p. 35) She was kept off work pending approval for an injection to her left knee. (PX 4 p. 34)

On January 13, 2022, Petitioner presented to the office of Dr. Matthew Bradley for left knee pain. (PX 7 p. 2) He took the history of her prior 2018 injury and subsequent treatment. *Id.* He noted her history of a right knee meniscus tear, and that Dr. Lehman felt this was due to compensation for her left knee injury. *Id.* He noted she had a meniscus repair on the right knee by Dr. Lehman in June 2021 and that since then, her left knee had flared up. *Id.* He indicated that injections gave her short term relief in the left knee. (PX 7 p. 2) A left knee exam and x-ray were performed and Dr. Bradley indicated that she had medial joint space narrowing with bone-on-bone in the left knee. (PX 7 p. 3) His assessment was left knee medial joint arthropathy. *Id.* He recommended an MRI arthrogram, home exercise program, and utilization of Tylenol and ibuprofen. *Id.* He indicated that given the severity of her chondrosis, she would likely require some degree of arthroplasty. *Id.* She was placed on work restrictions for her left knee. *Id.*

On January 27, 2022, Petitioner returned to Dr. Bradley’s office, where he read her left knee MRI and noted there was a complex tear to the posterior horn of the medial meniscus that seemed to involve the posterior root of the meniscus. (PX 7 p. 6) He noted that Petitioner had no change in her symptoms and felt significant daily pain in her left knee. *Id.* He felt a left knee total knee arthroplasty was the only reliable way to improve her function and pain. *Id.* She was kept on restricted duty for the left knee only. (PX 7 p. 8)

On March 14, 2022, Petitioner returned to Dr. Bradley and indicated that she had severe medial-sided knee pain in the left knee. (PX 7 p. 9) He noted that she was currently utilizing diclofenac and Voltaren gel with minimal relief. (PX 7 p. 11) He indicated that she wished to proceed with his recommended surgical intervention. *Id.* She was kept on work restrictions. *Id.* There was no documentation of right knee symptoms or pain. *Id.*

MEDICAL EVIDENCE – POST-ACCIDENT

On April 15, 2022, Petitioner presented to Convenient Care Clinic and reported pain in her bilateral knees, low back, and buttocks. (PX 3 p. 1) It was noted that both knees were hurting, bruised, throbbing, and stabbing. *Id.* It was noted that she worked at Choate, was breaking up a fight with residents, and “went down to her knees hard during a scuffle at work.” (PX 3 p. 2) She was holding the resident down and was in that position for several minutes until the situation was controlled. *Id.* It was noted that she was twisted and that she also strained her back. *Id.* She worked the rest of her shift but had increased pain that night. *Id.* It was noted that she had worked that day, but she sat for most of her shift. (PX 3 p. 2) She reported she had previously had surgery on the right knee and was scheduled to have a left knee replacement. *Id.*

On exam, it was noted that Petitioner was in obvious discomfort and was limping and ambulating slowly. (PX 3 p. 2) She had crepitus to her bilateral knees on extension, and tenderness of the right lumbar paravertebral muscles. (PX 3 p. 4) The assessments were 1) pain of right knee joint, 2) pain of left knee joint, 3) low back strain, and 4) acute low back pain. *Id.* She was given prescriptions for hydrocodone, tramadol and cyclobenzaprine, and was instructed to rest, use ice and elevation, and to follow up with an orthopedic physician. *Id.* X-rays were ordered, and it was noted that she would be called with the results the following day. *Id.*

X-rays taken that day showed mild tricompartmental osteoarthritis of both knees, as well as trace joint effusion in the right knee only. (PX 3 p. 5)

On April 25, 2022, Petitioner presented to Dr. Bradley with right knee pain following a new injury at work. (PX 7 p. 12) He noted that a patient attacked a staff member in another room, that Petitioner jumped in to get control, that that she had the patient down until a nurse came to assist. *Id.* He noted that another patient tried to involve himself in the altercation, and after the patient was extracted, Petitioner was unable to move due to being on her knees for an extended period. *Id.* He noted that she had pain in her right groin. *Id.*

Dr. Bradley noted he previously recommended Petitioner be in a desk work only capacity; however, she attended an IME appointment where she was placed at full duty and proceeded to be attacked and injured. (PX 7 p. 12) On exam of the right knee, Petitioner had positive McMurray's testing with pain catching and clicking. (PX 7 p. 13) Her left knee showed mild ecchymosis to the anterior tibia. *Id.* X-rays of her bilateral knees were taken, and the right knee showed medial joint space narrowing. *Id.* The left knee showed severe medial narrowing with bone on bone deformity. *Id.*

Dr. Bradley's assessment was left knee arthropathy, right hip contusion with possible labral tear, and right knee contusion with possible medial meniscus tear. (PX 7 p. 14) He recommended MRIs of the right hip and right knee. *Id.* He noted that Petitioner was scheduled to have her left knee replaced and he felt it was safe for her to proceed with same. *Id.*

On April 26, 2022, Petitioner underwent a left total knee arthroplasty with Dr. Bradley. (PX pp. 16-19; PX 9) At Petitioner's initial postoperative visit of May 9, 2022, Dr. Bradley noted that she had significant swelling in her left knee, was using crutches to ambulate, and was taking Percocet and Valium daily. (PX 7 p. 19) She was kept off work. (PX 7 p. 21)

On June 27, 2022, Petitioner returned to Dr. Bradley for a follow up of her left total knee replacements where it was noted that she was doing very well. (PX 7 p. 22) He noted that with respect to her right knee, she continued to have pain along the medial aspect which felt similar to when she tore her medial meniscus several years prior. *Id.* She had undergone a right knee MRI that morning, but the images were not yet available. *Id.* She reported that her right hip pain had resolved. *Id.* For her left knee, he recommended continuation of physical therapy and utilizing Percocet on an as-needed basis. (PX 7 p. 24) He indicated that her right knee had findings

consistent with a medial meniscus tear, but that he would follow up with her in four weeks to go over the findings of the MRI. *Id.* She was kept on work restrictions. *Id.*

Petitioner returned to Dr. Bradley on August 8, 2022. (PX 7 p. 26) He noted that just prior to undergoing her left knee arthroplasty, she was supervising 20 individuals when there was an attack where and she went to the ground on both knees which caused visible bruising on same. *Id.* He noted that she continued to have difficulty with kneeling and had lateral lower extremity pain with repetitive use. *Id.* He noted that her right knee continued to be painful and that she had pain with steps and squatting. *Id.*

Dr. Bradley reviewed her June 27, 2022, right knee MRI and indicated that it showed blunting of the free margin of the body of the medial meniscus likely related to prior partial medial meniscectomy. (PX 7 p. 27) There was no evidence of recurrent tear. *Id.* There was a 13×7 mm full thickness chondral defect involving the posterior weight-bearing lateral femoral condyle. *Id.* There was mild-to-moderate medial compartmental osteoarthritis, mild patellofemoral osteoarthritis with areas of grade II to III chondrosis throughout the mid to inferior patellar apex, and diffuse articular cartilage loss throughout the femoral trochlea. (PX 7 pp. 27-28)

Dr. Bradley believed Petitioner was doing well status post left knee arthroplasty, and that she experienced an exacerbation of her underlying degenerative right knee disease. (PX 7 p. 28) For the left knee, he recommended continuation of her home exercise program and utilization of Tylenol and ibuprofen. *Id.* With respect to her right knee, he noted that she was already using anti-inflammatory medication and performing home exercise, and that she should continue same. *Id.* He recommended a steroid injection to the right knee and same was performed in his office that same day. *Id.*

On October 17, 2022, Petitioner returned Dr. Bradley, who noted that she was doing great with her left knee. (PX 7 p. 29) He felt her strength and range of motion were excellent. *Id.* Her greatest complaint was medial-sided right knee pain which mostly occurred with prolonged standing and use. *Id.* Dr. Bradley's assessment was that Petitioner was doing well status post left knee total arthroplasty and that she had an aggravation of the underlying degenerative disease in her right knee. (PX 7 p. 31) He indicated that she had a new job which allowed her to work from home without prolonged standing, and that she had a home exercise program for her bilateral knees. *Id.* He placed her at maximum medical improvement for her left knee. *Id.* With respect to the right knee, he felt that she continued to suffer an aggravation. *Id.* He noted they had been treating the right knee nonoperatively, including a steroid injection at her last visit. (PX 7 p. 31) He noted that her pain was bothersome, but not limiting and that she would continue to treat same non-operatively. *Id.* He indicated she could follow up on her right knee in three months or on a PRN basis. *Id.*

On June 12, 2023, Petitioner returned to Dr. Bradley for a follow up of her severe right medial knee pain. (PX 7 p. 32) She was doing well with respect to her left knee replacement. *Id.*

She had some occasional achiness at night but same was resolved with rest and ibuprofen. *Id.* With respect to her right knee, she had increasing pain along the medial aspect. (PX 7 p. 23) Ice, elevation, home exercise, and activity modification had failed to provide relief. *Id.* Dr. Bradley stated that she had fairly severe bone-on-bone arthritis, but that she wished to be treated nonoperatively. (PX 7 p. 35) He recommended anti-inflammatory medication, ice, compression therapy, a neoprene knee sleeve, and a corticosteroid injection, the latter of which was performed that same day in his office. *Id.* Petitioner was returned to work with no restrictions. *Id.*

On September 18, 2023, Petitioner returned to Dr. Bradley and reported that the injection gave her minimal relief for just a few days. (PX 7 p. 36) Dr. Bradley stated that he again discussed Petitioner's April 2022 right knee injury and found her right knee had been hurting since. *Id.* He noted Petitioner made a full recovery following her previous right knee surgery and was able to return to work with no restrictions to the right knee. *Id.* He stated that her June 2022 MRI showed the partial meniscectomy and areas of chondral defect and chondrosis. (PX 7 p. 39) Dr. Bradley recommended another right knee MRI. *Id.*

On October 12, 2023, Petitioner underwent an MRI arthrogram of her right knee, which showed abnormal midbody medial meniscus and anterior horn, presumably due to prior resection without definite acute tear. (PX8) There were adjacent degenerative changes with subchondral bone marrow changes and chondral thinning that were likely related and appeared to be chronic. *Id.* There was an MCL sprain, which was possibly acute, and patellofemoral degenerative changes. *Id.*

That same day, Petitioner returned to Dr. Bradley, who reviewed her MRI. (PX 7 p. 40) He appreciated a complete extrusion of her medial meniscus outside of her knee as well as bone and bone deformity medially. (PX 7 p. 42). He appreciated cartilage loss to the central portion of the trochlea and patella. *Id.* He noted that she had increasing medial right knee pain and a feeling of instability. *Id.* Dr. Bradley opined Petitioner sustained an injury to her bilateral knees when she fell on April 15, 2022, and that this caused ecchymosis and pain in both her knees. *Id.* He stated that her left knee was treated with a total knee arthroplasty, but she continued to have pain in the right knee. (PX 7 p. 42) He indicated she took a desk job with less activity and had less pain in her knee, but with the change of seasons and whether she noticed increased medial-sided pain. *Id.* His assessment was aggravation of underlying right knee arthritis. *Id.* He noted she had tried and failed non-operative treatment and recommended proceeding with a right knee replacement. *Id.*

SECTION 12 REPORTS AND DEPOSITION OF DR. FARLEY

At Respondent's request, Petitioner attended a Section 12 examination with Dr. Farley on December 21, 2021, in reference to her prior 2018 injury. (PX 12) He noted that she had left knee surgery in July 2018. (PX 12 p. 2) He noted that between January 2019 and March 2021, she was dealing with a right knee condition. *Id.* He noted that her current symptoms were pain, stiffness, weakness, loss, and sense of instability in the left knee and his diagnosis was symptomatic arthritis

of the left knee. *Id.* He indicated that she had no signs of symptom magnification. (PX 12 p. 7) He did not note any right knee symptoms or pain. (*See generally* PX 12) Dr. Farley diagnosed her with varus osteoarthritis of her left knee. (PX 12 p. 7) He did not think the surgery performed on July 16, 2018, was indicated and may have caused her degeneration to accelerate. *Id.* Dr. Farley recommended viscosupplementation and possible knee replacement. *Id.*

At Respondent's request, Petitioner submitted to a Section 12 examination with Dr. Timothy Farley on June 11, 2024. (RX 2) He noted that during her April 2022 injury, she discovered a staff member being attacked and "went to the ground," impacting both knees. (RX 2 p. 2) He noted that she was on the ground for some time trying to hold the attacker still, that after this, she had bilateral knee as well as back pain, and that she sat to the side on the ground for an extended period of time after the event before eventually being helped up. *Id.* He reviewed Petitioner's medical records and noted that she had a left knee partial medial meniscectomy in 2018, a right knee partial medial meniscectomy in June 2021, and a left total knee replacement in 2022. *Id.* He indicated that she returned to work full duty in September 2021. *Id.* He noted that after her release in September 2021, she had no complaints in her right knee. (RX 2 p. 5)

Regarding causation, he did not believe her right knee was related to her April 15, 2022, accident, and stated that she had degenerative changes with complaints from 2018 until September 2021 and that she "then had further complaints in April of 2022." (RX 2 p. 6)

He opined that the partial medial meniscectomy in June 2021 might have hastened the progression of her arthritis and opined that her arthritis would have become symptomatic with or without the injury in April 2022. *Id.*

He did not believe her mechanism of injury in April 2022 represented "an appropriate mechanism to *cause* the pathology." *Id.* [emphasis added]

He did not believe her medical treatment to date was related to the work accident because "treatment is typically required episodically with degenerative arthritis." *Id.* He opined that knee replacement could be considered due to Petitioner's symptoms, but that same was unrelated to the work accident. *Id.*

Dr. Farley testified via deposition on August 27, 2024. (RX 3) Respondent's counsel indicated that the focus of the deposition was with respect of Petitioner's right knee. (RX 3 p. 7) On direct examination, Dr. Farley testified consistently with his June 11, 2024, report. He felt that Petitioner's right knee meniscus scope in 2021 dealt with the meniscus tear but did not do anything for the arthritis. (RX 3 pp. 14-15) He opined that "almost assuredly" Petitioner would have had symptoms in her right knee without the work accident. (RX 3 p. 18)

On cross examination, he testified that he performs two to three IMEs per week, which are typically at the request of the defense. (RX 3 pp. 20-21)

He testified that in his December 2021 report, he “didn’t really get into” her right knee. (RX 3 p. 22) He testified that he was not provided with any treatment records from September 2021, through April 15, 2022, which indicated Petitioner had sought treatment for right knee symptoms. (RX 3 p. 24) Dr. Farley admitted that Petitioner reported she did not have symptoms during that interim. (RX 3 pp. 24-25) He testified that it was possible that Petitioner’s fall on her knee could have caused an aggravation of her underlying condition. (RX 3 pp. 25-26) Dr. Farley was not aware of any interval trauma to Petitioner’s right knee following her work accident. (RX 3 p. 29)

Regarding Petitioner’s baseline, Dr. Farley was asked:

Q. And she has not -- as of the date of your examination, she had not returned to her baseline in her right knee as it was before the April 15, 2022, accident, correct?

A. I don't know. (RX 3 p. 27)

DEPOSITION OF DR. MATTHEW BRADLEY

Dr. Bradley testified via deposition on April 3, 2024. (PX 11) He testified that he is a board-certified orthopedic specialist who treats knee conditions every day. (PX 11 p. 7) He stated his treatment of same makes up one-third of his practice. *Id.*

Dr. Bradley testified that when he saw Petitioner for her left knee on March 14, 2022, she did not report any right knee pain. (PX 11 pp. 15-16) He stated after Petitioner’s April 25, 2022 accident, she had significant pain in her right knee. (PX 11 pp. 16-17) He testified that her mechanism of injury of April 25, 2022 was consistent with her symptoms and exam findings, noting:

It was a scuffle with a patient. She fell and hurt herself. He was resisting getting calmed down or restrained. During these kind of things you typically see some twisting injuries. When people go to the ground, you see impact injuries that puts a little bit of force into the hip and a twist in the knee. I see these kind of injuries quite frequently with my mental health technicians or my correctional officers. They are trying to subdue a patient or restrain a client. (PX 11 p. 18)

Dr. Bradley testified that it was unclear whether or not there was a twisting-type mechanism, but that Petitioner had subsequent pain following her accident. (PX 11 p. 45) He felt that whether Petitioner had twisted did not matter much because she had bruising on her knees, which showed the severity of the force of her fall. (PX 11 pp. 45-46)

Dr. Bradley testified that when Petitioner returned to him on October 17, 2022, she was still having right knee pain and that they decided to treat it non-operatively to see what would happen over the next few months. (PX 11 p. 24) He testified that when she returned on June 12, 2023, she had been doing everything that he had instructed her to do, namely, using ice, elevation, exercise, and avoidance of heavy lifting and impact activities, but continued to have increased

pain. (PX 11 pp. 24-25) He testified Petitioner did not report any intervening accidents. (PX 11 p. 25)

With respect to causation regarding the work accident of April 15, 2022, Dr. Bradley noted Petitioner had a prior injury and surgery to her right knee as well as pre-existing arthritis, but that since the surgery, she returned to work full duty for her right knee until the accident, at which point her pain became severe. (PX 11 pp. 28-29) He stated that she had bruises over the front of both knees showing the amount of force and energy that went into her knee. (PX 11 p. 29) He opined it was not the fall that caused the chondrosis or the meniscus to be partially resected, but the fall caused it to become painful, and he was not able to get the pain to settle back down. *Id.* He testified she had an exacerbation of her underlying condition as a result of the accident. *Id.*

Dr. Bradley opined that Petitioner's history of right knee treatment made her more susceptible to having a new injury. (PX 11 p. 29) He explained that taking away the knee's ability to absorb energy and trauma left her more susceptible to an injury such as she had. *Id.* Dr. Bradley felt the recommended right knee replacement was causally related to her April 15, 2022, accident as the it caused an exacerbation of her underlying disease which failed nonoperative treatment. (PX 11 p. 30) He felt the need for surgery was a direct result of the April 15, 2022 injury. *Id.*

Dr. Bradley testified the only reason to perform surgery is pain, and that the reason a knee replacement was chosen over another procedure such as a scope had to do with the loss of cartilage and loss of a portion of the meniscus. (PX 11 p. 59)

In discussing Petitioner's right knee, he testified that Petitioner was working in a job where she was employed with desk work only. (PX 11 p. 62) He testified that if she had stayed at her previous job where she had to have interaction with patients who could become violent, he would have had to discuss whether her pain would place her or her colleagues at risk, and that she may or may not have been able to perform full duty work. (PX 11 p. 63)

With regard to her exacerbation injury to the right knee, he testified:

She has never had a period where her pain went back to its baseline and was sustained there for any period of time. If you look at my notes, most of it is pain, pain, increasing pain, and now she has severe pain. The word "exacerbation" may not be there. She exacerbated it several months ago, and it has continued the whole time. Never once do you see me document in my notes, "For the last six months she has been pain free. She returned to duty pain free, and everything is great," and now it is painful again. We never got to that point. (PX 11 p. 53)

DOCUMENTARY EVIDENCE

An Illinois Form 45 injury report prepared by Anjeanette Felix documented that on April 15, 2022, Petitioner was helping staff who was being attacked, and that she suffered bruising and pain to both knees, her lower back, buttocks, and right leg. (RX 1) A handwritten notice of injury

prepared by Petitioner indicated that Petitioner applied a physical hold to the individual while on her knees, and that she suffered left knee pain with radiation down to her foot and swelling, bruising, and throbbing, right knee pain in the posterior and medial areas with swelling, bruising and stabbing pain, as well as soreness to her right low back and buttocks. *Id.* A witness report completed by Melissa Clark indicated that Petitioner had to have assistance getting up from the floor. *Id.* A supervisor's report indicated corroborated the other reports and indicated Petitioner had throbbing, swelling, and bruising to her bilateral knees.(RX 1) The supervisor indicated that the cause of the accident was a recurrent issue of the unit being understaffed around aggressive individuals. *Id.*

PETITIONER'S TESTIMONY CONTINUED

Petitioner testified that the notation in her April 16, 2022, records of a golf cart injury the Thursday before her accident was inaccurate and that the incident with the golf cart occurred in 2017 and did not involve her right knee at all. (Tr. pp. 20-21)

Regarding her return to work following her June 2021 right knee surgery, she testified that she wanted to return to work but was scared to do so for fear of injury because she knew they were short staffed and that a lot of attacks were happening. (Tr. p. 33)

She testified that prior to April 15, 2022, Dr. Bradley had never recommended treatment to her right knee. (Tr. pp. 21-22) She testified that she lost 70 pounds after April 26, 2022, and continued to have right knee pain despite her weight loss. (Tr. pp. 26, 41-42)

Petitioner testified that she asked Dr. Bradley to release her to desk work for her knee specifically because she wanted to accept a desk work position, which she began in July of 2022. (Tr. pp. 23-24, 33-34) She did not believe she would have been able to return to her old position at Choate with her current right knee condition because to accept that position, "you have to be able to do a shuttle run in 30 seconds, do a dead lift of 50 pounds, and walk a mile in under 18 minutes." (Tr. pp. 42-43)

Petitioner testified that when she was released at MMI for her left knee in October 2022, she continued to have right knee pain, aching, and swelling. (Tr. p. 23) When asked why she did not return to Dr. Bradley for her right knee from October 2022 through June 2023, she stated that Dr. Bradley had given her a right knee injection and told her the only option was a knee replacement, and she did not want another knee replacement at her age. (Tr. pp. 24-25) She stated she tried to live with her symptoms and that Dr. Bradley called in pain medicine for her at times; however, as the weather became warmer, she became more active and felt that she could not live with the continued pain. (Tr. pp. 24-25) She testified that when she returned to Dr. Bradley in June 2023, her right knee pain was "bad." (Tr. p. 25)

She testified she has daily pain in her right knee and takes Valium almost every day for same. (Tr. pp. 26, 37) She takes Gabapentin to help her sleep; however, she tries not to take it

during work because it makes her forgetful. (Tr. pp. 26, 37-39) Her doctor prescribes Lyrica for her right knee; however, same makes her gain weight, and she does not want to regain weight she had lost. (Tr. pp. 26-27, 39) Her primary physician and Dr. Bradley have also prescribed Voltaren for her right knee. (Tr. pp. 39-40) She stated her right knee is not doing good because she has to be medicated daily. (Tr. pp. 26-27)

She testified that she has never gone back to feeling the way she was before her accident. (Tr. p. 27) She testified that there are activities she could perform prior to the accident that she cannot perform now, such as strenuous activities and maintaining her home. (Tr. pp. 27-28)

She testified that she wants to get her knee fixed and when questioned regarding same, she stated, “Because I can’t -- I can’t live with the pain. I can’t tolerate it. Like I said, I was going to try, but I -- It’s too painful.” (T. 28)

CONCLUSIONS OF LAW

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

The law holds that 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*, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 672-673 (2003). [Emphasis added]. Where a preexisting condition is present, Petitioner need only show that the prior condition was aggravated or the need for treatment accelerated. *Sisbro, Inc. v. Indus. Comm’n*, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 672-673 (2003); *Schroeder v. Illinois Workers’ Comp. Comm’n*, 2017 IL App (4th) 160192WC, 79 N.E.3d 833. Allowing a claimant to recover under such circumstances is a corollary of the principle that employment need not be the sole or primary cause of a claimant’s condition. *Land & Lakes Co. v. Indus. Comm’n*, 359 Ill. App. 3d 582, 834 N.E.2d 583 (2005). Employers are to take their employees as they find them. *A.C. & S. v. Industrial Comm’n*, 304 Ill. App. 3d 875, 710 N.E.2d 837 (1999) citing *General Electric Co. v. Industrial Comm’n*, 89 Ill. 2d 432, 434, 433 N.E.2d 671, 672 (1982).

Regarding treatment gaps, the law holds that “the ultimate issue is not whether there was a gap in treatment but rather, whether the initial accident was a causative factor in the condition of ill-being which was produced.” *William Gordon v. State of Illinois DOT Joliet Yard*, 07 I.W.C.C. 1599 (2007). The important issue is whether the symptoms and findings later in the treatment match up to the symptoms immediately following the accident, and whether the gap was logically explained. *Id.* In *Sharon Langorgen v. K-Mart*, 09 I.W.C.C. 1160 (2009), the Commission recognized that, although there was a gap in formal treatment between mid-2003 and September of 2005, the claimant continued to identify the accidental injury as the source of her complaints without rebuttal. *Langorgen*, 09 I.W.C.C. 1160 (2009). The Commission relied on her credible testimony and the circumstantial evidence, which showed an absence of any intervening accident, in holding that causal chain remained unbroken and awarding benefits. *Id.*

Regarding causation, the law holds that a “Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury.” *Fierke v. Industrial Commission*, 309 Ill. App. 3d 1037, 723 N.E.2d 846 (2000). The law is clear that if a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Rock Road Constr. v. Indus. Comm’n*, 227 N.E.2d 65, 67-68 (Ill. 1967), 37 Ill. 2d 123; see also *Illinois Valley Irrigation, Inc. v. Indus. Comm’n*, 66 Ill. 2d 234, 362 N.E.2d 339 (1977).

A compensable aggravation occurs when a claimant’s need for surgery is accelerated. *Judith Wheaton v. State of Illinois/Choate Mental Health Center*, 13 I.W.C.C. 0467; *Bowman v. Gateway Reg’l Med. Ctr.*, 14 I.W.C.C. 1022; *Clutterbuck v. UPS*, 15 I.W.C.C. 0046; *Howard v. St. Clair Hwy. Dept.*, 16 I.W.C.C. 0187, modified 16 MR 106.

The Appellate Court has found that where an accident results in pain, that the pain, in and of itself, is a compensable aggravation of a claimant’s preexisting condition. *Tazewell County v. Illinois Workers’ Compensation Commission*, 2025 IL App (4th) 230754WC. Specifically, the Court found that when a preexisting condition is asymptomatic and then becomes painful as the result of work-related activity, that symptomatic condition is compensable under the Act as an aggravation of the preexisting condition even in the absence of an organic or structural change in the preexisting condition. *Id.* When a preexisting asymptomatic condition becomes painful for reasons other than an organic or structural change or natural progression, it follows that the preexisting condition was aggravated by something. *Id.* The Court held that if the aggravation was work-related and caused solely pain, that the pain suffered by a claimant, in and of itself, was a compensable aggravation of the preexisting condition. *Id.*

The Arbitrator notes that the Commission denied causation of Petitioner’s prior right knee overuse claim, noting Dr. Lehman’s testimony that according to the MRI, Petitioner’s symptoms could have been meniscal or arthritic. (PX 10) The Commission specifically stated that there was no evidence of a meniscal tear in the right knee. (PX 10) Following Arbitration, Petitioner underwent right knee surgery with Dr. Lehman, who confirmed intraoperatively that Petitioner did, in fact, have significant tearing in her meniscus. (PX 4; PX 6)

The evidence shows that after her meniscus tears were addressed in June 2021, Petitioner did well, and when she presented for postoperative visits for her right knee, most of her complaints were regarding her contralateral left knee. (PX 4) At Petitioner’s final visit with Dr. Lehman in September 2021, his comments suggested that Petitioner was doing very well postoperatively, as he stated that he was “really pleased” with her progress and that if things continued to go “this well” he would release her with respect to her right knee in three to four weeks. *Id.*

Petitioner testified that she was fully released for her right knee in September 2021. (Tr. pp. 31-32) Petitioner subsequently saw Dr. Farley for a left knee IME in December 2021, where he noted that Petitioner had dealt with a right knee condition from January 2019 through March 2021, but he did not document any current symptoms to her right knee. (PX 12) Moreover, when

Petitioner began treating with Dr. Bradley for her left knee, no right knee symptoms were documented until after her April 2022 accident. (PX 7) There is no evidence that Petitioner suffered symptoms or sought medical treatment with respect to her right knee in the interim between her release from Dr. Lehman around September 2021 until the time of her April 15, 2022, work accident. (PX 7; Tr. pp. 19, 40; RX 3, pp. 24-25) Even Dr. Farley noted in his June 2024 report that after she was released in September 2021, she had no right knee complaints. (RX 2; RX 3, pp. 24-25)

Following Petitioner's April 2022 accident, however, her right knee symptoms, including swelling, throbbing, and stabbing pain, and visible bruising were reported to her employer immediately and were documented at Convenient Care Clinic the following day. (RX 1; PX 3) The injury reports from Respondent and the medical evidence corroborate Petitioner's detailed account of the accident as well as her immediate right knee symptoms. (RX 1; PX 3; PX 7; Tr. p. 17) Although Petitioner underwent a total left knee replacement shortly following her April 15, 2022, accident, her continued right knee symptoms were documented at each postoperative visit. (PX 7)

Regarding Petitioner's gap in treatment with Dr. Bradley from October 2022 to June 2023, the Arbitrator finds that this gap is logically explained. Petitioner was released from her left knee replacement at that time and credibly testified that she had been given an injection in her right knee, and she was told the only option was a knee replacement. (Tr. pp. 24-25) As she did not wish to undergo another knee replacement at her young age, she attempted to live with her symptoms, which were managed with pain medication; however, after failing to tolerate her symptoms, she returned to Dr. Bradley with severe symptoms. (Tr. pp. 24-25) The records and testimony of Dr. Bradley corroborate Petitioner's testimony, as he also indicated that during this interim, Petitioner attempted to treat her knee nonoperatively over the following months but that when she returned in June 2023, her symptoms were severe despite implementing all the nonoperative measures he had suggested. (PX 11, pp. 24-25)

The Arbitrator has considered the opinions of Dr. Bradley and Dr. Farley and finds the opinions of Dr. Bradley to be more logical, persuasive, and congruent with Illinois law. Namely, Dr. Farley stated in his June 2024 report that Petitioner had degenerative changes with complaints from 2018 until September 2021 and "then had further complaints in April of 2022," which frames her April 2022 symptoms as simply a continuation of her surgically treated meniscus tears. (RX 2) He felt that her arthritis would have become symptomatic with or without the April 2022 injury, and he did not feel her medical treatment was related to the accident because "treatment is typically required episodically with degenerative arthritis." *Id.* The Arbitrator finds that Dr. Farley's statements in this regard are akin to predicting the future, as even he admitted that Petitioner had no complaints between her release in September 2021 until her April 2022 injury. *Id.* Moreover, there is no evidence that Petitioner was on a course requiring treatment after her release. The Arbitrator finds that it is impossible to remove the work accident from the equation and attempt to determine not only *if* Petitioner would have developed symptoms absent the work injury, but also

when those symptoms might have hypothetically surfaced. Even when speculating that Petitioner's condition would have progressed to where she required eventual treatment, there is no way to predict at what point in her life she would have required that treatment, nor the nature of said treatment excluding the work injury.

Dr. Farley admitted that Petitioner's fall on her knee could have caused an aggravation of her underlying condition, and when asked if Petitioner's right knee had returned to baseline as of his June 2024 IME, Dr. Farley admitted that he did not know. (PX 3, pp. 25-27)

In contrast, Dr. Bradley explained that Petitioner's mechanism of injury, which possibly included twisting, but at the very least, consisted of a forceful impact, was consistent with her symptoms. (PX 11, pp. 18, 28-29, 45-46) Dr. Bradley further opined that Petitioner's prior surgery made her more susceptible to injury because it had taken away some of the knee's ability to absorb trauma and energy. (PX 11 p. 29) The Arbitrator finds this to be logical. Dr. Bradley's opinion that Petitioner's exacerbation to her knee remained sustained because she never returned to baseline is consistent with the medical records and Petitioner's credible testimony, as there is no evidence that the symptoms in Petitioner's right knee ever returned to their pre-accident status. (PX 11, p. 53; Tr. p. 27; PX 7)

Pursuant to the above facts and law, the Arbitrator finds and concludes that Petitioner's current condition of ill-being with respect to her right knee is causally related to her April 15, 2022 work injury.

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?

Petitioner has undergone significant conservative treatment to her right knee, including injections, icing, elevation, exercise, medication, compression therapy, and a knee sleeve. (PX 11, pp. 24-25; *See also* PX 7) She has attempted to tolerate her symptoms to avoid surgery, but she is no longer able to do so. (Tr. pp. 27-28) Dr. Bradley has recommended a right total knee arthroplasty, and Petitioner wishes to undergo same. (Tr. p. 28; PX 7) Dr. Farley opined that knee replacement could be considered due to Petitioner's symptoms. (RX 2)

Therefore, pursuant to the above findings on causal connection, the Arbitrator finds and concludes that the medical treatment rendered to Petitioner's right knee is reasonable, necessary, and causally related to her April 15, 2022, injury, and that Respondent is liable for the payment of medical expenses as outlined in Petitioner's Exhibit 1. Furthermore, Petitioner is entitled to prospective medical treatment to her right knee, including, but not limited to, total right knee replacement surgery.

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.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	14WC029291
Case Name	Jamie Simenson v. Rosewood Care Center
Consolidated Cases	
Proceeding Type	8(a)/19(h) Petition
Decision Type	Commission Decision
Commission Decision Number	25IWCC0506
Number of Pages of Decision	31
Decision Issued By	Amylee Simonovich, Commissioner, Kathryn Doerries, Commissioner

Petitioner Attorney	Mitchell Horwitz
Respondent Attorney	Elaine Newquist

DATE FILED: 12/22/2025

/s/ Kathryn Doerries, Commissioner

Signature

DISSENT

/s/ Amylee Simonovich, Commissioner

Signature

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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)
☐ Modify Choose direction	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMIE SIMENSON,

Petitioner,

vs.

NO: 14 WC 029291

ROSEWOOD CARE CENTER,

Respondent.

DECISION AND OPINION ON §19(h) AND §8(a) PETITION

This matter comes before the Commission on Petitioner's petition for benefits under sections 19(h) and 8(a), seeking compensation for medical expenses and alleging a material increase in disability since the Commission's previous Decision and Opinion on Review, 21 IWCC 0061, dated February 10, 2021. A hearing on the Petition was held before Commissioner Kathryn Doerries in Chicago, Illinois, on December 13, 2024. Oral argument was heard on October 21, 2025. The Commission, having reviewed and considered the entire record, finds that Petitioner failed to prove a material increase in disability and therefore denies Petitioner's request for additional permanent disability benefits under section 19(h). The Commission finds Petitioner is entitled to compensation for the medical bills from Advanced Psychiatric Solutions, Frankfurt Surgery Center, Pain Management Institute, and Prescription Partners, as provided under sections 8(a) and 8.2. The Commission denies medical benefits for the bill from Rehab Assist, Inc. The Commission further denies medical benefits for companion care provided by Petitioner's son and denies Petitioner's request for prospective medical care as there are no pending treatment recommendations at issue and Petitioner's entitlement to reasonable, necessary and causally related medical care to cure or relieve the effects of the work-related injury remains open under section 8(a).

Background

On March 23, 2014, Petitioner was employed as a certified nursing assistant for Respondent when she felt a pop in her left wrist while helping a fallen resident off the floor. In

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May of 2014, Petitioner presented with complaints of paresthesia in all digits of the left hand, mild pain over the medial aspect of the left elbow, and numbness and tingling in the left forearm. On August 7, 2014, Petitioner underwent surgery consisting of synovectomy and TFCC repair. On October 6, 2014, Petitioner reported intermittent numbness in the ring and small fingers and intermittent swelling in the knuckles. Petitioner continued treating and later presented with color changes in the left arm and intermittent swelling, prompting a referral to a neurologist for evaluation of possible Complex Regional Pain Syndrome (CRPS). A neurologist diagnosed CRPS, and on February 3, 2015, Petitioner began pain management treatment with Dr. Alzoobi. After stellate ganglion blocks failed to provide relief, Dr. Alzoobi indicated a trial spinal cord stimulator (SCS) should be considered if symptoms failed to resolve.

For a period of time, Petitioner declined to undergo placement of the trial SCS and continued with medication management without improvement. On the referral of Dr. Alzoobi, Petitioner saw Dr. Anwar, another pain management specialist, on August 4, 2015. Dr. Anwar diagnosed CRPS, and given Petitioner's lack of significant benefit from the nerve blocks and medication management, recommended that Petitioner proceed with a trial SCS. On November 4, 2015, Petitioner underwent placement of a trial dorsal column stimulator. Petitioner subsequently reported 70% reduction of her left forearm and hand pain. On April 26, 2016, Petitioner underwent implantation of a permanent SCS. On May 12, 2016, Petitioner reported 80% reduction in her pain complaints and Dr. Anwar released Petitioner to return to work with restrictions of no lifting, carrying, pushing, or pulling in excess of 5 pounds, and a 15-minute rest break ever two hours.

Petitioner continued treating with Dr. Anwar for medication management and stimulator maintenance. On March 20, 2017, Dr. Anwar increased Petitioner's allowable weight limit from 5 pounds to 10 pounds. On September 16, 2017, Dr. Anwar supplemented his prior work restrictions with an added restriction to avoid working with combative patients in order to minimize the risks associated with migration of the SCS leads. On May 18, 2018, Petitioner reported she was pleased with the results. On July 16, 2018, Petitioner saw Dr. Anwar and reported she was receiving adequate stimulation from the SCS; however, she exhibited swelling in the forearm and hand. Her medication regimen included Norco, Gabapentin, Ambien, Meloxicam, Omeprazole, Trazadone, and Xanax. Dr. Anwar stated that Petitioner would require ongoing monitoring of the SCS implant and medication management. Dr. Anwar maintained her work restrictions imposing a 10-pound maximum weight limit for lifting, pushing and pulling, with fifteen-minute breaks every two hours and no direct contact with combative residents. The doctor also added that Petitioner may work no more than eight hours per day or forty hours per week.

Petitioner's claim proceeded to trial on August 13, 2018. The issues in dispute included causation, TTD, TPD, medical expenses, and nature and extent of disability. Arbitrator Dollison found in favor of Petitioner on the issue of causation. The Arbitrator awarded TTD benefits but denied TPD disability based on lack of evidence. The Arbitrator awarded medical expenses of \$243,693.61, subject to adjustments based on the negotiated rate, if any, or the fee schedule. The Arbitrator further determined Petitioner sustained 32.5% loss of the person as a whole under section 8(d)2. On February 10, 2021, the Commission affirmed and adopted the Arbitrator's findings and conclusions of law, subject to minor modifications.

On June 30, 2023, Petitioner filed the present petition under sections 19(h) and 8(a). Petitioner claims her level of disability has increased and seeks an award for permanent total disability. Petitioner also seeks payment for medical expenses incurred for treatment received since the Commission's decision, and medical benefits for companion care provided by Petitioner's son. Petitioner also requests prospective medical care based on a future life care plan prepared by a certified life care planner.

Arbitration hearing on August 13, 2018

The evidence regarding the nature and extent of Petitioner's left upper extremity injury and condition of ill-being is described in the Arbitrator's decision dated October 11, 2018, and admitted into evidence. (PX1) A copy of the arbitration transcript was also admitted into evidence. (PX2) The Commission incorporates by reference herein the findings of facts and conclusions of law set forth in the arbitrator's decision, affirmed and adopted by the Commission.

Before the trial stimulator was placed, Petitioner testified she felt horrible and could barely sleep. (PX2 at 33) Petitioner testified she would go home in tears after working light duty. The pain affected her left hand and forearm up to her elbow, which she described as constant and sharp. (PX2 at 33-34) After the trial stimulator, Petitioner was able to sleep and function better than before. (PX2 at 33) Petitioner testified she received the permanent stimulator on April 14, 2016. Petitioner testified her pain was less intense and she was able to sleep. (PX2 at 37) Petitioner testified her pain level decreased by 80% after placement of the permanent stimulator. (PX2 at 38) Petitioner testified that the permanent stimulator required re-programming every couple of months. Petitioner also underwent periodic x-rays to confirm placement of the leads. Petitioner testified that on one or two occasions the leads migrated which necessitated non-invasive procedures via computer to relocate the leads into their proper position. (PX2 at 38-39) Petitioner testified she remained under Dr. Anwar's care for maintenance of the stimulator with instructions to return on a monthly basis. (PX2 at 39-40) Petitioner testified she underwent fluoroscopic examination every three months. (PX2 at 40)

Petitioner further testified regarding the medications prescribed for medication management at the time of the arbitration hearing. Petitioner testified she was taking Gabapentin, Norco, and Trazodone. (PX2 at 40-41) Petitioner also testified she was taking Ambien for bedtime and Xanax for anxiety. (PX2 at 41) Petitioner was also taking Meloxicam, a non-steroidal anti-inflammatory, and Prilosec with Omeprazole for stomach issues due in part to the medications she was taking. (PX2 at 41-42) Petitioner further testified she was using ointments containing compounded medications made up special by the pharmacy which included muscle relaxant and pain relieving ingredients. (PX2 at 42-43) Petitioner testified she was working for Respondent at the time of the arbitration hearing with a 10-pound weight limit. (PX2 at 43) Petitioner was also directed to avoid combative patients. Petitioner testified her job primarily involved computer work, charting the residents' food intake, and performing blood glucose levels among other tasks. (PX2 at 44)

On cross-examination, Petitioner testified she is right-hand dominant. (PX2 at 45) Questioned about her ongoing monthly follow-up care with Dr. Anwar, Petitioner testified the

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purpose behind the ongoing care is pain management, checking her arm for swelling, and obtaining lab testing to monitor the effects of her medication regimen and monitor the implanted stimulator. (PX2 at 52) She further noted Boston Scientific is responsible for re-programming her SCS device when needed. (PX2 at 52-53)

On re-direct, Petitioner testified the permanent stimulator afforded her a greater level of functionality. (PX2 at 54) Petitioner testified she could help assist and pour drinks and perform charting in the computer. Petitioner testified she continued to have residual pain and symptoms in her arm. (PX2 at 55) Petitioner described her residual symptoms as an “ache from my hand to my elbow but it’s more of a dull ache than it was before where it was a strong shooting pain.” (PX2 at 56)

The Arbitrator’s decision provided a detailed recitation of the medical findings and treatment. (PX1) The Arbitrator noted the pre-operative and post-operative diagnosis for the implantation of the permanent stimulator was “CRPS with neuropathic pain, upper extremity.” (PX1 at 8) Based on the permanent restrictions issued by Dr. Anwar, the Arbitrator found Petitioner was precluded from performing the full range of her employment duties. The Arbitrator further noted that where an injury incapacitates a claimant from pursuing the job duties in their usual and customary line of employment, but does not result in impairment of earnings, an award of compensation for permanent partial disability to the whole person is permitted under section 8(d)2. As mentioned, the Arbitrator found Petitioner had sustained a 32.5% loss of the person as a whole, and the Commission affirmed.

Commission hearing on December 13, 2024 pursuant to sections 19(h) and 8(a)

Testimony of Petitioner

Petitioner testified she was now aged 44 and would be turning age 45 in a week. (T. 10, 20), Petitioner testified she has three sons and resides with her two youngest children who are ages 22 and 21. Her youngest child, Randy, serves as her caregiver. (T. 11)

Petitioner testified she recalled giving testimony regarding her work accident and injury in August 2018. (T. 10) At that time, Petitioner was employed with Respondent and working with permanent restrictions. (T. 11) Petitioner testified she was later let go in February of 2020. Petitioner testified she remained unemployed through the date of this section 19(h) hearing. Petitioner testified she looked for work but no one will hire her with her weight restrictions. (T. 11-12)

Petitioner agreed she was under the care of Dr. Anwar for her CRPS when she last testified in August 2018, and has remained under his care since then. (T. 12) Petitioner agreed her spinal cord stimulator continued to provide relief until she reported left arm numbness on January 9, 2020. Petitioner further agreed she returned to Dr. Anwar on July 23, 2020 due to problems with her IPG generator not working. (T. 13) Petitioner agreed there was a year-long delay in being able to repair the generator. Petitioner underwent a spinal cord stimulator revision of the IPG generator with dual lead replacement on June 30, 2021. (T. 13-14) Petitioner agreed Dr. Anwar took her off

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work commencing on June 30, 2021. (T. 13) Petitioner testified she has not received any compensation from workers' compensation since being taken off work.

Since undergoing the revision procedure on June 30, 2021, Petitioner obtained relief from the SCS device over the course of a year. (T. 14) Petitioner agreed, however, that on June 20, 2022, she returned to Dr. Anwar due to increasing pain radiating from the left side of her neck down her shoulder and arm. (T. 14) Petitioner agreed, per her medical records, that a representative from Boston Scientific reviewed her spinal cord stimulator on October 22, 2022, and found a lead had migrated. (T. 14) Petitioner agreed her pain progressively worsened. (T. 14-15) Petitioner agreed that Dr. Anwar noted in his records on July 6, 2023 that she was dependent on her son, Randy. (T.15)

Petitioner agreed Dr. Anwar provided a referral on April 15, 2024 to see Dr. Lubenow for a second opinion regarding her non-functioning SCS and migrating leads. (T. 15) Petitioner also agreed Dr. Anwar provided a referral to see "William" Brennan for life care planning. Petitioner agreed she then saw Dr. Lubenow on June 6, 2024. Dr. Lubenow diagnosed CRPS and recommended a lead revision for the SCS. Petitioner underwent the procedure for a lead revision on August 5, 2024. (T. 16)

Regarding her current condition, Petitioner testified her symptoms in the left arm, which she described during the 2018 arbitration hearing as a dull ache from her hand to her elbow, are now worse. (T. 16-17) Petitioner testified she now feels a shooting pain that goes from her fingers to her elbow, and she has more spasms than before. (T. 17) Petitioner acknowledged that she experienced spasms and numbness and dropped things in "the original case, but now it's worse." (T. 17) Petitioner testified, "I can't do as much." Petitioner testified she once dropped a plate of lasagna while handing the plate to her son, and she drops dishes while rinsing them for placement in the dishwasher. Petitioner described difficulty with lifting a pot of water. Petitioner further testified her pain is a lot worse and she feels more exhausted doing things. Petitioner testified she has to stop and take a half-hour to 45-minute rest break while performing household chores and frequently takes a break every 8 to 14 minutes during the course of an activity. (T. 17-18) Petitioner confirmed she is right-hand dominant. (T. 18) Petitioner testified that she can cook food but has difficulty cutting meat which takes both hands and has difficulty stirring the contents in a pot while holding the pot. Petitioner also noted she can experience spasming which may cause her to squeeze a beverage container and spill the drink. Petitioner further testified her ability to use her left arm has diminished since she last testified in 2018. (T. 19) Petitioner explained that her hand may jerk while holding down a piece of paper if she needs to write her signature. (T. 19-20) Petitioner testified she feels like an 80-year old woman because she drops things and needs her children to help her with everything. (T. 20) Petitioner testified she was independently functioning with activities of daily living when she last testified in 2018, whereas now she cannot perform laundry or make the bed. (T. 21) Petitioner later testified she is able to wash her clothes but has trouble folding heavier items like blankets and towels. (T. 24) Petitioner testified she could clean the floors before whereas now she can clean the floors but must take breaks. (T. 21-22) Petitioner testified she is able to eat food but reiterated she has difficulty with cutting. (T. 22) Petitioner attributed her difficulties to her left hand jerking due to muscle spasms which have worsened. Petitioner testified her children take out the garbage and she is no longer able to perform yard work

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or shovel snow. (T. 24-25) Petitioner testified that on days when she feels stronger and performs household chores herself then she typically sleeps for 14 hours. (T. 25) Petitioner testified she was previously able to work in 2018 and continued working until she was laid off in February 2020. (T. 26)

Petitioner further testified her two sons who live with her provide about two hours' worth of help each day, which includes vacuuming, taking out garbage, cooking, and laundry. (T. 26) Her youngest son Randy reminds her to take her medicine and brings her plates of food for meals. (T. 26-27) Petitioner testified she can still drive a car to visit the doctor or go on small shopping errands for groceries. (T. 28) When shopping for groceries, Petitioner testified she can lift with her right hand but seeks assistance for placement of the bags into her car. (T. 28-29) At home her children will remove the groceries from the car. (T. 29) Petitioner testified the drive to Dr. Anwar's office is two and a half hours which she is able to handle, though she will take a rest break to stretch her legs and move around after an hour of driving. (T. 29-30) Longer drives as a passenger can be exhausting. (T. 31) Petitioner testified she uses her right arm and avoids using her left arm. (T. 33-34) Petitioner testified regarding the lifecare plan prepared by "William" Brennan. (T. 34-35) Petitioner agreed the lifecare plan would meet her needs. (T. 36) Petitioner testified she has good and bad days. (T. 37)

On cross-examination, Petitioner testified regarding her current medication regimen in comparison with the medications she was taking at the time of the original hearing in 2018. At that time, Petitioner was taking Gabapentin, Trazadone, Norco, Xanax, Meloxicam, Ambien, Prilosec, and Omeprazole. Since the hearing, Petitioner has discontinued taking Trazadone, Ambien, Prilosec, and Omeprazole. (T. 43-44) Petitioner continues taking Gabapentin, Norco, Xanax, and Meloxicam and her prescriptions have remained unchanged for those medications. (T. 42-44)

Petitioner agreed she had a spinal cord stimulator implant at the time of her hearing in 2018. (T. 44) Petitioner testified the stimulator provided pain relief. (T. 44-45) After the hearing, Petitioner experienced issues with her device. Petitioner testified the battery stopped charging properly when she plugged her device into the electrical socket at home. (T. 45-46) Petitioner testified she underwent surgery to have the battery replaced, after which the spinal cord stimulator was working again. (T. 46) Petitioner testified the device later began providing less relief, after which Dr. Anwar put in a new lead but it took two years to obtain authorization. (T. 46, 48) Petitioner testified her battery is implanted in her lower back just right of the midline and above the waistline with wires running through her spinal cord and up into the left side of her neck. (T. 47-48) Petitioner testified the wires had moved to the right side. (T. 48) Petitioner agreed Dr. Anwar performed surgery in August of 2024 to reposition the leads into their correct positions. (T. 48-49) Petitioner agreed there has been some improvement since the leads were repositioned but overall the pain is worse than it was at the time of her arbitration hearing. (T. 49)

Regarding her employment, Petitioner testified she was working at reception in 2018 where she checked in patients and performed charting work. (T. 50) Petitioner testified she continued in that job until she was let go in February 2020. Petitioner testified the facility was bought out by another company and the new company laid her off. (T. 50-51) Petitioner testified she looked for new employment but did not have documentation corroborating her job search efforts. (T. 51)

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Petitioner has not worked since she was laid off. (T. 56) In 2018, Petitioner was living with her mother in Joliet and she later bought a house further south in the town of Catlin near Champaign, closer to where her brother and nieces live. (T. 51, 53-54) Petitioner testified she continued treating with Dr. Anwar since her relocation to Catlin. (T. 54)

Petitioner agreed she had not undergone a new FCE since the hearing in 2018. (T. 57) Petitioner agreed she has no time limit for standing but can only sit for two hours before needing a break. (T. 60) Petitioner agreed she can drive but longer distance take a lot out of her. Petitioner testified she drives to her doctor's appointments, the grocery store, and running occasional errands. (T. 61) Petitioner testified her youngest son, Randy, is unemployed and lives with her and is the son who takes care of her. (T. 62)

On re-direct examination, Petitioner testified her spinal cord stimulator is currently working. (T. 63) Petitioner testified she continued to have the same symptoms she described despite the relief she gets from the stimulator. Petitioner agreed she is currently off work per Dr. Anwar's orders. (T. 63) Petitioner reiterated she has not worked since she was laid off. (T. 65) Petitioner testified the change in her condition has occurred gradually. (T. 68) She further testified to being prescribed muscle relaxants for her muscle spasms, which has worsened since her hearing in 2018. (T. 68-69)

Testimony of Randy Farmer

Mr. Farmer identified Petitioner as his mother and testified he is unemployed, age 21, and resides with Petitioner. (T. 71-72) Mr. Farmer testified he has lived with Petitioner his entire life. (T. 73) Mr. Farmer testified Petitioner was working light duty in 2018 and had more energy at that time. Mr. Farmer testified Petitioner was unable to lift anything heavy at that time, and she was in a lot of pain at that time, but she had the energy to cook and clean and do laundry after working. (T. 73) Petitioner used her left arm in 2018 except for "super heavy stuff." Mr. Farmer testified "we all pitched in" and he would occasionally make food as he was in cooking class and liked cooking.

Mr. Farmer further testified Petitioner's condition has worsened since she last testified in 2018. (T. 75) Whereas Petitioner was able to work and then come home and clean and cook in 2018, she cannot work and she gets worn out easily. Mr. Farmer testified he often helps out with taking out the garbage, doing dishes, and cleaning the blankets, towels, and bedding sheets. He also makes her bed. Mr. Farmer testified the change in Petitioner's condition occurred over the past two to three years. (T. 76) Describing his current day-to-day responsibilities, Mr. Farmer testified he usually cooks, cleans, sometimes does the dishes, takes out the trash, and performs yard work. Mr. Farmer testified he helps out every day. (T. 77) Whenever they are in the car together, he is the one driving. (T. 78) Mr. Farmer testified his mom is in a lot of pain and often tired. (T. 79) Petitioner testified Petitioner has good days when she can be more active. (T. 80) Mr. Farmer testified that Petitioner goes by herself to the grocery store two to three times a month. (T. 81-82) She also occasionally walks for exercise. (T. 83)

Mr. Farmer testified Petitioner's muscle spasms occurred rarely when they started four years ago. (T. 80) Then the spasms started occurring more often about two to three years ago. Mr. Farmer testified it would be difficult for Petitioner if he stopped acting as her caregiver. (T. 84) Mr. Farmer testified he had seen the lifecare plan report prepared by "William" Brennan and agreed he spends 10 to 15 hours a week providing companion services. (T. 85-86) On cross-examination, Mr. Farmer agreed his companion care does not include sitting with her and keeping an eye on her. (T. 88) Mr. Farmer further agreed Petitioner has no limitations with her right hand. (T. 89)

Life Care Plan by Henry Brennan

Mr. Brennan is a certified life care planner and prepared a life care plan at the request of Petitioner's attorney. (PX12) Mr. Brennan visited Petitioner and conducted interviews at her residence on July 19, 2024. Mr. Brennan's report, dated August 22, 2024, noted by way of history that Petitioner injured her left arm in March 2014, which necessitated a tendon repair surgery. Mr. Brennan noted Petitioner developed CRPS and a SCS was placed on April 26, 2016. Per the report, Petitioner was now living with her three adult children and requires assistance with various tasks, including lawn care, cooking, housekeeping, transportation for long distances, medication reminders, lifting heavy objects, laundry, and grocery shopping. The youngest son, Randy, typically helps Petitioner with those tasks. Mr. Brennan indicated he reviewed medical records documenting Petitioner's treatment between January 15, 2018 and June 6, 2024. He also reviewed a "future medical expenses report" from Dr. Anwar, dated August 19, 2024. Attached to the report is the proposed life care plan which calculated total future medical expenses ranging between \$3,937,432.47 and \$4,383,154.39. This plan contemplates future expenses for a number of services, including but not limited to, replacement of the spinal cord stimulator and programming analysis, lawn care and snow removal services, companion services, and medication management over the course of Petitioner's remaining life expectancy.

Testimony of Dr. Anwar

Dr. Anwar testified via deposition on September 10, 2024, about five weeks after repositioning the leads for Petitioner's spinal cord simulator on August 5, 2024. Dr. Anwar testified that spinal cord stimulators generally provide between 50% and 60% relief. (PX11 at 21-22). Pain management physicians prescribe opiates along with adjunctive medications, including muscle relaxants, for additional relief. *Id.* Dr. Anwar testified that spinal cord stimulators, in combination with the medications, generally provide maximum pain reduction of 70% to 80%, possibly up to 90% relief. (PX11 at 22-23) For some patients, psychological care is recommended to help deal with anxiety and depression.

Dr. Anwar testified he has been treating Petitioner for the past nine years. (PX11 at 23) Dr. Anwar testified that Petitioner's implanted stimulator was working successfully for her in 2018 and 2019 without any difficulty. (PX11 at 27) He noted Petitioner was getting significant benefit. (PX11 at 27) Then in 2020, Petitioner began to experience increasing pain in the upper extremity. (PX11 at 29) Dr. Anwar testified he saw Petitioner on twelve occasions during that year. Dr. Anwar testified he arranged for reprogramming which was attempted multiple times. *Id.* Dr. Anwar also

examined the generator and leads under fluoroscopy. (PX11 at 30) Dr. Anwar testified, looking at his July 23, 2020 progress note, that the IP generator was not charging even after they provided Petitioner with a new charging device. *Id.* Boston Scientific then recommended replacement of the IP generator. (PX11 at 31)

Dr. Anwar testified he later issued a work status note taking Petitioner off work on June 30, 2021. (PX11 at 32-35) Dr. Anwar testified they replaced the generator and that per his note Petitioner was totally incapacitated at that time. (PX11 at 33-35, 37) Dr. Anwar testified Petitioner's disability had increased because she was unable to get any benefit from the stimulator for about a year. (PX11 at 35-36) With the stimulator not functioning, she was left with the medications which were providing only 20% to 30% relief. *Id.*

Dr. Anwar further testified that by the beginning of 2022 everything was successful and the stimulator was providing benefit. (PX11 at 37) During subsequent reprogrammings, it was noted there was slight migration of the lead but it was not significant enough to do anything. Unfortunately, Petitioner was starting to have arm and shoulder area pain and 2022 became a "struggle year" for Petitioner. (PX11 at 38, 41-42) Dr. Anwar testified they tried a multitude of physical therapies, none of which provided significant relief. (PX11 at 38-42) Dr. Anwar testified they looked at the leads and found they had migrated laterally such that they were not running up and down. (PX11 at 39-40) Dr. Anwar testified Petitioner was no longer experiencing significant relief from the spinal cord stimulator. (PX11 at 41-42). Dr. Anwar recommended a lead revision and an increase in home care. *Id.* By 2023, according to Dr. Anwar, Petitioner was totally dependent on her son for activities of daily living, as her condition had worsened while waiting for approval for the lead replacement. (PX11 at 42-43)

Dr. Anwar testified he performed the lead replacement in July or August of 2024, about six weeks prior to his deposition. (PX11 at 46) Dr. Anwar testified that after the lead replacement was completed the Petitioner had more chronic disability and a life care plan was discussed with "Dr. William Brenner" (*sic*). (PX11 at 48) Dr. Anwar went on to testify that Petitioner was now "getting better" and "getting relief." (PX11 at 49) Dr. Anwar corrected the timing of the last procedure and stated the lead replacement was completed in August 2024, or about 4 to 5 weeks before this deposition. (PX11 at 50) Asked in follow-up regarding the CRPS condition following the lead replacement, Dr. Anwar testified that the CRPS condition cannot be "fixed" as the CRPS has already developed and progressed to the point where she will have more neuropathic and more myofascial issues. *Id.* The goal is to help the patient by improving her quality of life by decreasing the pain. *Id.*

Dr. Anwar testified regarding the post-operative protocol following the lead replacement and stated he saw Petitioner for follow-up on three occasions. (PX11 at 50) Dr. Anwar explained that during the first three to four weeks, the patient is asked to limit use of the stimulator for a very brief period of time for testing purposes and avoid using the device beyond that for healing purposes.

Dr. Anwar opined the lead migration resulted in a non-functioning stimulator over a significant period of time which caused Petitioner's CRPS to progressively worsen. (PX11 at 54)

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Dr. Anwar therefore opined that Petitioner's disability had increased due to an increase in CRPS symptoms, notably an associated neuropathic pain in the forearm. *Id.* Dr. Anwar further commented that the wait for workers' compensation approval was a factor. Dr. Anwar further opined that the progression of symptoms would be permanent. (PX11 at 55) Dr. Anwar also opined that Petitioner is unable to work due to this progression of symptoms. (PX11 at 56)

Dr. Anwar testified he disagreed with Dr. Konowitz's opinion that the CRPS had resolved and replaced with a different condition. Explaining the basis for his disagreement, Dr. Anwar testified that CRPS is a neuropathic pain and myofascial pain and sympathetically mediated pain, which are different terminologies used to describe CRPS; they're all the same thing. (PX11 at 56) Dr. Anwar further testified that Petitioner's CRPS had been progressing and became "more severe now than before" and preventing her from being able to work. (PX11 at 57-58)

Dr. Anwar further testified regarding Petitioner's anticipated condition of ill-being in the future and whether the concept of MMI applies for patients with CRPS. Dr. Anwar explained Petitioner's treatment for the past four or five years had been unsuccessful because she was unable to obtain more than 50% pain relief due to the issues with her spinal cord stimulator, but going forward:

If we continue to treat her 100 percent with stimulator, with medication, with all the supportive life care and everything else and she continues to get 80 percent relief, we'll be able to help her out with her improved quality of pain, an improved quality of life, but it will not change the further progression of the CRPS symptoms, which has already damaged the area. It's irreversible. That's what I would say. (PX11 at 60-61)

Asked for clarification, Dr. Anwar confirmed the period of time when Petitioner was failing to obtain more than 50% relief was the period during which the IPG generator was not responding and the leads were not working. (PX11 at 61)

Finally, Dr. Anwar opined that the treatment provided to Petitioner since 2018 was reasonable and necessary. (PX11 at 61) Dr. Anwar also agreed that Petitioner needs companion care, like family care, which is very important. (PX11 at 63)

On cross-examination, Dr. Anwar testified Petitioner's pain only improved when the stimulator was working. (PX11 at 91) Dr. Anwar testified that spinal cord stimulators are a last resort after conservative treatment measures have failed which include nerve blocks and medication management. (PX11 at 92) Questioned regarding the change in Petitioner's condition that resulted in his off-work restriction in June 2021, Dr. Anwar testified the battery in the stimulator failed. (PX11 at 96) Dr. Anwar reiterated that in early 2020 it was discovered there was an issue with the charging device. A new charging device was obtained; however, the system was still not working and a new IPG generator implant was recommended. (PX11 at 96, 98) Dr. Anwar testified Petitioner did not have a functioning spinal cord stimulator for two to three years. (PX11 at 97) Dr. Anwar later testified, early in the course of Petitioner's treatment there was "an initial loss of care" which is why Petitioner had issues with the implant, but "the implant is working."

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(PX11 at 99) Dr. Anwar went on to testify that during the past ten years there have only been two problems with the stimulator; the first being the generator and the second being migration of the lead. (PX11 at 99-100) Dr. Anwar further stated that timely approval of his treatment recommendations would have prevented some of the severity of the symptoms. *Id.* As to the second problem, Dr. Anwar testified he repositioned the leads four weeks ago. (PX11 at 101) Dr. Anwar further testified,

Patient is – has a functioning spinal cord stimulator now. Her leads are working. We are already talking to the patient about maybe weaning her down (*sic*) medication now which we had raised up. * * * Implant is functional. We don't have a problem with that. Her generator is still very new. It's been replaced in 2021. It is still have (*sic*) six, seven – six to seven years of life. So we are good with the – we are good with the implant, We are good with the leads. We're not looking at anything else at this point. (PX11 at 101)

Dr. Anwar also testified that issues with spinal cord stimulators are common. (PX11 at 109) Finally, Dr. Anwar was questioned regarding the benefit Petitioner will receive now that the leads have been repositioned and testified as follows:

Q. Now that the leads have been repositioned, do you expect petitioner to experience improvement in her pain?

A. Yes.

Q. About how much would you say?

A. I think with leads, will give her 50 to 60 percent relief.

Q. What makes you think that?

A. Because she has an established improvement in the past. (PX11 at 114-115)

Dr. Anwar indicated the treatment plan going forward will consist of managing the implant and the opiates. (PX11 at 115-116) Dr. Anwar also testified he would try to wean down on the existing narcotics. *Id.* On re-direct, Dr. Anwar testified it was his opinion that Petitioner's condition worsened since 2018. (PX11 at 120)

Medical Records following August 5, 2024 revision

On August 5, 2024, Dr. Anwar performed a revision procedure to reposition the leads. (PX4 at 584-586) Petitioner returned to Dr. Anwar for post-operative one-week follow-up on August 12, 2024. (PX4 at 22) Dr. Anwar noted good wound healing and there were no complications. Petitioner next saw Dr. Anwar on August 26, 2024. (PX4 at 14) Dr. Anwar indicated Petitioner was seen for follow-up regarding the stimulator and opiate medication

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management. Patient also underwent fluoroscopic examination. (PX4 at 19) No subjective complaints were documented and there were no problems with the generator or leads noted.

As described above, Dr. Anwar testified via deposition on September 10, 2024. (PX11)

Petitioner next saw Dr. Anwar on November 18, 2024. (PX4 at 4) Dr. Anwar noted Petitioner was seen for her monthly medication management and fluoroscopic examination. Electrical analysis of the stimulator and peripheral programming was done. Petitioner was then taken to the fluoroscopy operating room. Under fluoroscopic view, x-rays were taken for lead migration and generator placement analysis. Dr. Anwar indicated “lead migration noted.” (PX4 at 9) There were no subjective complaints documented and there were no problems with the generator or leads reported.

Testimony of Eric Miller / Surveillance Video

Mr. Miller testified for Respondent. He is employed as a senior investigator with Research Consultants Group. (T. 91-92) Mr. Miller conducts surveillance work which includes videotaping services. Mr. Miller downloads videos from the camera into a computer where it goes into the company’s portal, and the company then forwards the video to the client. In preparation for his appearance, Mr. Miller testified the company downloaded two videos onto thumb drives which he brought to the Commission. Mr. Miller testified the two videos are true and accurate copies of the videos he took in this case. He identified Petitioner as the subject in the videos. The videos recorded Petitioner’s activities over three days on November 29 and November 30 and December 8, 2024. (RX3) In the surveillance videos Petitioner is seen taking trips in her vehicle and driving errands, often with one or both sons traveling as passengers. Petitioner is seen using her left hand to carry her purse, carry shopping bags and other items, using both hands to push a shopping cart, using her left hand to smoke and hold a cigarette. Viewing the video, there is no evidence of muscle stiffness or spasming of the left hand. Petitioner is seen walking briskly without any visible pain behaviors.

Testimony of Dr. Konowitz

At Respondent’s request, Petitioner underwent two independent medical evaluations with Dr. Konowitz on May 4, 2022 and June 7, 2023. (RX1) Dr. Konowitz also issued addendums to those reports on November 29, 2022, and December 13, 2023. *Id.* Based on his first examination on May 4, 2022, Dr. Konowitz testified it was his diagnosis Petitioner had at that time neuropathic pain in the left forearm, with ulnar dysesthesias, meaning there was an irritable ulnar nerve. (RX1 at 20) Dr. Konowitz testified “there were past features of complex regional pain syndrome but there were exam findings today which would – indicated that those were less important.” *Id.* Dr. Konowitz also identified a left supraclavicular trigger point causing pain in the fourth and fifth digits. *Id.* Dr. Konowitz further testified Petitioner had ulnar allodynia and some swelling; however, the multiple other features she previously had were not present anymore. (RX1 at 21) Dr. Konowitz testified her temperatures were symmetric, her skin looked okay without sweating differently, and her weakness “wasn’t crazy.” (RX1 at 21-22) He further commented that exams can change over time. *Id.*

Dr. Konowitz testified he recommended continued use and reprogramming of the stimulator. (RX1 at 22) Dr. Konowitz made multiple medication-related recommendations, including the use of duloxetine to down-regulate pain replacing hydrocodone with buprenorphine. Dr. Konowitz indicated there was a concern for hyperalgesia, which is “where the opioids start to cycle around, triggering more pain...opioids, over time, become less effective...It’s tolerance.” (RX1 at 17) Dr. Konowitz stated, “So when you get them off the opioids and replace them with buprenorphines often there is a change or down-regulation of their pain scores because they’re not as symptomatic.” (RX1 at 18-19). Dr. Konowitz also recommended physical therapy and manual therapy to address the supraclavicular trigger point. (RX1 at 24)

Dr. Konowitz further testified regarding his second examination on June 7, 2023. (RX1 at 27). Dr. Konowitz noted a few areas of improvement compared to his earlier exam findings. (RX1 at 29-30) Dr. Konowitz testified Petitioner exhibited reasonable strength, decreased sharp touch, no allodynia, and decreased vibratory sense in the left hand. He further testified light touch now had changed, it was normal except distally right around the left hand. There was some decreased light touch around the left hand and the left elbow. (RX1 at 30) Dr. Konowitz determined that the ulnar symptoms that were more prominent during the last exam had either gone away or became lessened. *Id.* Dr. Konowitz again recommended buprenorphine as a replacement for opioids, which continued to show little improvement. (RX1 at 28-31). Dr. Konowitz testified Petitioner had “sharp touch” that was great enough to be called allodynia but by the second IME it was no longer there. (RX1 at 31) That said, Dr. Konowitz testified Petitioner still had an irritable ulnar nerve and a positive Tinel’s at the wrist. *Id.* Based on the pain disability index completed at the second IME, Dr. Konowitz testified that Petitioner’s subjective side was no better but objectively she was improved. (RX1 at 32) Regarding his treatment recommendations, Dr. Konowitz noted the spinal cord stimulator was not functional and yet despite the non-functioning device it was his view that Petitioner’s neuropathy had been improving. *Id.* Dr. Konowitz again recommended changes in her medications and felt that psychiatric referral and testing would be appropriate. (RX1 at 32-33)

Conclusions of Law

I. Jurisdiction

For accidents occurring after July 1, 1955, section 19(h) provides that any agreement or award may at any time within 30 months 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). Pursuant to Section 19(f), the Commission’s decision became final twenty days after receipt of the Commission’s decision. 820 ILCS 305/19(f). During the hearing held before Commissioner Doerries, Petitioner represented that the Commission’s Decision and Opinion on Review became final on March 11, 2021. (T. 7) Respondent did not dispute the date provided by Petitioner. Petitioner filed this petition under section 19(h) on June 30, 2023, well within the 30-month period permitted under section 19(h). Accordingly, the Commission has jurisdiction to hear this matter.

II. Section 19(h) petition

The purpose of a proceeding under section 19(h) is to determine if a Petitioner's disability has "recurred, increased, diminished or ended" since the time of the Commission's original decision. *820 ILCS 305/19*; *Howard vs. Industrial Comm'n*, 89 Ill. 2d 428, 433 N.E.2d 657 (1982). To warrant a change in disability benefits, the change in a Petitioner's disability must be material. *Fraley vs. Illinois Workers' Comp. Comm'n*, 2025 IL App (4th) 241191WC-U, P55, and *Gay vs. Industrial Commission*, 178 Ill. App. 3rd 129, 532 N.E.2d 1149 (1989). In reviewing a section 19(h) petition, the evidence presented in the original proceeding must be considered to determine whether Petitioner's disability has changed materially since the time of the Commission's first decision. When a material change is found, the Commission must then determine, in a second analytical step, whether the material change was itself causally related to the original work accident. *Miller vs. Ill. Workers' Comp. Comm'n*, 2020 IL App (2d)218577WC-U, P57. Only if the claimant's condition has materially changed would there be any occasion to address causation. *Id.* at P57.

Whether there has been a material change in a claimant's disability is an issue of fact to be resolved by the Commission. *Howard*, 89 Ill. 2d at 430. The Court's decision in *Gay* offers guidance for determining whether a change in a claimant's condition was material. In *Gay*, the Court indicated that the claimant in that case had failed to present evidence of a "substantial difference" in comparison with the disability that existed at the time of the initial arbitration hearing. *Gay*, 178 Ill. App. 3rd at 133. The decision in *Gay* was also instructive in one other respect. In *Gay*, the claimant underwent a total knee replacement after her award; however, the Court determined the Commission properly denied benefits because the *symptoms* described at the 19(h) hearing were also apparent at the original hearing. In other words, the post-award joint replacement in and of itself was not enough to qualify as a material change in disability, particularly since the Commission had previously considered the need for future knee replacement during its original award. *Gay*, 178 Ill. App. 3rd at 133-134. The Court's analysis in *Gay* is relevant here, as the post-award surgical procedures to repair or replace the Petitioner's spinal cord stimulator components do not in and of themselves establish a material increase in disability.

Based on the record before us, the Commission finds there has been no material change in Petitioner's disability. We find has been no change in diagnosis. Petitioner was diagnosed with CRPS and neuropathic pain involving the left hand and arm in the underlying claim and Dr. Anwar's diagnosis remains the same today. We further find there has been no change in the overall treatment plan. At the time of the original hearing, Petitioner had a permanent spinal cord stimulator implanted and required ongoing medication management under the guidance of a pain management specialist. Currently, Petitioner continues to use the spinal cord stimulator and continues to require medication management under the guidance of a pain management specialist. Spinal cord stimulators, as noted by Dr. Anwar, are a measure of last resort, and her chronic neuropathic pain was deemed to be a permanent condition by the time of the original arbitration hearing. Dr. Anwar testified that issues with spinal cord stimulators, like the issues Petitioner had following the arbitration hearing, are common. Ongoing monitoring of the device and fluoroscopic examinations of the generator and leads are required and are routine. The onset of problems resulting in loss of function are not unexpected and are addressed with reprogramming and

procedures for repair of the generator and/or repositioning of the leads like the procedures provided to Petitioner. Dr. Anwar testified that over the past ten years, Petitioner's stimulator has had two problems, the first dealing with the generator which required replacement, and second involving the leads which required repositioning. Those two problems were exacerbated by treatment delays caused by delays in securing approval from Respondent. The issue to be decided here, however, is whether Petitioner's permanent condition of ill-being and resulting disability at the time of the section 19(h) hearing has materially increased as claimed by Petitioner.

It is clear from the records and testimony that Petitioner's symptoms increased after the arbitration hearing due to a non-functioning spinal cord stimulator. The two issues causing the stimulator to fail were addressed; Dr. Anwar testified that the stimulator is now functioning. Dr. Anwar testified that spinal cord stimulators, as a general rule of thumb, provide between 50% and 60% relief, and the prescribed opiates along with adjunctive medications, including muscle relaxants, provide additional relief, and the combination of the two treatment modalities generally provide maximum pain reduction of 70% to 80%, possibly up to 90% relief. (PX11 at 21-23). At the arbitration hearing, Petitioner testified her pain level decreased by 80% after placement of the permanent stimulator, which was consistent with Dr. Anwar's testimony regarding the combined benefits from opiates and spinal cord stimulators. (PX2 at 38) Dr. Anwar opined Petitioner's disability increased after the arbitration hearing, and he further opined that as of June 2021 Petitioner was no longer able to work; however, his opinion testimony was unpersuasive relative to Petitioner's condition following the August 5, 2024 procedure to reposition the leads. We find significant Dr. Anwar's testimony during the following exchange:

Q. Now that the leads have been repositioned, *do you expect petitioner to experience improvement in her pain?*

A. **Yes.**

Q. About how much would you say?

A. *I think with leads, will give her 50 to 60 percent relief.*

Q. What makes you think that?

A. Because she has an established improvement in the past.

(Emphasis added.) (PX11 at 114-115) Dr. Anwar also testified he will try to wean down on the existing narcotics. *Id.*

Dr. Anwar's testimony regarding the benefits from spinal cord stimulators, the resumption of functionality in Petitioner's stimulator, and his statements quoted above, implies an expected return to baseline, or at least a near-return to baseline, which conflicts with Dr. Anwar's other statements that the maintenance issues with the stimulator caused a permanent increase rather than a temporary increase. Furthermore, assuming there has been a permanent increase in disability, Dr. Anwar never expressly opined that the increase was a substantial or material increase in

disability.

Petitioner had neuropathic pain associated with CRPS in both the left arm and left hand at the time of the arbitration hearing and she continues to have neuropathic pain in both the left arm and left hand today. Petitioner testified she had an achy pain extending from her hand to her elbow at the arbitration hearing and claims the pain is now worse. Petitioner acknowledged that she experienced spasms and numbness and dropped things in “the original case, but now it’s worse.” (T. 17) Petitioner has the burden to prove a “material change” in her condition and disability, and given the recent restoration of Petitioner’s stimulator to a properly functioning device, we are not persuaded that there has been a material change. Petitioner testified there has been some improvement since the leads were repositioned. (T. 49) Given Petitioner’s admission that the restored functioning of her stimulator has resulted in some improvement, it is difficult to quantify or gauge the claimed subjective increase in pain and symptoms. Further, any change must be substantial to qualify as a material change. *Gay*, 178 Ill. App. 3rd at 133.

We further question the reliability of Dr. Anwar’s opinion testimony regarding her current condition. Dr. Anwar was deposed on September 10, 2024, *about five weeks* after repositioning the leads for Petitioner’s spinal cord simulator on August 5, 2024. Dr. Anwar testified regarding the post-operative protocol following the lead replacement and stated that during the first three to four weeks after the procedure the patient was asked to limit use of the stimulator to a very brief period of time for testing purposes; otherwise she was to avoid using the device beyond that for healing purposes. (PX11 at 50) Dr. Anwar’s post-operative progress notes did not document any complications, pain complaints, or other symptoms. We further note there has been no updated FCE ordered. Petitioner agreed she had not undergone a new FCE since the arbitration hearing in 2018. (T. 57) As such, given the timing of his deposition so soon after function was restored to the stimulator, and the absence of documented symptoms in the most recent office visit records, Dr. Anwar’s opinion that Petitioner sustained a permanent increase in disability rather than a temporary increase is speculative. Furthermore, the notion that Petitioner’s disability will not improve is inconsistent with Dr. Anwar’s testimony indicating he will try to wean down on the existing narcotics. (PX11 at 115)

Finally, the surveillance video suggests Petitioner’s current condition is not as disabling as claimed in comparison with the nature and extent of her disability at the time of the arbitration hearing. As described above, Petitioner was seen using her left hand to carry her purse, carry shopping bags and other items, use both hands to push a shopping cart, use her left hand to smoke and hold a cigarette, and there were no episodes of observable muscle stiffness or spasming in the left hand. Petitioner was also seen walking briskly without any visible pain behaviors. Additionally, her son, Randy, testified that he does the driving whenever they are in the car together (T. 78); however, his testimony is inconsistent with the surveillance video which shows Petitioner driving on multiple occasions with one or both sons seated in the passenger side. Since relocating to Catlin, Illinois, Petitioner has continued treating with Dr. Anwar, whose office is located in Frankfurt, Illinois. Petitioner testified she drives to Dr. Anwar’s office and indicated the drive is now two and a half hours each way which she is able to handle, though she will take a rest break to stretch her legs and move around after an hour of driving. (T. 29-30)

III. Temporary total disability (TTD):

In the parties' Request for Hearing form, Petitioner claimed TTD from June 30, 2021 through the date of trial, followed by PTD benefits from the date of hearing onward for life. In Petitioner's brief, however, Petitioner withdrew the claim for TTD and argued Petitioner's period of PTD commenced on June 30, 2021. (Petitioner's brief at 16) As set forth in Petitioner's brief, "the correct finding is she became permanently and totally disabled as of June 30, 2021. Petitioner modifies the claim for TTD after June 30, 2021 to permanent total disability based upon the evidence." (Petitioner's brief at 16) We further observe that Respondent did not address the issue of TTD benefits, presumably because the claimed entitlement to TTD was withdrawn. Accordingly, as the claim for TTD has been withdrawn, we do not decide the issue.

IV. Section 8(a) petition

Section 8(a) provides that employers shall be required to pay for all necessary treatment services that are "reasonably required to cure or relieve the effects of an accidental injury." *Elmhurst Memorial Hospital vs. Industrial Comm'n*, 323 Ill. App. 3d 758, 764, 753 N.E.2d 1132 (2001). The Court further commented that the obligation to pay for medical treatment is continuous so long as the medical services are required to relieve the effects of the injury. *Id.* Dr. Anwar testified that Petitioner's medical care has been reasonable, necessary, and related to the work accident. Dr. Konowitz agreed that the treatment was reasonable and necessary. The Commission therefore finds Petitioner is entitled to compensation for the medical bills set forth in PX13, with the exception of the bill from Rehab Assist, Inc., as provided under sections 8(a) and 8.2 of the Act. Accordingly, Respondent shall pay Petitioner for the reasonable and necessary medical services of Advanced Psychiatric Solutions, LTD (\$400.00); Frankfort Surgical Care Centers (\$37,240.00); Pain Management Institute (\$13,073.56); and Prescription Partners (\$51,522.39), subject to the negotiated rate, if any, or the lesser of the actual charges or the applicable fee schedule amounts.

The Commission finds that Henry Brennan did not provide treatment services within the meaning of section 8(a). The Commission finds the bill from Rehab Assist, Inc., which relates to the Life Care Plan he prepared represents expenses incurred for services he provided in his capacity as Petitioner's expert and therefore represents a cost of litigation. The Commission has previously denied compensation for services provided by a life care planner. See *Kosla vs. Cook County*, 21 IWCC 0062; 2021 Ill. Wrk. Comp. LEXIS 163 (corrected decision issued March 8, 2021). In *Kosla*, which also involved a life care plan prepared by Henry Brennan, we observed that:

[i]n a compensable workers compensation case, the Respondent will be liable for all past, present and future reasonable, necessary and related medical expenses, subject to the fee schedule or contract negotiated fee, whichever is less, pursuant to §8(a) and §8.2 of the Act, however, *the costs are payable as they are incurred*. The Commission has no authority to commute the cost of future medical benefits, to which Petitioner is entitled, to an amount payable in a lump sum. (Emphasis added.)

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In *Kosla*, the Commission concluded, “we do not appreciate the necessity of Brennan’s service,” We likewise arrive at the same conclusion in this matter.

Petitioner also seeks compensation for the companion care services provided by Petitioner’s son, Randy, as well as prospective medical compensation for future companion care, and relies on section 8(a) of the Act which provides that, “If as a result of the injury the employee is unable to be self-sufficient the employer shall further pay for such maintenance or institutional care as shall be required.” 820 ILCS 305/8(a). Based on the evidence before us, we find Petitioner has not been rendered unable to be self-sufficient, though she requires assistance with various household duties. The subject of companion care by spouses and family members has been addressed by our reviewing courts and by this Commission. In *Rousey vs. Industrial Comm’n*, 224 Ill. App. 3d 1096, 587 N.E.2d 26 (1992), the Court set forth the following:

A majority of cases have recognized the general rule that shopping, cooking, and other household services performed by a spouse or other family members are considered gratuitous and cannot form the basis for an award for attendant care services. (DeLong v. 3015 West Corp. (Fla. App. 1986), 491 So. 2d 1306.) The rationale for denying compensation for ordinary household duties when performed by a spouse is that a spouse performs such activities for both parties as part of the marital relationship. (Currier v. Roman L. Hruska U.S. Meat Animal Research Center (1988), 228 Neb. 38, 421 N.W.2d 25.) As one court observed one spouse has agreed to care for the other "in sickness and in health." (Spiker v. John Day Co. (1978), 201 Neb. 503, 530, 270 N.W.2d 300, 314.) For this reason, a distinction has been drawn, for compensation purposes, based on the status of the individual performing those services. Although not necessary to the decision in Burd, this court embraced that concept when it stated that mere household duties provided by a spouse who is otherwise "obligated" to perform them by virtue of the marital relationship are not compensable, whereas a different result may be obtained when an individual not legally or otherwise required to perform the services does so. (Emphasis added.) Rousey, 224 Ill. App. 3d at 1101.

Consistent with *Rousey*, we conclude that the household services provided by Petitioner’s son must be considered gratuitous and cannot form the basis for an award for attendant care services.

We also deny Petitioner’s request for prospective medical benefits as outlined in the life care plan prepared by Henry Brennan. As mentioned above, the Commission has no authority to commute the cost of future medical benefits, to which Petitioner is entitled, to an amount payable in a lump sum. In our workers’ compensation system, the costs for future medical treatment are payable as they are incurred. In *Oziminski vs. U.S. Tobacco Co.*, the Commission reversed an arbitrator’s award for prospective medical benefits where there was no prescribed treatment at the time of the arbitration hearing. “As there is no pending prescription for any treatment, an award of prospective medical treatment is improper.” *Oziminski vs. U.S. Tobacco Co.*, 24 IWCC 0326; 2024 Ill. Wrk. Comp. LEXIS 337. However, the Commission notes Petitioner’s rights to reasonable, necessary and causally related medical care to cure or relieve the effects of the work-related injury remain open under section 8(a) of the Act.

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IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition under §19(h) of the Act is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay reasonable and necessary medical expenses for the medical bills from Advanced Psychiatric Solutions, Frankfurt Surgery Center, Pain Management Institute, and Prescription Partners, as provided under sections 8(a) and 8.2. Medical benefits for companion care services provided by Petitioner's son and the bill from Rehab Assist, Inc. are hereby denied. Respondent shall be entitled to a credit for amounts paid, if any, towards these medical bills.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for prospective medical benefits as outlined in the Life Care Plan is denied.

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 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.

December 22, 2025

KAD/swj

O: 102125

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/s/ Kathryn A. Doerries

Kathryn A. Doerries

/s/ Stephen J. Mathis

Stephen J. Mathis

DISSENT

I respectfully dissent from the opinion of the majority and would grant Petitioner's motions pursuant to Sections 19(h) and 8(a) of the Act with regard to temporary total disability, permanent total disability and continued medical care.

Background

It is the law of the case that Petitioner's complex regional pain syndrome ("CRPS") is related to her work injury of March 23, 2014. As the Commission pointed out in its decision on February 10, 2021, "Four treating physicians have diagnosed CRPS secondary to Petitioner's work

injury on March 23, 2014: Dr. Chen, a hand surgeon; Dr. Wilson, a neurologist; and Drs. Alzoobi and Anwar, both pain management specialists. Dr. Nacke, an orthopedic hand specialist suspected CRPS.” Comm’n Dec. p. 1, para. 3. The Commission placed great weight on the conclusions of these treating physicians. Comm’n Dec. p. 1, para. 4. The Decision goes on to state, “In particular, Dr. Anwar treated Petitioner both before and after the trial SCS and the permanent SCS. The doctor was in the best position to assess Petitioner’s condition pre- and post- operative and her improvement following the implant.” Arb. Dec. p. 10, para. 4.

In assessing factor (v) of Section 8.1b(b), the Arbitrator stated, “permanent work restrictions have been placed on Petitioner consisting of ten pounds maximum lifting, pushing and pulling, with fifteen-minute breaks every two hours and no direct contact with combative residents, and no work in excess of eight hours per day or forty hours per week. While Petitioner is now more functional than she was before the SCS implant, she still experiences a dull ache in her left arm, and although she continues to gradually wean down on her prescription medication, particularly Norco, Gabapentin and Meloxicam, she still maintains a prescription regimen that includes Ambien, Omeprazole, Trazadone, Xanax, and compounded muscle relaxant and analgesic creams, in addition to the reduced doses of Norco, Gabapentin and Meloxicam.” Arb. Dec. p. 12.

At the time of the original trial, it was expected that she would require routine maintenance care. The Arbitrator noted, Dr. Anwar’s finding that Petitioner would require “fluoroscopic analysis twice a year for the SCS implant, and ongoing medication management by a pain specialist.” Arb. Dec. p. 9, para. 3.

Following the hearing on August 13, 2018, Petitioner continued to get adequate stimulation with her SCS, albeit with some weather-related aggravation of her pain and swelling throughout 2018 and 2019. As Dr. Anwar had anticipated, Petitioner underwent fluoroscopic analysis of lead placement quarterly. During this time, she continued to work full-time with restrictions.

Beginning on January 9, 2020, Petitioner’s treatment began to show a deviation from the expected maintenance care, when she presented to Dr. Anwar with a new complaint of numbness and weakness in the left upper extremity. T. 479. Petitioner was then laid off in February 2020 when the Rosewood facility was bought out by another company. T. 11, 51. Petitioner testified she was unable to secure alternative employment with her weight limitations on lifting and break time restrictions. T. 12, 51.

On March 6, 2020, Petitioner presented to Dr. Anwar with a new complaint of pain underneath the implant site. T. 473. Her pain became acute and she presented to Morris Hospital Emergency Department. On March 12, 2020, Dr. Anwar noted that stimulation was increased to decrease the pain around the generator site. He assessed paravertebral spasm and performed a trigger point injection. T. 470. On April 2, 2020, she reported feeling much better after adding cyclobenzaprine as a muscle relaxant. T. 467. By May 28, 2020, Petitioner was noted to be managing her residual pain with medications. T. 461. No lead migration was noted on fluoroscopy on June 25, 2020. T. 458.

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On July 23, 2020, Petitioner reported her SCS was not working due to charging issues. Boston Scientific recommended different programming. T. 455-56. However, on August 20, 2020, her SCS remained non-functional. As a result, Boston Scientific recommended a replacement. T. 452-53. In February 2021, it was noted Petitioner continued to have severe flareups as the SCS remained non-functional. T. 429. Request for authorization for replacement was reiterated on March 22 and April 19, 2021. T. 423, 426.

Petitioner's SCS replacement surgery was finally performed almost a year later on June 30, 2021 (T. 13-14; T. 1437-1439).

Dr. Anwar completed work status reports on June 30, July 6, July 13, and July 27, 2021, indicating Petitioner was totally disabled and would need ongoing care. T. 2131-2134. On July 27, 2021, Dr. Anwar noted that the revision was successful. T. 409. However, on August 10, 2021, charger issues were again noted. T. 405. The last historical entry at this visit was #22: "Patient is successfully using a spinal cord stimulator implant based on my evaluation dated 7/27/2021. Fluoroscopic examination of the leads was done. IPG generator incision site is healing. No lead migration is noted." T. 406.

On September 8, 2021, entries #23-25 are added:

"23. Patient reports plans to begin seeking new employment. Work status documentation was applied with continued 10 pound weight restriction.

24. Patient reports increased pain of her neck and shoulder on the left side. Boston Scientific representative helped the patient to reprogram her stimulator for more appropriate pain control.

25. Fluoroscopic examination of the leads was done. There is mild cephalad migration noted of the right lead. IPG generator incision site is completely healed with no signs of infection or discharge." T. 403.

On October 4, 2021, Petitioner returned to see Dr. Anwar and reported severe spasm in her upper extremities. Cyclobenzaprine was discontinued and Soma was added. T. 399. Dr. Anwar added #26: "Based on patient history of complex regional pain syndrome secondary to her injuries patient had developed chronic pain in left upper extremity which is neuropathic in nature and patient is considered to be disabled at this time based on her medical condition." T. 400.

On February 21, 2022, Petitioner reported a flareup of chronic pain in her left upper extremity, which she described as throbbing and aching in nature. She was scheduled to see psychiatrist Dr. King on March 12, 2022. T. 382. Reprogramming was also recommended and ultimately conducted on March 21, 2022. T. 378.

On April 25, 2022, Dr. Anwar noted Petitioner was managing more than 50% of the pain in her left upper extremity with SCS. Her residual pain was managed with medications providing up to an additional 30% reduction. She remained on Gabapentin, Norco, Xanax, meloxicam, omeprazole, Trazodone, and muscle relaxant. T. 372. At the time of trial on August 18, 2018,

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Petitioner did not require an oral muscle relaxant and was receiving 80% relief from the SCS. T. 191.

On June 20, 2022, Petitioner reported left-sided neck and shoulder pain with radiating pain to the left upper extremity. Additional reprogramming was considered. T. 364. This continued, and on July 21, 2021, acoustic massage therapy was performed for left trapezius and levator scapula muscle spasm. T. 362.

On August 22, 2022, Dr. Anwar had the opportunity to review the Section 12 report of Dr. Konowitz. He agreed with Dr. Konowitz's recommended changes to Petitioner's medications. T. 359. On September 22, 2022, Petitioner reported that her first session of acoustic massage therapy provided one week of relief. T. 355. Therapy was again administered on her left mid-trapezius and left rhomboid.

Petitioner presented to Dr. Anwar with progressively worsening pain on October 20, 2022. Fluoroscopic analysis of the leads showed right-sided cephalad migration. T. 350. It was recommended she try a new program for four weeks, and if no relief, revision of the leads would be recommended. T. 351. On November 21, 2022, it was noted that Petitioner was not satisfied with the new program and continued to get intense pain in the left upper extremity with only 30% relief. Lead revision was recommended. T. 347. Fluoroscopic lead migration was again documented on January 16, 2023. T. 338. On February 13, 2023, Petitioner reported increased frustration and depression and was referred to Dr. Thapur with behavioral health. She continued to report left upper extremity and shoulder pain. It was noted that medication weaning would be considered once she showed improvement in pain after SCS lead revision. T. 335-336.

On March 13, 2023, due to increased anxiety, depression, and left neck and shoulder pain with associated upper extremity pain, Petitioner was advised to discontinue Norco, Trazadone, and Ambien, and these were replaced with Percocet, and another referral to behavioral health was made. T. 331-332.

On May 8, 2023, Petitioner continued to report increased left-sided neck and shoulder pain with associated upper extremity pain. She was advised to decrease Percocet. She had not been seen by psychiatry or behavioral health. Dr. Anwar's recommendations for behavioral health and revision were unchanged. T. 322.

On July 6, 2023, Dr. Anwar reiterated his opinion that Petitioner was considered disabled from performing any activities. T. 314. On July 18, 2023, Dr. Anwar noted left upper extremity pain, sensitivity, edema and decreased range of motion of the left wrist. He added Belbuca (buprenorphine) mcg Q12h sublingual film, as recommended by Dr. Konowitz. T. 310. Unfortunately, this was not covered by her insurance. T. 943, 936. On August 3, 2023, this was replaced with tramadol 50 mg one per day. Lead revision remained prescribed. T. 306. On August 31, 2023, Dr. Anwar noted left upper extremity pain, swelling, sensitivity, spasm, weakness, and coolness. T. 299. On October 26, 2023, Dr. Anwar noted left upper extremity pain, sensitivity, edema, and decreased range of motion of the left wrist. T. 289.

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Medication management continued into 2024. On April 15, 2024, Dr. Anwar noted that Petitioner continued to report inadequate stimulation with her existing SCS implant. It was recommended she undergo a revision, but the interim plan was to continue to manage her pain with her current medication regimen. Dr. Anwar opined she was permanently disabled, unable to work and do normal chores at home. He noted her examination showed signs of allodynia, asymmetrical temperature, edema, and decreased range of motion. Dr. Anwar noted she had had multiple flareups in her left upper extremity CRPS over the last two years due to lead migration. He requested psychological clearance, a second opinion with Dr. Lubenow, as well as rehabilitation and home health assistance evaluation with Dr. William Brenner. T. 265.

On May 13, 2024, Petitioner was noted to have continuous left wrist throbbing pain around her incision site, with significant weakness, weak grip, cold and swelling. T. 257.

On June 6, 2024, Petitioner was evaluated for a second opinion with Dr. Lubenow, who agreed lead revision was necessary. T. 1486. Dr. Lubenow found Petitioner's "pain and symptom relief have returned to levels prior to the SCS placement, and her narcotic burden has increased as a result to include additional norco and tramadol."

On August 5, 2024, Petitioner underwent a SCS revision of the lead implants. T. 1430-1432.

On August 26, 2024, additional reprogramming was recommended to focus more relief below the elbow on the left side. Her rehabilitation assist life care plan was reviewed and approved. T. 234.

On November 18, 2024, lead migration was again noted under fluoroscopy. T. 224.

At the time of the hearing on December 13, 2024, Petitioner testified that the SCS was working, but she continued to suffer symptoms in spite of the relief from the SCS. T. 63. Just prior to hearing Petitioner was prescribed Gabapentin 300 mg two capsules three times per day, Alprazolam (Xanax) 0.5 mg 1 tablet daily, Tramadol HCl 50 mg 1 tablet as needed twice per day, Lidocaine patch twice per day, Hydrocodone-Acetaminophen (Norco) Tablet 10-325 MG, 1 tablet three times per day, Carisoprodol (Soma) 350 mg 1 tablet twice per day. T. 223. In contrast, at the time of trial on August 18, 2018, she was taking Norco, Gabapentin, Trazodone, Ambien, Meloxicam, Prilosec, and Xanax. T.42-44; T. 193-194. The addition of the narcotic Tramadol is the notable change.

Respondent obtained surveillance on November 29, 30, and December 5, 6, 7, 8, and 9, 2024. T. 108. However, video was only shown for November 29, 30, and December 8. Petitioner was not captured on the remaining days. T. 109-110. On November 29, Petitioner went to Casey's gas station and back home. On November 30, she picked up a male (assumed to be her son), and went to Skateland, where she handed him two packages.

At the time of hearing on December 13, 2024, Petitioner testified that her pain was no longer a dull ache from her hand to her elbow as she had testified to during the previous trial on

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August 13, 2018, but was now a lot worse with a shooting pain from her fingers to her elbow. She also reported more spasms, dropping things more often, and becoming more exhausted after doing things for 8-12 minutes. T. 16-18. She detailed occasions where her spasms have occurred in public, causing her to fling food at a server, drop popcorn at the movies, and spill drinks. T. 19.

Petitioner testified that at the time of trial on August 13, 2018, she was able to independently perform her activities of daily living. T. 21. However, since her condition worsened, she could not do the heavier laundry, make the bed, or perform more detailed work with her hands. *Id.* She reported experiencing cuts and burns when eating. T. 22. She explained that the cold weather still caused numbness, and the warm weather still caused swelling, but it was the muscle spasms that changed her ability to complete a task. T. 23. She estimated she received about two hours of help from her son per day. T. 26.

Petitioner testified to experiencing some improvement after the lead replacement in August 2024, but “there’s still a lot of pain...It helps. The pain has worsened, like I said, since originally.” T. 49.

Petitioner’s son, Randy Farmer, corroborated her testimony. He testified that previously she could work light duty, and while she was still in a lot of pain, she had energy. He further testified that when she came home from work, she could cook, clean and do laundry. T. 73. He agreed that as of the date of trial by doing simple tasks she got worn out easily and needed to lay down or take a lot of breaks to do simple things like vacuuming or dishes. T. 75. He testified he helped with dishes, making beds, laundering blankets and towels, taking out trash, cooking and yardwork. T. 75-76. He testified the changes to his mom’s condition had gradually worsened over the prior three years. T. 76. He confirmed she had good days where she tried to do more and bad days where she would have spasms and drop stuff. T. 79-80. He agreed it did not happen every time she carried something. T. 81.

Dr. Anwar was deposed on September 10, 2024. PX11. He agreed that in 2020, Petitioner started having more pain in the left upper extremity. T. 1543. Multiple reprogramming sessions were undertaken, and an issue with the charger needing to be replaced occurred. T. 1543-45.

Dr. Anwar testified that in 2021 Petitioner continued to report a lack of significant benefit with the SCS implant. T. 1545. He testified that when attempts to restore charging and reprogramming failed, replacement was required. T. 1545-46. Starting on June 30, 2021, Dr. Anwar restricted Petitioner from all work. T. 1546-47. He opined that it was at this time her disability increased. T. 1549-50.

Dr. Anwar testified that he placed Petitioner on permanent disability at that time because although she was using the implant and it was helping with her hand pain, she had begun having issues with her arm and the shoulder area. T. 1551-52. Shockwave therapy had been performed because she was getting myofascial pain. T. 1553. He explained that it was common for CRPS patients to have restricted activity of the limb and develop spasms and contractures in the muscles. *Id.* At the end of 2022, he noted she had lead migration with intense pain and was unable to get more than 30% relief with the SCS because only two of the eight electrodes were stimulating. T.

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1555. Dr. Anwar summarized that 2022 “was a struggle year where we thought everything was going to work functionally and fine, and then the lead was not working fine, the electrodes were not giving enough relief because of the lateral movement; and then decision was done that we should go under and do the revision of the lead...” T. 1555-56.

Dr. Anwar testified that 2023 continued to be a difficult year because although he had recommended that she undergo lead replacement, they were “not able to do the lead replacement” and had to manage the Petitioner’s pain with medication. T. 1556-57. Dr. Anwar testified that Petitioner was having more psychological issues, was continuously dealing with pain, and needed more home care. T. 1557. Dr. Anwar agreed that she was totally dependent on her son for activities of daily living and was too disabled to do any activities. *Id.*

Dr. Anwar explained how important family supportive therapy was in the late stages of CRPS where the patient had chronic disability. He noted supportive therapy was not unique to Petitioner’s family. He explained the natural progression “into a second, third stage of CRPS where patient[s] have chronic disability and now other matters have developed.” T. 1560.

At the time of Dr. Anwar’s testimony, Petitioner was four weeks status post lead replacement surgery. T. 1560. Despite this lead revision, Dr. Anwar testified Petitioner remained totally and permanently disabled: “I mean, this patient – you have to understand, it’s not that this – the lead replacement is not going to fix the CRPS. The CRPS is already developed and progressed to a point where patient have more neuropathic and more myofascial issues. So her disability is permanent at this point. All we are helping her is improving the quality of life by decreasing the pain. She has developed significant motor changes. She’s got developed stiffness, and she’s also developed some other spasms which are going on daily basis which we are not able to control it for some reason.” T. 1563-64.

Respondent’s Section 12 examiner, Dr. Konowitz, was deposed on April 10, 2024, and provided a history of his two examinations of Petitioner, as well as his findings over his four reports. Overall, Dr. Konowitz felt that Dr. Anwar’s reports were light in their overall documentation. T. 2185. He noted Petitioner was a complicated patient, as she had evidence of depression and anxiety, based upon her pain disability index and Beck’s depression index. T. 2191. He recommended changing to buprenorphine in order to provide pain relief, prevent withdrawal and avoid narcotics tolerance issues. T. 2193. Dr. Konowitz diagnosed Petitioner with neuropathic pain, left forearm with ulnar dysesthesias. T. 2195. At the time of his initial examination of Petitioner on May 4, 2022, he found past features of CRPS, but did not find them significant. T. 2197. He found Petitioner had left supraclavicular trigger point issues, causing fourth- and fifth-digit pain. He found decreased sensitivity to global vibration throughout the hand and increased sharp touch sensitivity in the ulnar nerve. He did not find differences in her hands with regard to temperature, skin appearance, sweating or significant weakness. *Id.* He testified that the exam only showed the diagnosis on that day, but it didn’t mean the features of the condition not present didn’t get treated. T. 2197.

At the time of his second evaluation of Petitioner, on June 7, 2023 he had similar physical findings. He noted there were lumbar spine issues, decreased sharp touch to the left ulnar

distribution, vibratory sense in the left hand was decreased globally, but strongest on the ulnar side. Her light touch sensation was decreased at the left hand and left elbow, with some trace edema and tenderness over the cubital tunnel with a positive Tinel's. T. 2205-2206. Dr. Konowitz found Petitioner was objectively getting better, but subjectively still feeling badly, so he opined there was an overlying issue of mood, noting a prior psychiatric referral. T. 2206-2207. He continued to recommend a change to buprenorphine over opioids. He further recommended a psychiatric referral and testing, noting that just because she had a stimulator didn't mean she had to keep it in, as he found she was getting better when it was off. T. 2208. He opined the best stimulators in neuropathic pain disorders worked in the beginning, not always at the end. T. 2209. He also opined stimulators placed late, after five years, rarely did well to provide a lot of function or improvement in pain. *Id.* He found her situation was heading down a route of a stimulator that was problematic and other options should be investigated to improve function. *Id.* Dr. Konowitz further testified to his findings in his December 13, 2023 addendum report. T. 2209-2210. After a review of additional updated records, he noted no significant changes to her treatment or her pain reports and function. T. 2210. He found the June 7, 2023 report supported a return to work with limited left arm use at no more than 10 pounds. He gave a restriction based on the one extremity on the ulnar side, where her symptoms were. T. 2211.

On cross examination, Dr. Konowitz testified he did not believe Petitioner was lying, faking or telling him anything untruthful at the time of her examinations. T. 2218. He agreed that while he did not see certain Budapest criteria on his examination, he did not dispute Dr. Anwar's findings and noted that exam findings, including pain complaints, could wax and wane. T. 2249-2250. He also testified that he did not diagnose her with active CRPS only due to the fact she did not demonstrate symptoms at the time of his two examinations of her. T. 2252.

Dr. Konowitz agreed that when the spinal cord stimulator was covering where it needed to, it provided relief on her left side. T. 2264-2265. He agreed that Petitioner's treatment to date was related to her work accident and that the treatment provided had been reasonable and necessary, with the exception of the number of x-rays performed and drug testing performed. T. 2266. He agreed that Petitioner's subjective pain complaints worsened over the years. T. 2267. Objectively, at the time of his examination, he found decreased vibration sensitivity and decreased allodynia. *Id.*

When asked if he thought she should have the SCS replaced, he testified she should have a psychological evaluation first, much like before she received the initial SCS. T. 2269. He testified that when the stimulator was working, he was fine with continuing the current care. T. 2270. It was after the stimulator failed; he recommended further evaluation. *Id.* He was not of the opinion that that SCS should be removed, but that further psychological evaluation be performed. T. 2271. He also recommended medication management, as he thought she could have better function. *Id.* After this, then a decision as to the reasonableness of keeping the SCS could be made. T. 2269.

Analysis

At the very essence of a 19(h) Petition is the question as to whether there has been a material change in the claimant's condition since the award of benefits. I find Petitioner has made a more than adequate showing of a change in condition and moreover a demonstration of permanent total disability.

At the time of the original trial on August 13, 2018, Petitioner was still working and functioning with restrictions of ten pounds maximum lifting, pushing and pulling, with fifteen-minute breaks every two hours, no direct contact with combative residents and no work in excess of eight hours per day or forty hours per week. It was expected she would require routine maintenance care. However, Petitioner's testimony at the time of the December 13, 2024 hearing, as well as the medical records and expert opinion of Dr. Anwar demonstrate a very different reality. As of January 9, 2020, Petitioner's treatment began to move beyond mere routine maintenance, as she developed new complaints of numbness and weakness in the left upper extremity. As established in detail above, Petitioner had nothing but problems with her spinal cord stimulator. She continuously had flareups while her SCS was non-functioning. She was forced to endure over a year of flareups before she was able to have the SCS replaced on June 30, 2021. Immediately following the revision, she was taken off work. T. 2131. A few months after the revision, Petitioner advised Dr. Anwar she was planning to begin seeking employment, causing him to provide her with light duty restrictions. T. 403. However, as Petitioner's condition continued to worsen, after a month, Dr. Anwar opined that although the SCS was technically functioning, Petitioner had developed chronic pain in her left upper extremity which was neuropathic in nature. T. 400. So, if there was some hope following the revision that she would be able to return to work, this was quickly abandoned. The assessment of medical permanent disability remained in place throughout the remainder of 2021.

Petitioner continued to have flareups of her left upper extremity chronic pain. There were reprogramming recommendations due to objectively identified lead migration. A SCS revision was recommended. She was forced to increase her medications to alleviate some of the pain due to the nonfunctioning of the SCS and she understandably began suffering from depression and anxiety, additional diagnoses which were not active diagnoses at the time of her initial hearing in 2018. A second opinion by Dr. Lubenow agreed with the need for a revision. On August 5, 2024, Petitioner underwent the revision surgery, a little less than two years after a recommendation of the revision of the lead implants was made. Dr. Anwar's opinion as to Petitioner's medical permanent and total disability did not change. He explained that at that point, the lead replacement was not going to fix Petitioner's CRPS, as it had already developed and progressed to a point where she had more neuropathic and myofascial issues. T. 1563. Petitioner's disability was permanent.

Respondent relies upon the opinions of Dr. Konowitz to dispute Petitioner's medical disability status. I did not find Dr. Konowitz' opinions to be in line with the medical treatment evidence or the testimony presented at hearing. Dr. Konowitz noted several times in his deposition that he could not make a finding of CRPS, as he personally could not reproduce the alleged symptoms. However, he conceded that it was possible for CRPS to be in existence even when a patient was not displaying symptoms every day. He also testified he had no doubt that Dr. Anwar's

findings of the Budapest criteria were accurate, his only dispute being how often those findings were recorded. This should not change the findings of an underlying diagnosis.

I find Dr. Konowitz' opinion on Petitioner's restrictions to be particularly unfounded. He finds that Petitioner is only restricted to ten pounds on her left upper extremity. This is presumably due to his lack of CRPS findings and his resulting narrow focus on his diagnosis of neuropathic pain of the left forearm with ulnar dysesthesias. Dr. Konowitz noted that Petitioner's pain was worse but opined her condition had improved. These findings are inapposite and negatively affect his credibility. While it is understandable he would rely upon his own physical exam findings when forming his opinions, while dealing with a condition which he himself has admitted does not present symptoms 100% of the time, it does not follow that he would completely ignore the findings documented in the medical records. The medical records, as shown above in detail, demonstrate a change in condition, beginning in 2020, which included not just an increase in pain, but neuropathic and myofascial issues, resulting in a decrease in function and objective lead migration findings via fluoroscopy, all of which support the Petitioner's subjective pain complaints. They demonstrate significant delays in the repair of her pain mitigation device, with Petitioner sometimes waiting years for reprogramming, and/or replacement of her SCS. By ignoring these objective findings and delays, he minimizes Petitioner's pain complaints, which are excessively worse than they were at the time of the original hearing, when mere maintenance was the prospective medical plan. His opinions also do not take into account Petitioner's complaints of impaired function, which were supported by the medical records and the testimony of her son at hearing. He also does not actively comment on Dr. Anwar's opinion as to permanent and total disability. For these shortcomings, I find Respondent's reliance on Dr. Konowitz' opinion for rebuttal of Dr. Anwar's permanent and total disability designation to be misplaced.

Respondent also relies upon video surveillance in their attempt to refute the Petitioner's permanent and total disability status. However, nothing in the surveillance demonstrated a significant difference from Petitioner's admitted abilities/deficits at trial. While Petitioner testified she often had functional deficits, she further testified they did not happen all the time. Given the limited amount of time Petitioner was surveilled and the limited amount of substantial left arm usage during that time, the video surveillance, without any supporting medical opinion, did not present a significant basis for rebuttal of a finding of medical permanent and total disability.

What constitutes disability which renders an employee wholly and permanently disabled, was summarized by our Supreme Court in the case of *Ceco Corp v. Indus. Comm'n*, 95 Ill.2d 278, 447 N.E.2d 842, 69 Ill.Dec. 407 (1983) as follows: This court has frequently held that an employee is totally and permanently disabled when he "is unable to make some contribution to the work force sufficient to justify the payment of wages." (e.g., *Gates Division, Harris 371 Intertype Corp. v. Ill. Indus. Comm'n*, 78 Ill.2d 264, 268 (1980); *Arcole Midwest Corp v. Ill. Indus. Comm'n*, 78 Ill.2d 271, 275 (1980). Ultimately, medical evidence alone is sufficient to demonstrate permanent and total disability. An expert medical opinion indicating that a Petitioner is totally disabled will shift the burden to the employer to demonstrate employability. *Electro-Motive Division, General Motors Corp. v. Ill. Indus. Comm'n*, 240 Ill.App.3d 768 (1st Dist. 1992). A Petitioner can prove a permanent total disability by a preponderance of the medical evidence. This type of permanent total disability is proven when the Petitioner's medical condition makes them obviously unemployable. *ABB C-E Services v. Ill. Indus. Comm'n*, 316 Ill.App.3d 745 (5th Dist. 2000). This

case is not the circumstance of an “odd lot” permanent total, but a permanent total of a medical finding. Petitioner need not present evidence, such as age, training, education and work experience. Dr. Anwar remains in the best position to assess Petitioner’s condition. His treating records and testimony make it clear that beginning on January 9, 2020, Petitioner began to have new complaints and nothing but issues with her SCS persisted for years. Dr. Anwar explained that although Petitioner received some relief from her SCS, her CRPS condition had progressed such that she was totally and permanently disabled. Petitioner’s change in condition was not represented solely by her increase in pain, but rather in the four years of on and off pain flare ups, which resulted in neuropathic changes, a decline in overall function and a renewed need for treatment of psychological conditions. Based upon the medical evidence as a whole and the testimony provided, I find Dr. Anwar’s opinion to be more credible than that of Dr. Konowitz. Respondent failed in refuting that credible medical opinion. I, therefore, find Petitioner has met her burden of demonstrating permanent and total disability and would grant her Petition with regard to this issue.

When Petitioner was laid off in February 2020, she remained on permanent restrictions that Respondent was no longer able to accommodate. Subsequent to the layoff, she was also actively treating, with a visit to the emergency department in March 2020 for new pain at the implantation site which required follow-up with trigger point injection and change to her medication regimen. Then in July 2020 her SCS became non-functional due to charging issues and replacement was ultimately recommended. For these reasons, Petitioner is entitled to temporary total disability benefits from the time of her layoff in February 2020, until such time as she was declared permanently and totally disabled by Dr. Anwar on June 30, 2021. I would grant the pending Petition with respect to temporary total disability benefits.

In conjunction with my finding of a credible and reliable medical finding of permanent and total disability, I also find Petitioner’s burden has been met with regard to her disability and her need for continued medical care. I would grant the Petition for past and prospective medical care pursuant to Section 8(a) and 8.2 of the Act. I agree with the Majority’s position on the denial of the \$7766.25 Rehab Assist bill as a cost incurred in preparation for litigation. The bill does not fall under the purview of Section 8(a) and should not be included in the award of medical.

While the Majority seems to consider the estimated future medical costs in the life care plan by Henry Brennan to be introduced as a request for a lump sum award, I do not think that was the Petitioner’s intention. The life care plan and cost estimations contained therein were introduced to demonstrate Petitioner’s ongoing disability, not as a specific monetary award demand. Those costs were not listed in the Request for Hearing outstanding bills list, nor in Petitioner’s Exhibit 13 bills. To the extent the life care plan was offered as a monetary request for benefits, I would agree with the Majority that such an award would be inappropriate.

I also agree with the Majority’s denial of reimbursement for past and prospective companion care. The evidence does not support reimbursement as the care provided did not fall under necessary medical, surgical, or hospital services within the meaning of Section 8(a) of the Act. In determining whether an award for home care services is appropriate, we must look to the types of duties performed and the status of the party rendering them. *Burd v. Ill. Indus. Comm’n*,

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207 Ill. App. 3d 371 (1991). Here, the Petitioner's son lived with her and testified to performing household duties. As an adult living within her home, the duties her son testified to performing within the home are duties that anyone living within their own home would be performing, i.e. doing yardwork, taking out the trash, switching heavy loads of laundry. Courts have generally recognized that shopping, cooking, and other household services performed by family members are considered gratuitous and cannot form the basis for an award for attendant care services. *Rousey v. Ill. Indus. Comm'n*, 224 Ill. App. 3d, 1096, 1101 (4th Dist. 1992). Further, the Petitioner's testimony at trial was not that she could not perform most household tasks, but rather it took longer for her to perform them and required more recovery time to perform them. I would find Petitioner did not meet her burden with regard to her request for companion care reimbursement.

For the foregoing reasons, I would grant Petitioner's Petition for Review under Sections 19(h) and 8(a) of the Act in part and deny it in part.

/s/ Amylee H. Simonovich

Amylee H. Simonovich

December 22, 2025

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	23WC028830
Case Name	Jarod McLaughlin v. Prairie State Generating Company
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	25IWCC0507
Number of Pages of Decision	14
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	Thomas C Rich
Respondent Attorney	Daniel Broombaugh

DATE FILED: 12/22/2025

/s/Maria Portela, Commissioner

Signature

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)
☐ Modify	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAROD MCLAUGHLIN,

Petitioner,

vs.

NO: 23 WC 28830

PRAIRIE STATE GENERATING COMPANY,

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, causation, medical expenses, 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, but makes a clarification as outlined below.

The Commission affirms and adopts the Decision of the Arbitrator, though notes that the Arbitrator should have analyzed this case pursuant to the Workers' Compensation Act rather than the Occupational Diseases Act. The Arbitrator erred in treating Petitioner's claim as an occupational disease rather than a work accident since Petitioner dismissed his hearing loss claim. While there are specific requirements to prove hearing loss as an occupational disease under the Act, the Commission noted in *Moran v. Village of Winnetka* that the Act does not require any minimum exposure for a certain length of time to prove injury for tinnitus. *Moran v. Village of Winnetka*, 08 I.W.C.C. 0289. However, the Commission finds that even under this standard the Petitioner did not prove accident and affirms the Arbitrator's Decision denying accident.

Additionally, the Commission strikes the Conclusions of Law beginning on page 5 of the Decision and replaces it with the below:

Issue C: Did the Petitioner suffer an accident which arose out of and in the course of his employment by the Respondent?

In a workers' compensation case, the claimant has the burden of proving, 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*, 207 Ill.2d 193, 203 (2003). An injury "arises out of" employment when "the injury had 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." *Id.* 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*, 129 Ill.2d 52, 58 (1989).

The Commission notes that this case consisted primarily of testimony and very little documentary evidence. The medical records contained in the record show that Petitioner complained of ringing in his ears as far back as 2012. (Rx2)

Petitioner did not submit any evidence regarding the noise level in the mines. Although the Petitioner testified that there was heavy machinery everywhere and described the level of noise as constant, (T. 15-16) there was no evidence to support the level of noise to which Petitioner was exposed was greater than that of the general public. First, Petitioner did not describe how long he was underground per day. He also did not state the specific type of machinery in the vicinity, for how long he was around that machinery, or the decibel level of noise in the mine. Second, Petitioner testified he wore hearing protection throughout his employment with Respondent. There is no evidence to substantiate the level of noise to which Petitioner was exposed beyond his testifying it was noisy.

Additionally, the Petitioner did not submit a causation opinion, nor did he submit any records into evidence supporting the proposition that his tinnitus was aggravated by his employment. Petitioner underwent a hearing evaluation a few months prior to leaving employment with Respondent in May of 2023. Petitioner was noted to have hearing loss in both ears and was recommended to follow up with an ENT and to potentially obtain a hearing aid consultation. (Px3) The medical records entered into evidence did not note the tinnitus or contain a causation opinion.

The only causation opinion in this case came from Respondent's Section 12 examiner, Dr. Malak, who performed an independent medical examination. As part of same, Dr. Malak conducted 3 separate hearing tests. Dr. Malak opined that based on his comparison of hearing tests to the pre-employment exam, that there was a 0% of hearing loss attributable to Petitioner's employment with Prairie State. (Rx1, p. 14) Regarding Petitioner's tinnitus, Dr. Malak testified that Petitioner reported that his tinnitus was not affecting his day-to-day activities and was not interfering with his life. Dr. Malak also noted that Petitioner had reported having tinnitus at the time he was hired in 2012. (Rx1, p. 16) Dr. Malak ultimately opined that Petitioner's hearing actually got better while working for Respondent. (Rx1, p. 17) Dr. Malak did not provide a causation opinion regarding the tinnitus but noted it as a subjective complaint. Dr. Malak further indicated Petitioner had tinnitus prior to his employment with Respondent and that Petitioner told him that the tinnitus did not interfere with his day-to-day activities and therefore, Petitioner suffered no disability as a result of the tinnitus. (Rx1, p. 18 and Rx1, Section 12 Examiner Report)

Ultimately, the Commission finds that only evidence in the record in support of Petitioner's claim is that Petitioner may have worked in a noisy environment, but Petitioner testified that he wore hearing protection throughout the course of his employment. Petitioner had a history of hearing loss and tinnitus prior to his employment with Respondent. Petitioner continued to have hearing loss and tinnitus after he left employment with Respondent, but the only evidence of hearing loss is that it may have slightly improved or stayed the same as it was when he was hired. There was no evidence beyond the testimony of Petitioner that the tinnitus worsened during his employment with Respondent.

Although 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 of laypersons, expert testimony is necessary to show that claimant's work activities caused the condition complained of." *Nunn v. Industrial Comm'n*, 157 Ill.App.3d 470, 477-78 (1987); see also *Johnson v. Industrial Comm'n*, 89 Ill.2d 438 (1982). Cases involving aggravation of a preexisting condition primarily concern medical questions and not legal questions. *Berry v. Industrial Comm'n*, 99 Ill.2d 401 (1979); *Nunn*, 157 Ill.App.3d at 478. Where there is evidence of a preexisting degenerative condition, medical opinion evidence is necessary to establish a causal connection between the repetitive trauma injury and the claimant's work duties. *Nunn*, 157 Ill.App.3d at 478 (affirming Commission's finding of no accident arising out of the employment where the claimant had a history of prior back problems and degenerative disc disease, she presented no expert medical testimony that might have established whether or not her current back condition had "developed over a period of several years" before she began the relevant repetitive work activities, and the only evidence connecting the claimant's back condition to her work duties was the claimant's own undisputed testimony, which the Commission was entitled to find not credible).

In the instant case, the Commission finds that Petitioner presented insufficient evidence to prove he sustained an accident arising out of or in the course of his employment. Accordingly, all other issues are moot.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 26, 2025 is hereby affirmed and adopted with the changes set forth 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.

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.

23 WC 28830

Page 4

DECEMBER 22, 2025

/s/ *Maria E. Portela*

Maria E. Portela

MEP/dmm

O: 110625

49

/s/ *Christopher A. Harris*

Christopher A. Harris

/s/ *Marc Parker*

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
DECISION SIGNATURE PAGE

Case Number	23WC028830
Case Name	Jarod McLaughlin v. Prairie State Generating Company
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	9
Decision Issued By	Jeanne AuBuchon, Arbitrator

Petitioner Attorney	Thomas C Rich
Respondent Attorney	Michael Karr

DATE FILED: 2/26/2025

/s/ Jeanne AuBuchon, Arbitrator
Signature

THE INTEREST RATE FOR THE WEEK OF FEBRUARY 25, 2025 4.18%

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**

Jarod McLaughlin

Employee/Petitioner

Case # **23** WC **028830**

v.

Consolidated cases: _____

Prairie State Generating 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 **Jeanne L. AuBuchon**, Arbitrator of the Commission, in the city of **Collinsville, Illinois**, on **January 23, 2025**. 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 **8/26/23**, 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/occupational disease that arose out of and in the course of employment.

Timely notice of this accident **is not applicable**.

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

In the year preceding the injury, Petitioner earned **\$116,439.44**; the average weekly wage was **\$2,239.22**.

On the date of accident, Petitioner was **41** years of age, *married* with **2** dependent children.

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 **\$Any paid** under Section 8(j) of the Act.

ORDER

Benefits 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.

Jeanne L. AuBuchon

Signature of Arbitrator

February 26, 2025

PROCEDURAL HISTORY

This matter proceeded to trial on January 23, 2024, on all disputed issues. The issues in dispute are: 1) whether the Petitioner sustained accidental injuries that arose out of and in the course of his employment; 2) whether the Respondent was given proper notice; 3) the causal connection between the accident and the Petitioner's tinnitus; 4) payment of medical bills; and 5) the nature and extent of the Petitioner's injuries.

FINDINGS OF FACT

At the time of the accident, the Petitioner was 41 years old and employed by the Respondent as a section supervisor. (AX1, T.13-14) He had worked for the Respondent for 11 years and had started out there as a mine tech. (T. 13-14) He worked as a mine tech for approximately two years until becoming a supervisor in 2014. (T. 27-28) Prior to working for the Respondent, he was a mine tech for another mining company for seven years and as an ironworker for about two and a half years before that. (T. 14, 34) He said he had minimal noise exposure as an ironworker. (T. 34) He explained that while working for the Respondent, there was heavy machinery everywhere – continuous miner, drills, dump trucks, scoops, feeder – running near him in rooms 18-20 feet wide and 6-8 feet tall. (T. 15-17) He said the level of noise is constant and similar day to day. (T. 16) He said he wore ear plugs but was still exposed to a lot of noise. (T. 17)

The Petitioner acknowledged undergoing pre-employment testing before starting his employment with the Respondent that included a hearing test. (T. 31) Following an examination on November 8, 2012, by Nurse Practitioner Valerie Blechle at Sparta Community Hospital, the Petitioner was found physically able to perform essential functions of the job (RX2) The Petitioner reported a medical history of ringing in the ears and that he used ear protection. (Id.)

The Petitioner testified that he noticed spotty ringing in his ears 10 or 11 years ago, and in August 2023 – the time of his last exposure – it progressed to where it's present all the time. (T. 18, 28) He said that after working for the Respondent, the ringing went from some of the time to all of the time and picked up in volume. (T. 42) He said that coworkers would say things to him and he couldn't hear them. (T. 19-20) He said he had conversations with his supervisor in which he could not hear him. (T. 20) He agreed that the crews working with him were aware of the ringing in his ears and his lack of hearing. (Id.) He acknowledged that he did not report his injury. (T. 21) He said he waited to report his injury until after leaving his employment with the Respondent because he had a good job and did not want to lose it. (T. 26)

On May 19, 2023, the Petitioner presented to Midwest Sinus Sleep Allergy for a hearing evaluation required for work. (PX3) He reported a history of occupational noise exposure as a coal miner. (Id.) An audiogram showed right ear normal hearing sensitivity notching to moderately severe sensorineural hearing loss with excellent speech discrimination ability and left ear normal hearing sensitivity with sloping to severe sensorineural hearing loss with excellent speech discrimination ability. (Id.) Audiologist Dr. Elizabeth Fernandez diagnosed bilateral sensorineural hearing loss and recommended follow-up with an otorhinolaryngologist (ENT), retesting, hearing protection use in noise and a hearing aid consultation. (Id.)

The Petitioner testified that his visit to Midwest Sinus Sleep Allergy was required as part of his pre-employment evaluation for his current job at the Mine Safety and Health Administration (MSHA) that he had to pay for because he failed three of MSHA's tests. (T. 38) He said he was seeking treatment but found out he could not afford it. (T. 38-39)

On September 10, 2024, the Petitioner underwent a Section 12 examination performed by Dr. Paul Malak, an occupational medicine physician with Ortho Missouri. (RX1 Deposition

Exhibit B) The Petitioner described his work history and reported that his wife and kids started telling him he was having hearing issues around five years ago. (Id.) The Petitioner reported that he recently started having ringing in his ears that he noticed throughout the day but that the ringing did not affect his day-to-day activities or interfere with his sleep. (Id.) He reported that he “just tunes it out.” (Id.)

Dr. Malak reviewed the November 8, 2012, Sparta Community Hospital audiological evaluation and a hearing test from November 18, 2016, that was not submitted as evidence at arbitration. (Id.) Dr. Malak reviewed an electromyography nerve conduction (EMG/NCS) report from November 28, 2023, and orthopedic records from February 19, 2024, regarding carpal tunnel syndrome. (Id.)

Dr. Malak performed audiometric evaluations on three separate days and opined that the Petitioner did not suffer any hearing loss from his work activities or exposures while working for the Respondent. (Id.)

Regarding tinnitus, Dr. Malak pointed out that the Petitioner’s pre-employment hearing evaluation noting ringing in his ears was not consistent with his report of only having ringing in the ears recently. (Id.) Dr. Malak stated that tinnitus occurs commonly in adult populations in individuals exposed to and not exposed to industrial noise or head trauma. (Id.) He said the exact cause of the condition is not known but has been reported in cases of industrial noise exposure and trauma even though certain individuals exposed to high levels of industrial noise or significant trauma do not report tinnitus. (Id.) He said the presence or absence of tinnitus is generally based on patient history taken at face value. (Id.) He said the degree of bother from tinnitus can be estimated by the degree to which it interferes with the patient’s life and by previous attempts at treatment. (Id.) Dr. Malek opined that the Petitioner had no disability due to his tinnitus based on

the Petitioner not having any significant change in his hearing loss from his pre-employment test, having tinnitus prior to his employment with the Respondent and his tinnitus not interfering with his day-to-day activities. (Id.)

The Petitioner identified inaccuracies in Dr. Malak's report – specifically him saying the ringing started recently and saying he had no effects on his day-to-day activities. (T. 29, 39-40) He said Dr. Malik asked if the ringing started in the past 5-10 years. (T. 30) He acknowledged his statement to Dr. Malak that he tuned out the ringing and clarified that he "kind of" got used to it, but said it's always there, and he doesn't notice it until it interferes with something he needs to hear. (T. 40)

Dr. Malak testified consistently with his report at a deposition on October 18, 2024. (RX1) On cross-examination, Dr. Malak was told that the Petitioner was going to testify that the tinnitus got worse as a result of his work for the Petitioner and was asked if there was any reason to agree or disagree with that. (Id.) Dr. Malak answered: "I can't agree or disagree with that. It's his statement." (Id.)

At the time of arbitration, the Petitioner was working as an inspector with MSHA. (T. 13) He said he is still working underground with exposure to high noise volumes but only for less than eight hours a week. (T. 21) He said he is not up at the face where all the action is taking place but walks old areas of the mine where there is no action. (T. 22) He said his hearing is still terrible and he has constant ringing, demonstrating the sound. (T. 22-23) He said he has to read lips to help him. (T. 23) He said that when working and has to listen for things like a roller rubbing to look for dangers. (T. 23-24) He said he almost did not get hired for his current job because of the ringing in his ears, but gets a waiver every year so that he can continue working. (T. 24) He said there is nothing he can do to stop the ringing. (T. 24-25) He said his wife and daughters yell at

him and tell him to turn is phone down and that the TV is too loud. (T. 25) He said he has talked to people about hearing aids but had not purchased them. (T. 39)

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law as set forth below. As a preliminary matter, the Arbitrator conducts the analysis herein under the Occupational Diseases Act (ODA).

Issue C: Did the Petitioner suffer an occupational disease which arose out of and in the course of his employment by the Respondent?

Section 1(d) of the ODA provides that the term “Occupational Disease” means a disease arising out of and in the course of the employment or which has become aggravated and rendering disabling as a result of the exposure of the employment. Further, such aggravation shall arise out of a risk peculiar to or increased by the employment and not common to the general public. Section 1(e) of the ODA defines disablement as 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.

From the Petitioner’s description of his work environment, the Arbitrator finds he was exposed to noise in the mines that was not common to the general public.

As to whether the Petitioner’s tinnitus was a disease that arose out of and in the course of his employment or became aggravated as a result of the exposure, the Arbitrator finds there is circumstantial evidence supporting the proposition that the workplace noise aggravated his pre-existing ear-ringing – specifically the Petitioner’s testimony that the tinnitus worsened while

working for the Respondent. However, the Petitioner presented no medical evidence in support of this element. The Commission has denied claims for compensation for tinnitus conditions, citing claimant's failure to present a medical opinion to support causation between the tinnitus and the claimant's workplace exposure. *Ellner vs. Consolidation Coal*, 09 IWCC 475; *Monti vs. Consolidation Coal*, 09 IWCC 1007; *Johnson v. Cargill*, 24 IWCC 436.

Therefore, the Arbitrator finds the Petitioner failed to prove by a preponderance of the evidence that he suffered an occupational disease which arose out of and in the course of his employment by the Respondent.

Based on these findings, the Arbitrator does not reach the element of disablement under Section 1(e) nor any of the other disputed issues.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	21WC000190
Case Name	INSURANCE COMPLIANCE v. DELICATE PLASTICS INC
Consolidated Cases	
Proceeding Type	Petition for Penalties
Decision Type	Commission Decision
Commission Decision Number	25IWCC0508
Number of Pages of Decision	8
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	Megan Murphy
Respondent Attorney	

DATE FILED: 12/22/2025

/s/Maria Portela, Commissioner

Signature

21WC000190; 17INC433

STATE OF ILLINOIS)
)
 COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ILLINOIS DEPARTMENT OF INSURANCE,
 INSURANCE COMPLIANCE DEPARTMENT,

Petitioner,

vs.

NO: 21WC000190
 17INC433

DELICATE PLASTICS, INC.,
 JIN ZHENG, AND PING CAI,
 INDIVIDUALLY AND AS OFFICERS,

Employers/Respondents.

DECISION AND OPINION REGARDING INSURANCE COMPLIANCE

Petitioner, the Illinois Department of Insurance, Insurance Compliance Department brings this action, by and through the Office of the Illinois Attorney General, against the above captioned Respondents alleging violation of Section 4(a) of the Illinois Workers' Compensation Act for failure to procure mandatory workers' compensation insurance. Petitioner alleges that Respondents knowingly and willfully lacked workers' compensation insurance for 244 days. A hearing was held before Commissioner Maria Portela in Chicago, Illinois on July 29, 2025. Proper and timely notice was provided to Respondents. Px1. Petitioner was represented by the Office of the Attorney General. Respondents did not appear in person or through counsel. A record was taken.

Petitioner seeks the maximum fine allowed under the Act, \$500.00 per day for each of the 244 days, from April 1, 2016 to December 1, 2016, when Respondents did business and failed to provide coverage for their employees. Petitioner also seeks reimbursement for payment by the Injured Workers' Benefit Fund to an employee of Respondent in case number 17WC002223 in the amount of \$5,533.35 as well as payment to the Illinois Department of Healthcare in the amount of \$400.00. Petitioner seeks a total award of \$127,933.35.

The Commission, after considering the record in its entirety and being advised of the applicable law, finds that Respondents knowingly and willfully violated Section 4(a) of the Act and Section 9100.90 of the Rules Governing Practice before the Illinois Workers' Compensation Commission (Rules) during the period in question. As a result, Respondents shall be held liable for non-compliance with the Act and shall pay a penalty in accordance with Section 4(d) of the Act. For the following reasons, the Commission assesses a civil penalty against the Respondents under Section 4 of the Act in the sum of \$127,933.35.

I. Findings of Fact

Investigator Andrew Belanger personally served Respondent via Donald Shriver, registered agent with a Notice of Insurance Compliance Hearing on December 3, 2024. Px 2.

On July 8, 2025, Notices of Insurance Compliance Hearing were sent via certified mail to Delicate Plastics, Inc. c/o Jin Zheng, Delicate Plastics, Inc. c/o Donald Shriver, Jin Zheng, and Ping Cai for the July 29, 2025 hearing date. Px 1.

George Sweeney, the Assistant Deputy Director of the Workers' Compensation Compliance Division for the Illinois Department of Insurance, Insurance Compliance Department, testified at the hearing.

Sweeney identified Petitioner's Exhibit 3 as a Notice of Non-Compliance and Notice of Informal Conference mailed to Jin Zheng, individually and as president and secretary of Delicate Plastics, Inc. The notices state that the Commission's records indicate that Jin Zheng and Delicate Plastics, Inc. were not in compliance with the requirements of Section 4(a) for the periods from March 3, 2015 to December 31, 2016, and July 29, 2017 to present. The Notice of Noncompliance includes an affidavit indicating service by mail on February 20, 2020. Px 3. The Notice of Informal Conference includes an affidavit indicating service by mail on October 26, 2020. Px 3.

Sweeney identified Petitioner's Exhibit 4 as a Business Entity Search for Respondents. The Report indicates that Delicate Plastics, Inc. was formed on March 3, 2015, and was dissolved on November 10, 2020. The report also indicates that Jin Zheng was the president of Delicate Plastics, Inc. and that the registered agent was Donald Shriver. Px 4.

Sweeney testified that in the regular course of his investigation, he also obtained documents related to Delicate Plastics, Inc. from the Illinois Secretary of State. The reports indicate that the company was incorporated on March 3, 2015, with Jin Zheng as the registered agent. Px 5, p. 3. Delicate Plastics filed an annual report for 2019 naming Jin Zheng as president, secretary, treasurer, and director and Donald Shriver as registered agent. *Id.* at 6. Delicate Plastics filed an annual report for 2018 naming Jin Zheng as president, treasurer, and director and Cai Ping as secretary and director. *Id.* at 11. Delicate Plastics filed an annual report for 2017 naming Jin Zheng as president and director and Ping Cai as secretary and director. *Id.* at 13-14. Delicate Plastics filed an annual report for 2016 naming Jin Zheng as president and Ping Cai as secretary. *Id.* at 15. The company dissolved on November 10, 2020. *Id.* at 5.

Sweeney testified that Delicate Plastics, Inc. falls under the Workers' Compensation Act's automatic coverage provisions because they used sharp edged cutting tools, gas or electronic machinery, sold goods or services to the public, operated a warehouse or general or terminal storehouse, and used corrosive acids.

Sweeney testified that Petitioner requested insurance information regarding the Respondents from the National Council of Compensation Insurance (NCCI) in Boca Raton, Florida. Px 6. The NCCI certified that it is the agent designated by the Commission for the purpose of collecting proof of insurance coverage information on Illinois employers and that Delicate

21WC000190; 17INC433

Plastics, Inc. did not file policy information showing proof of workers' compensation insurance at any time from March 3, 2015 to December 31, 2016, or from July 29, 2017 to March 15, 2021. *Id.*

Sweeney testified that Petitioner's Exhibit 7 was a certified finding from the Department of Self-Insurance that Respondents were not self-insured with the State of Illinois during the dates indicated and that it was the type of document requested in the ordinary course of Petitioner's investigations. The document indicates that no certificate of approval to self-insure was issued to Delicate Plastics, Inc. for the period of March 3, 2015 to December 31, 2016, or from July 29, 2017 to March 15, 2021. *Id.*

Sweeney testified that Petitioner's Exhibit 8 was a Commission Decision in case number 17WC002223, Dennis Stallworth v. Delicate Plastics, Inc. and State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund (IWBF). Px 8. The Commission found that Delicate Plastics, Inc. was required to have insurance pursuant to Section 3 of the Act because the business involved a warehouse or general or terminal storehouses as well as the use, storage or conveyance of corrosive acids. Px 8, p. 7. The Commission also found that an employer/employee relationship existed between the petitioner and Delicate Plastics, Inc. on December 1, 2016. *Id.* at 8. The Commission found that Petitioner worked for Respondent for approximately 8 months prior to the date of accident. *Id.* at 6. The Commission further concluded that the respondent was uninsured on the accident date. *Id.* at 10. The Arbitrator awarded the petitioner medical expenses, temporary total disability benefits, and permanent partial disability benefits. *Id.* at 5.

Sweeney testified that Petitioner's Exhibit 9 showed the IWBF payment made to Illinois Department of Healthcare, case 17WC002223, in the amount of \$400.00. Px 9.

Sweeney testified that Petitioner's Exhibit 10 showed the IWBF payment made to the petitioner, Dennis Stallworth, case 17WC002223, in the amount of \$5,533.35. Px 10.

Sweeney testified that in the regular course of his investigation, Petitioner requested information regarding the Respondents from the Illinois Department of Revenue. Petitioner submitted Petitioner's Exhibit 11 comprised of certified records of Illinois Small Business Corporation Replacement Tax Returns for 2015. Px 11.

Sweeney testified that based upon his investigation, Petitioner determined that Respondent did not have workers' compensation insurance for the period for which it requests relief, from April 1, 2016 to December 1, 2016.

II. Conclusions of Law

The Commission first considers whether Respondents are subject to the Act. Pursuant to Section 3 of the Act, certain employers and their employees are automatically subject to the provisions of the Act if they use sharp edged cutting tools, gas or electronic machinery, sold goods and services to the public, operated a warehouse or general or terminal storehouse, and used corrosive acids. 820 ILCS 305/3(4), (8), (15), (17), and (7) (West 2004).

The Commission finds that Respondents' business falls within Sections 3(4), (8), (15), (17), and (7) of the Act. This finding is based on Mr. Sweeney's testimony that they used sharp edged cutting tools, gas or electronic machinery, sold goods or services to the public, operated a

warehouse or general or terminal storehouse, and used corrosive acids and the IWBf decision finding that they operated a warehouse and used corrosive acids. Accordingly, the Commission finds that the work Respondents engaged in automatically subjected them to the provisions of the Illinois Workers' Compensation Act.

Pursuant to Section 4(a) of the Act, all employers who come within the auspices of the Act are required to provide workers' compensation insurance. See 820 ILCS 305/4(a) (West 2004). Section 9100.90(a) of our Rules similarly provides that any employer subject to Section 3 of the Act shall insure payment of compensation required by Section 4(a) of the Act "by obtaining approval from the Commission to operate as a self-insurer or by insuring its entire liability to pay the compensation in some insurance carrier authorized, licensed or permitted to do such insurance business in Illinois." 50 Ill. Adm. Code 9100.90(a) (1986). Section 9100.90(d)(3)(E) of our Rules similarly provides that a certification from a Commission employee "that an employer has not been certified as a self-insurer shall be deemed prima facie evidence of that fact." 50 Ill. Adm. Code 9100.90(d)(3)(E) (1986). Section 9100.90(d)(3)(D) of our Rules provides that "[a] certification from an employee of the National Council on Compensation Insurance stating that no policy information page has been filed in accordance with Section 9100.20 shall be deemed prima facie evidence of that fact." 50 Ill. Adm. Code 9100.90(d)(3)(D) (1986). Section 4 of the Act requires that all employers of at least one employee who come within the provisions of Section 3 of the Act, and any other employer who shall elect coverage under Section 2 of the Act, provide workers' compensation insurance for the protection of their employees. 820 ILCS 305/4.

In this case, Petitioner submitted a certified finding from the Department of Self-Insurance that no certificate of approval to self-insure was issued to Delicate Plastics, Inc. for the periods of March 3, 2015 to December 31, 2016, and July 29, 2017 to March 15, 2021.

Petitioner also submitted the NCCI certification showing that Delicate Plastics, Inc. did not file policy information showing proof of workers' compensation insurance at any time from March 3, 2015 to December 31, 2016, or from July 29, 2017 to March 15, 2021.

Sweeney testified that based upon his investigation, Petitioner determined that Respondents did not provide workers' compensation insurance for the period for which it requested relief, from April 1, 2016 to December 1, 2016.

Delicate Plastics, Inc. was a named respondent in a case before the Illinois Workers' Compensation Commission for date of accident December 1, 2016, in which the Commission found that the petitioner, Dennis Stallworth, was an employee of Delicate Plastics, Inc. for eight months prior to his accident, and Delicate Plastics did not have workers' compensation insurance on December 1, 2016.

Respondents did not attend the hearing and thus presented no evidence indicating that they provided workers' compensation insurance of any kind during the period in which they employed Mr. Stallworth. Accordingly, the Commission concludes that Petitioner proved that Respondents failed to comply with the legal obligations imposed by Section 4(a) of the Act from April 1, 2016, to December 1, 2016.

Regarding the issue of penalties for failure to maintain workers' compensation insurance coverage, Section 4(d) of the Act states:

Upon a finding by the Commission, after reasonable notice and hearing, of the knowing and willful failure or refusal of an employer to comply with any of the provisions of paragraph (a) of this Section, the Commission may assess a civil penalty of up to \$500 per day for each day of such failure or refusal after the effective date of this amendatory Act of 1989. The minimum penalty under this Section shall be the sum of \$10,000. Each day of such failure or refusal shall constitute a separate offense. The Commission may assess the civil penalty personally and individually against the corporate officers and directors of a corporate employer, the partners of an employer partnership, and the members of an employer limited liability company, after a finding of a knowing and willful refusal or failure of each such named corporate officer, director, partner, or member to comply with this Section. The liability for the assessed penalty shall be against the named employer first, and if the named employer refuses to pay the penalty to the Commission within 30 days after the final order of the Commission, then the named corporate officers, directors, partners, or members who have been found to have knowingly and willfully refused or failed to comply with this Section shall be liable for the unpaid penalty or any unpaid portion of the penalty.

820 ILCS 305/4(d) (West 2004).

Section 9100.90(b) of the Rules similarly provides that penalties may be assessed for non-compliance after a reasonable notice and hearing. 50 Ill. Adm. Code 9100.90(b) (1986). Section 9100.90(c) of the Rules describes the proper notice of non-compliance to be served upon the employer and provides that the employer may request an informal conference to resolve the matter. 50 Ill. Adm. Code 9100.90(c) (1986). Section 9100.90(d) of the Rules describes the manner of notice and service for an insurance compliance hearing and the procedure for conducting the hearing. 50 Ill. Adm. Code 9100.90(d) (1986).

In this case, Petitioner submitted into evidence the Notice of Non-Compliance mailed to Jin Zheng, individually and president of Delicate Plastics, Inc., in the form prescribed by our Rules and including an affidavit of service. Petitioner also submitted the notices for the January 9, 2025 insurance compliance hearing, in the form prescribed by our Rules, accompanied by signed investigative reports indicating that Delicate Plastics, Inc. was personally served via its registered agent. Petitioner also submitted notice of the July 29, 2025 hearing date by certified mail to the last known address of Delicate Plastics, via its registered agent, and the individual defendants were served via certified mail to their last known addresses. The insurance compliance hearing allowed the Department of Insurance to introduce evidence and testimony and afforded Respondents the opportunity to do the same, had they chosen to attend personally or through counsel. Accordingly, the Commission concludes that reasonable and proper notice of hearing was provided to Respondents.

On the merits, the Commission has considered the following factors in assessing penalties against an uninsured employer: (1) the length of time the employer had been violating the Act; (2) the number of workers' compensation claims brought against the employer; (3) whether the employer had been made aware of his conduct in the past; (4) the number of employees working for the employer; (5) the employer's ability to secure and pay for workers' compensation coverage; (6) whether the employer had alleged mitigating circumstances; and (7) the employer's ability to

pay the assessed amount. *See, e.g., State of Illinois v. Murphy Container Service*, Ill. Workers' Comp. Comm'n, No. 03 INC 00155, 7 IWCC 1037 (Aug. 2, 2007).

The Commission finds that the period of time during which the Respondents violated the Act by failing to obtain workers' compensation insurance was significant. The Respondents failed to have insurance for 244 days, from April 1, 2016 to December 1, 2016. There was one IWBF decision for date of accident December 1, 2016 indicating that Respondent had at least one employee for approximately eight months prior to December 1, 2016. Moreover, having reviewed the record, the Commission finds no evidence as to Respondent's inability to secure and pay for workers' compensation coverage and no evidence of mitigating circumstances.

The Commission concludes that Respondents knowingly and willfully failed to comply with the Act. Based on the significant period of time that Respondents failed to comply with the Act, the Commission assesses a penalty of \$122,000.00 as well as reimbursement of the IWBF payout in the amount of \$5,933.35, for a total of \$127,933.35 against Respondents, Delicate Plastics, Inc. and Jin Zheng and Ping Cai, individually and as officers of Delicate Plastics, Inc.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondents, Delicate Plastics, Inc. and Jin Zheng and Ping Cai, individually and as officers of Delicate Plastics, Inc., pay to the Illinois Workers' Compensation Commission the sum of \$127,933.35 pursuant to Section 4(d) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that payment shall be made according to the following procedure: (1) payment of the penalty shall be made by certified check or money order made payable to the Illinois Workers' Compensation Commission; and (2) payment shall be mailed or presented within thirty (30) days of the final order of the Commission or the order of the court on review after final adjudication to:

Illinois Workers' Compensation Commission
Fiscal Department
69 W. Washington Street, Suite 900
Chicago, Illinois 60602

Alternatively, pursuant to Illinois Workers' Compensation Commission Rule 9015, an electronic format may be used to accomplish the requirements of this Decision. Respondent(s) may arrange to make an electronic payment by contacting:

Illinois Department of Insurance
Attn: Workers' Compensation Compliance
115 S. LaSalle Street, 13th floor
Chicago, Illinois 60603
Phone: (312) 814-8224

This decision may be judicially reviewed only as described in Section 19(f). This decision may be enforced in the same manner as a judgment entered by a court of competent jurisdiction and is a debt due and owing to the State and can be enforced to the same extent as a judgment entered by a circuit court. Bond for the removal of this cause to the Circuit Court by Respondent

21WC000190; 17INC433

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.

DECEMBER 22, 2025/s/ Maria E. Portela

SE/

/s/ Christopher A. Harris

O: 12/18/25

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/s/ Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	24WC025973
Case Name	Jack Downen v. Poettker Construction
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	25IWCC0509
Number of Pages of Decision	14
Decision Issued By	Amylee Simonovich, Commissioner

Petitioner Attorney	Thomas C Rich
Respondent Attorney	Michael Karr

DATE FILED: 12/22/2025

/s/Amylee Simonovich, Commissioner
Signature

24WC025973
Page 1

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)
☐ Modify	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JACK DOWNEN,

Petitioner,

vs.

No. 24WC025973

POETTKER CONSTRUCTION,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent Poettker Construction 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, 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 (1980).

I. FACTUAL BACKGROUND

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 by Respondent on September 5, 2024. The Application alleged that Petitioner "Tripped and stumbled off of uneven concrete" and sustained an injury. AX 2.

The 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.

24WC025973

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Respondent disputed liability on the basis of the compensability of the accident and the causal relationship between the accident and the medical conditions alleged. AX 1.

Petitioner was employed by Respondent as a carpenter, and on September 5, 2024, Petitioner was working for Respondent remodeling a former Peabody Coal Company building, with an existing flat concrete pad. Petitioner described the jobsite in detail, relating that the ground around the building had been graded/excavated down unevenly. At most locations this concrete pad was at a height of 12 inches, and, because of a large rebar cage around the site, the most common area to step off the concrete pad was graded to 12 inches. However, in the area Petitioner was working at the end of that day, the pad was 24 or more inches in height above the ground. T. 12-14, 28-29.

At the time of the alleged accident, he had just completed setting concrete forms and went to help the foreman do layout work. Petitioner stepped off the concrete pad and misjudged the step, descending 12 inches further than he had anticipated. Petitioner almost fell, doing a 'big stumble' to prevent the fall. He then shook himself off and went back to work. T. 12-15, 31. He began experiencing lower back and hip pain that night after driving home and began experiencing neck pain two days after the accident. T. 21.

II. FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator found Petitioner proved by a preponderance of the credible evidence that he sustained an accidental injury arising out of and in the course of his employment by Respondent on September 5, 2024. The Arbitrator found that the alleged accident was a common bodily movement performed in a task incidental to and connected with his employment, and applied *McAllister v. Illinois Workers' Compensation Commission*, 181 N.E.3d 656 (Ill. 2020).

The Commission is in agreement with the Arbitrator's conclusion regarding compensability but finds a different employment risk than the Arbitrator. Consistent with the law, the Commission must consider the three categories of risk recognized in the case law: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks which have no particular employment or personal characteristics. *Illinois Institute of Technology Research Institute v. Industrial Comm'n*, 314 Ill. App. 3d 149, 162, 731 N.E.2d 795, 806 (1st Dist. 2000). Examples of employment-related risks include "tripping on a defect at the employer's premises, falling on uneven or slippery ground at the work site, or performing some work-related task which contributes to the risk of falling." *First Cash Financial Services v. Industrial Comm'n (Rios)*, 367 Ill. App. 3d 102, 106, 853 N.E.2d 799, 804 (1st Dist. 2006). Injuries resulting from a risk distinctly associated with employment are deemed to arise out of the claimant's employment and are compensable under the Act. *Steak 'n Shake v. Illinois Workers' Compensation Comm'n*, 2016 IL App (3d) 150500WC, ¶ 35, 67 N.E.3d 571.

The Commission finds that Petitioner has proven that his accidental injury arose out of his employment on a construction site which was inconsistently graded/excavated, with a difference

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Page 3

in graded heights of 12 inches (“an extra foot”). His step-down was between 12 and 24 inches, depending on which section of the site he was traversing, and he testified that at the place of the accident the height was 24 or more inches.. There is no evidence that the difference in grading was final, or by design, distinguishing this case from *Caterpillar vs. Industrial Comm'n*, 129 Ill. 2d 52, 541 N.E 2d 665 (1989), where a petitioner twisted his ankle on a slope which was present by design and was thereby not a defect. The Commission finds the step off of 24 inches is a hazard of the worksite distinctly associated with the employment.

The Commission therefore finds that the accidental injury arose out of a defect of the worksite. 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 on March 3, 2025, is modified as stated herein, and otherwise 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 \$56,800.00. 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.

DECEMBER 22, 2025

O: 11/4/25

AHS/ps

051

/s/ Amylee H. Simonovich
Amylee H. Simonovich

/s/ Stephen J. Mathis
Stephen J. Mathis

/s/ Kathryn A. Doerries
Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
DECISION SIGNATURE PAGE

Case Number	24WC025973
Case Name	Jack Downen v. Poettker Construction
Consolidated Cases	
Proceeding Type	19(b) Petition Remand Arbitration
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	10
Decision Issued By	William Gallagher, Arbitrator

Petitioner Attorney	Thomas C Rich
Respondent Attorney	Michael Karr

DATE FILED: 3/3/2025

/s/William Gallagher, Arbitrator
Signature

THE INTEREST RATE FOR THE WEEK OF FEBRUARY 25, 2025 4.18%

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)

Jack Downen
 Employee/Petitioner

Case # 24 WC 25973

v. Consolidated cases: n/a

Poettker Construction
 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 Mt. Vernon, on January 31, 2025. 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, September 5, 2024, 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 \$17,813.59; the average weekly wage was \$1,781.36.

On the date of accident, Petitioner was 52 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 \$0.00 under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

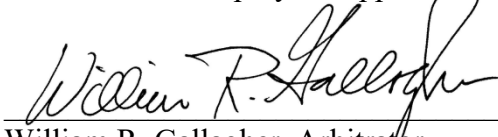
Respondent shall pay Petitioner temporary total disability benefits of \$1,187.57 per week for 20 ³/₇ weeks, commencing September 11, 2024, through January 31, 2025, as provided in Section 8(b) of the Act.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, low back surgery as recommended by Dr. Matthew Gornet.

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)

March 3, 2025

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 by Respondent on September 5, 2024. The Application alleged that Petitioner "Tripped and stumbled off of uneven concrete" and sustained an injury to "Bilateral hips, back/body as a whole" (Arbitrator's Exhibit 2). At trial, counsel for Petitioner made an oral motion to amend the Application to include the additional anatomical area of "neck" to the parts of the body affected. Counsel for Respondent had no objection to the motion and it was granted by the Arbitrator who added the "neck" to the parts of the body affected on the Application (Arbitrator's Exhibit 2).

The 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. In respect to temporary total disability benefits, Petitioner claimed he was entitled to temporary total disability benefits of 20 3/7 weeks, commencing September 11, 2024, through January 31, 2025 (date of trial). The prospective medical treatment sought by Petitioner was low back surgery, as recommended by Dr. Matthew Gornet. Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner was employed by Respondent as a carpenter. On September 5, 2024, Petitioner was working for Respondent remodeling a Peabody Coal Company building. Petitioner described the building as big and old and the remodeling job being performed by Respondent was putting on an addition to the building. At that time Petitioner sustained the accident, he was in the process of setting concrete forms. At that time, Petitioner stepped off of a ledge in order to go to another part of the job site to assist his foreman performing another task. When he did so, Petitioner misjudged the step. Petitioner stated that most of the steps were about 12 inches; however, the step Petitioner stepped off of was approximately 24 inches.

When Petitioner stepped off of the step, he described it as causing him to fall "...an extra foot further" than he thought he would. Petitioner did not fall to the ground, but did a "big stumble" to prevent himself from falling.

Petitioner testified that, as a carpenter, he had built a significant number of steps. He stated that while walking on steps, if one of them is different, you will trip on it. Petitioner testified he "misjudged" the depth of the step when he sustained the accident.

Petitioner testified the accident occurred toward the end of his work shift with approximately one and one-half to two hours remaining. Petitioner continued to work and proceeded to help the foreman. Upon completing his shift, Petitioner drove to his home which was approximately a one and one-half hour drive. By the time Petitioner got home, he was experiencing significant low back pain. The day of the accident, September 5, 2024, was a Thursday, and Petitioner did not work the following day and testified that on that day, he felt like he had been shot in his left hip.

On September 6, 2024, Petitioner sought medical treatment at the ER of Good Samaritan Hospital. At that time, Petitioner provided a history of the work accident and complained of excruciating

left hip pain which went down the anterior left thigh. A CT scan of Petitioner's lumbar spine was obtained which revealed a disc osteophyte complex and spinal stenosis at L3-L4. Petitioner was provided medication and discharged (Petitioner's Exhibit 3).

Petitioner returned to work the following Monday and Tuesday; however, he testified he could barely walk and used a steel rod like a cane to assist. Because Petitioner worked well with the crew, he was only required work on projects which were not very physically demanding.

On September 11, 2024, Petitioner was evaluated by Dr. Robert Dow, an orthopedic surgeon. At that time, Petitioner provided a history of the accident and complained of left buttock and left lateral hip pain which radiated down the left leg. Petitioner also stated he experienced parasthesias, numbness and weakness in the left leg. Dr. Dow reviewed the CT scan and opined it revealed severe disc degeneration at L3-L4 with left sided foraminal stenosis consistent with Petitioner's symptoms. He diagnosed Petitioner with lumbar disc degeneration, lumbar spinal stenosis, and radiculopathy. Dr. Dow recommended Petitioner undergo an MRI scan of the lumbar spine (Petitioner's Exhibit 4).

On September 17, 2024, Petitioner was evaluated by Dr. Matthew Gornet, an orthopedic surgeon. At that time, Petitioner advised Dr. Gornet of the work accident and complained of low back pain, pain in both buttocks/hips, left greater than right, and severe left leg pain. Petitioner also complained of mild neck pain and headaches. Petitioner informed Dr. Gornet he had received some chiropractic care for non-back related symptoms two to three years ago, and had a history of right hip pain for which he received a steroid injection which was also about two to three years ago (Petitioner's Exhibit 5).

Dr. Gornet obtained x-rays of the lumbar spine that same day. He opined they revealed loss of disc height at L3-L4, L4-L5, and L5-S1. He also ordered an MRI scan of Petitioner's lumbar spine (Petitioner's Exhibit 5).

The MRI of Petitioner's lumbar spine was performed on September 17, 2024. According to the radiologist, the MRI revealed circumferential disc bulges with central herniations at L3-L4, L4-L5, and L5-S1, extruded disc fragments at L4-L5 and L5-S1, central canal and bilateral foraminal stenosis at L3-L4, L4-L5, and L5-S1, and a circumferential disc bulge at L2-L3 (Petitioner's Exhibit 6).

Dr. Gornet reviewed the MRI scan and his interpretation of it was consistent with that of the radiologist. He ordered physical therapy and referred Petitioner to Dr. Helen Blake for steroid injections at L3-L4 and L5-S1 and he authorized Petitioner to remain off work. He also referred Petitioner to his primary care physician for evaluation of his headaches to determine if there was another cause for them. Dr. Gornet also indicated he would obtain an MRI of the cervical spine when he subsequently saw Petitioner. He opined Petitioner's current symptoms and need for treatment was causally related to the accident of September 5, 2024 (Petitioner's Exhibit 5).

Petitioner was subsequently treated by Dr. Helen Blake. On October 1, 2024, Dr. Blake administered an epidural steroid injection at L3-L4. On November 15, 2024, Dr. Blake administered an epidural steroid injection at L5-S1 (Petitioner's Exhibit 7).

Petitioner received physical therapy from October 2, 2024, through November 18, 2024. When initially evaluated on October 2, 2024, Petitioner gave a history of miss-stepping and tripping at work and experiencing low back and hip pain afterward. It was noted Petitioner was seen for evaluation of lumbar radiculopathy and a limited lumbar and hip range of motion (Petitioner's Exhibit 9).

Petitioner was again seen by Dr. Gornet on November 18, 2024. At that time, Petitioner advised he had been treated by Dr. Blake and received two steroid injections, one at L3-L4, and another at L5-S1. He advised the injections did not provide any long term relief. Dr. Gornet ordered an MRI scan of the cervical spine.

The MRI scan of Petitioner's cervical spine was performed on November 18, 2024. According to the radiologist, the MRI revealed central disk herniations at C3-C4, C4-C5, C5-C6, and C6-C7, as well as central canal and foraminal stenosis at all four levels (Petitioner's Exhibit 10).

Dr. Gornet reviewed the MRI of Petitioner's cervical spine when he saw him on November 18, 2024. His interpretation of the MRI was consistent with that of the radiologist. Dr. Gornet recommended Petitioner undergo CT scans of the lumbar and cervical spine as well as a CT bone density test. He opined Petitioner continued to be temporarily totally disabled. In respect to treatment, Dr. Gornet noted Petitioner's low back symptoms were the "bigger issue" for Petitioner and stated Petitioner would probably require a fusion at L5-S1 and disc replacements at L3-L4 and L4-L5 (Petitioner's Exhibit 5).

At the direction of Respondent, Petitioner was examined by Dr. Daniel Kitchens, a neurosurgeon, on December 16, 2024. In connection with his examination of Petitioner, Dr. Kitchens reviewed medical records and diagnostic studies provided to him by Respondent. Dr. Kitchens reviewed the MRI of Petitioner's lumbar spine of September 17, 2024, but he did not review the MRI of Petitioner's cervical spine of November 18, 2024 (Respondent's Exhibit 1; Deposition Exhibit B).

When evaluated by Dr. Kitchens, Petitioner advised him of the work-related accident of September 5, 2024, and that he had experienced left hip/leg, low back, neck and left shoulder pain symptoms afterward as well as headaches. Petitioner stated his neck, back and leg pain were present almost all of the time and were worsened by activity and prolonged sitting/standing (Respondent's Exhibit 1; Deposition Exhibit B).

In regard to his review of the MRI of Petitioner's lumbar spine of September 17, 2024, Dr. Kitchens opined it revealed severe degenerative disc disease at L3-L4, L4-L5, and L5-S1, but no disc herniations. On examination, Dr. Kitchens described a normal sensory examination other than a "patchy distribution" throughout Petitioner's arms, hands, legs and feet, which he described as "non-anatomic" (Respondent's Exhibit 1; Deposition Exhibit B).

Dr. Kitchens opined Petitioner had scoliosis of the lumbar spine, severe degenerative disc disease at L3-L4, L4-L5, and L5-S1, but no evidence of disc herniations, fractures or subluxations related to the accident of September 5, 2024. He also opined there was no evidence of lumbar radiculopathy or nerve root dysfunction. Further, Dr. Kitchens opined that none of the diagnoses

were caused, aggravated, or exacerbated by the accident of September 5, 2024, Petitioner was at MMI, and could return to work without restrictions (Respondent's Exhibit 1; Deposition Exhibit B).

Dr. Kitchens was deposed on January 29, 2025, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Kitchens' testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Specifically, Dr. Kitchens testified he diagnosed Petitioner with degenerative disc disease at L3-L4, L4-L5, and L5-S1, and stated the MRI did not reveal any disc herniations, fractures or subluxations related to the work accident. He also testified there was no evidence of radiculopathy, weakness or reflects changes indicative of nerve root dysfunction. Dr. Kitchens testified Petitioner's diagnoses were based on degenerative/age related conditions which were not caused, aggravated or exacerbated by the accident of September 5, 2024 (Respondent's Exhibit 1; pp 11-12).

On cross-examination, Dr. Kitchens was questioned about Petitioner's symptoms and he stated they were "...not truly signs of radiculopathy, they're just symptoms." However, Dr. Kitchens agreed Petitioner had radicular symptoms when he was seen in the ER. He also agreed that it was reasonable for Petitioner to seek treatment from an orthopedic surgeon following the visit to the ER and the recommendation Petitioner undergo an MRI scan was related to the accident (Respondent's Exhibit 1; pp 14-17).

When questioned as to when Petitioner's symptoms stop being related to the accident, Dr. Kitchens stated that Petitioner did not have evidence of an acute injury to the lumbar spine after undergoing the MRI. He also testified he disagreed with the radiologist's interpretation of the MRI (Respondent's Exhibit 1; pp 21-23).

Dr. Gornet was deposed on January 30, 2025, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Gornet's testimony was consistent with his medical record and he reaffirmed the opinions contained therein. In respect to the mechanism of injury, Dr. Gornet testified that missing a step which causes one to come down hard can cause a mechanical load and many times a twisting injury. Based on the preceding, Dr. Gornet stated the accident of September 5, 2024, aggravated Petitioner's underlying condition and caused a disc injury in respect to both the cervical and lumbar spine (Petitioner's Exhibit 12; pp 10-11).

At the time he was deposed, Dr. Gornet reviewed Dr. Kitchens' medical report. In respect to Dr. Kitchens' opinion that Petitioner did not sustain a traumatic injury, Dr. Gornet testified this was a "ridiculous statement" and that anyone who has missed a step and come down hard can experience a sudden jar (Petitioner's Exhibit 12; pp 16-17).

Dr. Gornet reaffirmed his opinion that the MRI of September 17, 2024, revealed disc pathology at L3-L4, L4-L5, and L5-S1. On cross-examination, when questioned about how long the extruded disc material had been present, Dr. Gornet agreed there was no way to tell this based on the MRI; however, he stated that he would have to rely on the patient's history. In this instance, Dr. Gornet noted Petitioner had no problems up until the accident and had been working full duty without restrictions (Petitioner's Exhibit 12; pp 10, 28).

Dr. Gornet testified Petitioner continued to be totally disabled from work and was in need of treatment. He stated the treatment would likely be a fusion at L5-S1, and disc replacements at L3-L4 and L4-L5 (Petitioner's Exhibit 12; pp 14-15).

At trial, Petitioner testified he had been previously treated by a chiropractor, but it was not for his low back and it was a long time ago. He also stated he previously received an injection into his right hip which was also a long time ago. Petitioner stated he continues to experience low back pain with shooting/stabbing pain down both legs which he never experienced prior to the accident. He has not been able to return to work and wants to proceed with the surgery as recommended by Dr. Gornet.

Conclusions of Law

In regard to disputed issue (C) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner sustained an accidental injury arising out of and in the course of his employment by Respondent on September 5, 2024.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified that he worked for Respondent as a carpenter and, on September 5, 2024, he was working on a remodeling job in which Respondent was putting on an addition to a building.

Petitioner stated that he stepped off of a ledge to go to another area of the jobsite and, when he did so, he misjudged the depth of the step and it was much greater than what he thought it was. He said that most of the steps were 12 inches, but this one was approximately 24 inches.

When Petitioner stepped off of the ledge, he did not fall to the ground, but "stumbled" and sustained a jarring type sensation which initially caused him to experience left hip pain and subsequently experience low back and neck symptoms.

Petitioner's testimony regarding the circumstances of the accident of September 5, 2024, was credible and unrebutted.

In the case of *McAllister v. Illinois Workers' Compensation Commission*, 181 N.E.3d 656 (Ill. 2020) the Illinois Supreme Court held that a risk is associated with employee's employment if, at the time of the occurrence, the employee was performing (1) an act he/she was instructed to perform by the employer; (2) an act which he/she had a common law or statutory duty to perform; or (3) an act the employee might reasonably be expected to perform incidental to his/her assigned duties. *McAllister* at 667.

In respect to common bodily movements and everyday activities, if the bodily movement which resulted in the accident had its origin in a risk connected with or incidental to the employment, there is a causal relationship between the employment and the accidental injury. Further, it is not necessary for the employee to prove that he/she was exposed to a risk of injury, either qualitatively or quantitatively, to a greater degree than the general public. *McAllister* at 670- 672.

In the *McAllister* case, the employee was a sous chef and he went into a walk-in cooler to locate a pan of carrots. He proceeded to kneel to locate the pan of carrots and when he stood up, he felt his right knee "pop." *McAllister* at 661.

In this case, Petitioner was performing a task incidental to and connected with his employment, misjudged the depth of a step and sustained an injury when he stepped off of a ledge.

The Arbitrator finds the holding in *McAllister* to be applicable and that Petitioner did sustain an accidental injury arising out of and in the course of his employment by Respondent on September 5, 2024.

In regard to disputed issue (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner's current condition of ill-being is causally related to the accident of September 5, 2024.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony regarding the circumstances of the accident of September 5, 2024, was credible and un rebutted.

There was no evidence Petitioner had any left hip, low back or neck injuries/symptoms prior to the accident of September 5, 2024.

When Petitioner initially sought medical treatment, he had complaints of left buttock/hip and left leg pain consistent with radiculopathy.

When seen by Dr. Gornet on September 17, 2024, Petitioner complained of low back pain, pain in both buttocks/hips, left more than right, and severe left leg pain. Dr. Gornet obtained an MRI of Petitioner's lumbar spine which, according to both he and the radiologist, revealed disc pathology at L3-L4, L4-L5 and L5-S1. Dr. Gornet opined Petitioner's current condition of ill-being was related to the accident of September 5, 2024.

Respondent's Section 12 examining physician, Dr. Kitchens, opined Petitioner had severe degenerative disc disease at L3-L4, L4-L5 and L5-S1, but no disc pathology at those levels. He specifically disagreed with both Dr. Gornet and the radiologist's review of the MRI scan. Dr. Kitchens further opined the findings were not caused, aggravated or exacerbated by the accident of September 5, 2024.

Dr. Kitchens opined his examination revealed no evidence of radiculopathy; however, on cross-examination, he agreed Petitioner had radicular symptoms when seen in the ER.

Dr. Gornet testified that the accident of September 5, 2024, aggravated Petitioner's underlying condition and caused a disc injury. When he was deposed, he stated he had reviewed the report of

Dr. Kitchens and noted that Dr. Kitchens had opined that Petitioner did not sustain a traumatic accident on September 5, 2024. He characterized this as a "ridiculous statement."

Based on the preceding, the Arbitrator finds opinion of Dr. Gornet to be more persuasive than that of Dr. Kitchens in respect to causality.

In regard to disputed issue (J) the Arbitrator makes the following conclusion of law:

Based upon the Arbitrator's conclusions of law in disputed issues (C) and (F), the Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and 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 1, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

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, but not limited to, low back surgery as recommended by Dr. Gornet.

In support of this conclusion the Arbitrator notes the following:

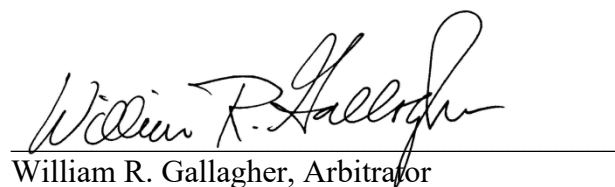
Dr. Gornet has recommended Petitioner undergo low back surgery consisting of a fusion at L5-S1, and disc replacements at L3-L4, and L4-L5.

In regard to disputed issue (L) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 20 3/7 weeks, commencing September 11, 2024, through January 31, 2025.

In support of this conclusion the Arbitrator notes the following:

Petitioner has been under active medical treatment and authorized to be off work during the aforesated period of time.



William R. Gallagher, Arbitrator

March 3, 2025

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	23WC005900
Case Name	Brandon Todd v. C & H Gravel
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	25IWCC0510
Number of Pages of Decision	18
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	John Bays
Respondent Attorney	Paul Dykstra

DATE FILED: 12/23/2025

/s/Maria Portela, Commissioner

Signature

23 WC 05900

Page 1

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))
☒ Modify ☐ up	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRANDON TODD,

Petitioner,

vs.

NO: 23 WC 05900

C & H GRAVEL,

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, medical expenses, temporary total disability benefits and prospective medical care 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 reverses the Arbitrator's Decision terminating causation as of the October 27, 2023, Section 12 medical examination, and finds that the Petitioner met his burden of proof that his current condition of ill being is causally related to the August 11, 2022, work accident. Accordingly, the Commission awards temporary total disability benefits as well as reasonable and necessary medical expenses through the date of the hearing on Arbitration, October 9, 2024. Additionally, the Commission reverses the Arbitrator's denial of prospective medical treatment and awards a follow-up evaluation with Dr. Mitry to obtain current treatment and diagnostic treatment recommendations.

Factual Background

Petitioner sustained an undisputed accident on August 11, 2022, while moving a heavy jack. Petitioner testified that when he set the jack down and went to come back up, "something slid, shifted. It really felt like it pulled apart in my lower back and I couldn't stand up." (T. 12) On the date of accident, Petitioner was seen by his chiropractor, Dr. Bergbower, to whom he gave a history of having injured his low back at work while lifting a heavy floor jack. (Px5) Petitioner testified Dr. Bergbower referred him to a walk-in clinic. Petitioner was seen at the walk-in clinic on the accident date with complaints of low back pain with radiculopathy. Petitioner was given Flexeril, Prednisone, and told

to follow up with his primary care doctor and to go home and rest. (Px3, Ex2) Petitioner continued to follow up with Dr. Bergbower for the next couple of weeks with no improvement and was referred to a medical provider for assessment and follow up care. (Px5)

On August 23, 2022, Petitioner presented to the Casey Family Medical Center for treatment with APRN Karen Huddlestun. Petitioner was taken off work pending MRI imaging and was advised to see an orthopedic specialist. (Px3, Ex3)

On August 31, 2022, Petitioner underwent a lumbar spine MRI which showed a posterior central disc protrusion at L5-S1 with an annular tear. (Px3, Ex4)

On October 10, 2022, Petitioner was seen by neurosurgeon, Dr. Nardone, who felt Petitioner was not a surgical candidate but recommended physical therapy and an injection. Additionally, Dr. Nardone opined that Petitioner's condition was causally related to the work accident. (Px3, Ex5)

Petitioner was referred back to her primary care physician and was seen on October 12, 2022, by FNP Karen Huddlestun who continued Petitioner's work restrictions. (Px3, Ex3) On November 3, 2022, Petitioner was seen again by Nurse Practitioner Huddlestun, at which time he complained the pain was moving into his upper back. Petitioner was continued off work and a thoracic spine MRI was ordered. (Px3, Ex3)

On November 7, 2022, Petitioner presented to APRN Heather Heicher, under the review of Drs. Mitry and Nardone, for injection and treatment of his back pain. He was assessed with lumbar radiculopathy. (Px3, Ex6) On November 16, 2022, Petitioner underwent a thoracic spine MRI which showed no acute findings. (Px3, Ex7)

On December 8, 2022, Petitioner was seen by Dr. Ragai Mitry, a pain management specialist, who suspected a component of lumbar facet pain in addition to the posterior central disc protrusion with annular tear. On that date Dr. Mitry administered a left TF ESI at S1-S2. (Px3, Ex8)

On January 16, 2023, Petitioner returned to FNP Huddlestun and received another off work note for another month. (Px3, Ex3)

On February 2, 2023, Petitioner followed up with APRN Heicher with complaints of low back pain that radiated into the left hip and down the posterior lateral left leg and into the bottom of the left foot with numbness in the bottom of the left foot and in the medial toes of the left foot. Petitioner reported compliance with back exercises though told APRN Heicher they were making his pain worse. Petitioner reported the epidural steroid injection did not provide much help. APRN Heicher examined Petitioner, and her impression was that he had mild lumbar spondylosis, most pronounced at L5-S1 where there was a central disc protrusion with annular tear. (Px3, Ex9) On February 13, 2023, Petitioner also saw FNP Huddlestun complaining of continued back pain. She examined Petitioner and kept him off work for another month. (Px3, Ex3)

On February 22, 2023, Dr. Beatty, Respondent's first Section 12 examiner, evaluated Petitioner. He reviewed the L/S MRI dated August 31, 2022, and opined that Petitioner had possible disc fragments that were causing his ongoing radicular symptoms and that the work injury of August 11, 2022, was the cause of Petitioner's current symptoms. Dr. Beatty suggested Petitioner undergo

additional diagnostic testing in the form of an updated lumbar MRI and EMG as well as work restrictions. Dr. Beatty opined that Petitioner had not reached maximum medical improvement. (Px4)

On February 27, 2023, Dr. Mitry examined Petitioner and treated him with a left transforaminal ESI L4-L5, L5-S1. (Px3, Ex10)

On March 13, 2023, Petitioner returned to APRN Huddleston. He reported the injections at the pain clinic were helping. Petitioner was continued off work. (Px3, Ex3)

On April 14, 2023, Petitioner returned to APRN Huddleston with complaints of worsened pain. An updated lumbar MRI and EMG were ordered, and Petitioner was kept off work another month. (Px3, Ex3)

On April 20, 2023, Petitioner underwent a repeat lumbar spine MRI which was identical to the prior one performed on August 31, 2022, which showed a L5-S1 posterior disc protrusion which abuts the traversing S1 nerve roots. (Px3, Ex11)

Petitioner continued monthly follow ups with APRN Huddleston who examined him at each visit. At each visit she kept him off work for another month. He was noted to have decreased strength and pain consistently at each exam. (Px3, Ex3)

On June 9, 2023, Petitioner was again examined by Dr. Mitry who opined Petitioner may have a component of lumbar facet pain. Dr. Mitry again noted the small posterior central disc protrusion with annular tear. At this visit, the Petitioner continued to complain of radiating low back pain. Following Petitioner's February 27, 2023, TF ESI at L4-5 L5-S1 the Petitioner reported 50% improvement at the 6-week mark and Dr. Mitry recommended an additional TF ESI at L4-5 L5-S1. (Px3, Ex12)

On June 24, 2023, Petitioner was seen for a neurology consult/EMG with Dr. Collins. The EMG was normal which Dr. Collins noted was surprising and he recommended an MRI scan of the cervical spine. (Px3, Ex13)

On August 18, 2023, Petitioner returned to APRN Heicher with radiating low back pain. He reported his February 27, 2023, injection had provided him with a more than 50% improvement in his pain for longer than 8 weeks, but that although the June 9, 2023, injection also provided him with more than 50% improvement, it lasted only for a few weeks. (Px3, Ex15)

On October 27, 2023, Petitioner underwent a Section 12 examination with Respondent's second choice of physician, orthopedic surgeon Dr. Timothy VanFleet. Dr. VanFleet diagnosed Petitioner with malingering on the basis that there were no significant findings on physical exam, or his MR imaging reports (Dr. VanFleet did not personally review the images). Dr. VanFleet opined that Petitioner's current complaints were no longer related to the August 11, 2022, work accident, did not recommend further treatment or restrictions and opined that Petitioner was at maximum medical improvement. (Rx1)

Based on the opinions of Dr. VanFleet, Respondent terminated benefits. After Petitioner's benefits were terminated, Petitioner was unable to return to see Drs. Mitry or Nardone for pain

management. Petitioner continued his monthly visits with APRN Huddlestun. (Px3, Ex3; Px6) At each visit, Petitioner continued to complain of back pain, was kept off work, and had a positive straight leg raise on the right. Petitioner continued to express his desire to resume injections with Dr. Mitry as well as obtain an updated MRI. At his June 28, 2024, visit, APRN Huddlestun opined that Petitioner would benefit greatly from additional cortisone injections in the pain clinic and an evaluation of a back specialist. (Px6)

Both Drs. Mitry and VanFleet were deposed.

Dr. Mitry is a pain management specialist. Based on his exam of the Petitioner as well as the MRI, Dr. Mitry felt Petitioner suffered from lumbar radiculopathy, but that some of Petitioner's pain was facet generated. (Px3, pp. 17-18) Dr. Mitry testified that facet joints could be subject to traumatic injury. (Px3, p. 19) Dr. Mitry agreed with Dr. Nardone that it was reasonable to assume that the work injury caused or contributed to the ongoing conditions from which Petitioner was suffering. (Px3, p. 20) Dr. Mitry opined that the work restrictions were reasonable. (Px3, p. 26) Additionally, Dr. Mitry also causally connected the thoracic condition to the work accident. (Px3, 27)

Ultimately, Dr. Mitry opined that the lumbar radiculopathy and thoracic radiculopathy were causally related to the work accident. (Px3, p. 40, 46) He also opined that the annular tear and disc protrusion seen on MRI were attributable to the trauma and that the trauma probably aggravated preexisting facet changes. (Px3, p. 41) Dr. Mitry further opined that Petitioner would need medial branch blocks and denervation in the future. (Px3, p. 45) Lastly, he opined additional treatments and testing were reasonable and causally related to the work accident. (Px3, p. 47)

Although Dr. Mitry testified "when it comes to surgical issues, I defer to board certified orthopedic surgeons and neurosurgeons," (Px3, p. 54) he also testified he is board certified in internal medical, anesthesiology and pain management. (Px3, p. 53) Dr. Mitry did not believe that Petitioner was at maximum medical improvement and noted that although he saw improvement in Petitioner, there had not been long-term improvement. (Px3, pp. 48-49) Dr. Mitry agreed with Respondent's Section 12 examiner, Dr. Beatty, regarding his opinions and further stated that there was nothing in the medical record that supports that Petitioner had problems before the date of accident. (Px3, p. 50)

Dr. VanFleet is an orthopedic spine surgeon. (Rx1, p. 6) He saw Petitioner for a Section 12 examination on October 27, 2023. (Rx1, p. 8) Dr. VanFleet testified that based on his exam and the material he reviewed, Petitioner's diagnosis was consistent with malingering. (Rx1, p. 12)

Dr. VanFleet testified that the disc protrusion and annular tear seen on MRI was consistent with degeneration. (Rx1, p. 13) (The Commission notes that Petitioner was 33 years old on the date of accident). Dr. VanFleet felt the MRI scans were normal and that Petitioner had a normal physical exam, thus leading to the conclusion of suspicion for symptom magnification and malingering. (Rx1, 17) Dr. VanFleet opined the findings on the MRIs were not acute findings and that they did not correlate with Petitioner's symptoms. (Rx1, pp. 17-18) Finally, Dr. VanFleet opined that it was his impression that there was nothing more to do for Petitioner as he was highly concerned about symptom magnification and malingering. (Rx1, p. 21) Dr. VanFleet agreed that Petitioner had a lumbar strain following the accident. (Rx1, p. 43) However, he indicated that as Petitioner had been seen by numerous practitioners and was making no progress, he felt Petitioner's condition consisted of non-organic pain manifestation, and that Petitioner was malingering. (Rx1, p. 46)

Dr. VanFleet agreed that generally, based on his knowledge and expertise, pain management specialists are probably trained to stop malingering. (Rx1, p. 24) Dr. VanFleet agreed that he did not see anything in the notes of any treating medical provider that there were concerns of malingering. (Rx1, p. 26) Dr. VanFleet conceded that Dr. Beatty did not express concerns that Petitioner may be malingering. (Rx1, p. 28)

Conclusions of Law

On August 11, 2023, the Petitioner sustained an undisputed work accident and immediately presented for medical treatment. When the initial medications and chiropractic treatment were not alleviating Petitioner's complaints of pain, he sought the opinion of a neurosurgeon who then referred him to pain management. Throughout his course of treatment with pain management, Petitioner also continued to follow up with his primary care physician's office.

Petitioner underwent Section 12 examination with Dr. Beatty at the request of Respondent nearly six (6) months after the work accident. Dr. Beatty did not diagnosis Petitioner with a lumbar strain but believed that there was something else going on to cause radicular symptoms. Dr. Beatty, Respondent's initial Section 12 physician, causally connected Petitioner's condition to the work accident and recommended additional treatment. Additionally, Dr. Beatty did not believe that there was a pre-existing condition. Dr. Beatty also recommended work restrictions (which were not accommodated). (Px4) Respondent sent Petitioner to Dr. VanFleet for a second Section 12 examination approximately 7 months after he was seen by Dr. Beatty. Dr. VanFleet found Petitioner to be displaying signs of symptom magnification and to be at maximum medical improvement. Dr. Beatty clearly disagreed with the causation opinion of Dr. Van Fleet who found the lumbar spine MRI findings to be degenerative in nature. The Commission finds it significant that Respondent chose NOT to introduce Dr. Beatty's report of his February 22, 2023, evaluation into evidence and it was Petitioner who did so (PX4). Additionally, the Commission finds it telling that the Respondent retained a second Section 12 physician to conduct an additional, more Respondent-favorable, independent medical examination rather than having Petitioner reevaluated by Dr. Beatty.

Following the initial Section 12 examination, Petitioner was seen and treated by his primary care physician's office as well as Dr. Mitry and APRN Heicher in the pain clinic. None of these providers, nor Dr. Beatty, noted symptom magnification. Additionally, at the *monthly* follow up visits Petitioner underwent, his complaints of pain did not change nor did the mechanism of injury. Petitioner expressed a desire to return to work and get better. Additionally, Petitioner reported improvement with the injections and was seeking approval for additional injections. Respondent's second Section 12 examiner, Dr. VanFleet, simply noted the injections were equivocal and did not comment in his report or testimony as to why Petitioner would have a positive response to the injections if he was simply magnifying his pain complaints.

All of Petitioner's medical treaters as well as both of Respondent's Section 12 examiners agree that Petitioner did not seem to have a history of prior injury or treatment to his low back prior to the August 2022 work injury.

Based on the totality of the evidence, the Commission reverses the Arbitrator's findings terminating benefits as of October 27, 2023. The Commission finds that Petitioner's current condition of ill-being is causally connected to the August 11, 2022, work accident and awards prospective medical treatment in the form of a follow up evaluation with Dr. Mitry to obtain current treatment

and/or diagnostic testing recommendations. Additionally, the Commission awards medical expenses for the reasonable and causally connected treatment after October 27, 2023. Finally, the Commission awards temporary total disability benefit payments from October 27, 2023, through October 9, 2024.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of \$628.60 per week for a period of 113 weeks, August 11, 2022 through October 9, 2024, 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 reasonable and necessary medical expenses through October 9, 2024, 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 authorize and pay for a follow-up evaluation with Dr. Mitry to obtain current treatment and diagnostic treatment recommendations.

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 \$68,762.00. 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.

DECEMBER 23 2025

/s/ Maria E. Portela

Maria E. Portela

MEP/dmm

/s/ Marc Parker

Marc Parker

O: 110625

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/s/ Christopher A. Harris

Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION
DECISION SIGNATURE PAGE

Case Number	23WC005900
Case Name	Brandon Todd v. C & H Gravel
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	11
Decision Issued By	Edward Lee, Arbitrator

Petitioner Attorney	John Bays
Respondent Attorney	Paul Dykstra

DATE FILED: 12/31/2024

/s/Edward Lee, Arbitrator

Signature

THE INTEREST RATE FOR THE WEEK OF DECEMBER 31, 2024 4.14%

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**

Brandon Todd

Employee/Petitioner

v.

C & H Gravel

Employer/Respondent

Case # **23** WC **005900**

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 **Champaign**, on **October 9, 2024**. 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 **Prospective medical**

FINDINGS

On **August 11, 2022**, 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 **\$49,030.78**; the average weekly wage was **\$942.90**.

On the date of accident, Petitioner was **33** years of age, *single* with **2** dependent children.

Petitioner *has not* 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 **\$28,915.60** for TTD, **\$0.00** for TPD, **\$0.00** for maintenance, and **\$0.00** for other benefits, for a total credit of **\$28,915.60**

ORDER***Causal Connection***

The Arbitrator finds that Petitioner's lumbar strain after the August 11, 2022 accident was causally related to the August 11, 2022 accident. The Arbitrator finds that the effects of the August 11, 2022 accident resolved by the October 27, 2023 Dr. VanFleet independent medical examination. Petitioner's condition after October 27, 2023 was and is not related to the August 11, 2023 accident..

Temporary Total Disability Benefits

The Arbitrator awards TTD benefits from August 15, 2022 to October 27, 2023. As the effects of Petitioner's August 11, 2022 accident resolved by October 27, 2023, and Petitioner was able to return to work without restrictions thereafter, TTD benefits after October 27, 2023 are denied.

Medical Expenses

As the effects of Petitioner's August 11, 2022 accident resolved by October 27, 2023, medical benefits after October 27, 2023 are denied. Medical benefits incurred before October 27, 2023 are awarded.

Prospective Medical Benefits

As the effects of Petitioner's August 11, 2022 accident resolved by October 27, 2023, prospective medical 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.

Edward Lee
Signature of Arbitrator

December 31, 2024

Brandon Todd . C & H Gravel
23 WC 005900

MEMORANDUM IN SUPPORT OF ARBITRATOR'S DECISION

I. Procedural History

This case was presented to arbitration on October 9, 2024 in Urbana/Champaign, Illinois, (*Id.*). Each party was represented by an attorney at arbitration. The only witness who testified live at arbitration was Brandon Todd ("Petitioner").

II. Findings of Fact

A. Petitioner's Testimony

Petitioner testified that, on August 11, 2022, Petitioner had worked for C & H Gravel ("Respondent") for almost four years. (Tr.8). Petitioner's job with Respondent was a maintenance worker, where Petitioner ran gravel plants. (*Id.*). Petitioner performed maintenance on plants and machines and ran heavy equipment. (Tr.9). Petitioner operated bulldozers, excavators, loaders, dump trucks, and used a floor jack. (*Id.*).

Petitioner described the floor jack. (Tr.9). The floor jack was really big. (*Id.*). The floor jack had wheels and weighed approximately eighty to one-hundred pounds and was approximately two and one-half to three feet long. (Tr.10). Petitioner would use the jack to hold an electrical motor in place. (*Id.*). The jack held the motor in the air while Petitioner welded mounting brackets. (*Id.*).

Petitioner had no low back problems, restrictions, or trauma prior to August 11, 2022. (Tr.11). Petitioner had seen a chiropractor four or five years earlier for upper back complaints but had no upper back complaints for four or five years prior to August 11, 2022. (Tr.12).

On August 11, 2022, Petitioner pulled a work truck into the shop garage. (Tr.12). Petitioner opened the truck tail gate and pulled the jack toward himself. (*Id.*). Petitioner turned around and went to set the jack on the ground. (*Id.*). Petitioner noticed that something slid or shifted, then had an onset of back pain. (*Id.*). Petitioner could not stand up due to the back pain.

Petitioner sat for an hour because of the back pain. (Tr.12). Petitioner was by himself. (Tr.13). Petitioner's low back pain was 10/10. (*Id.*). Petitioner's pain was in his low back, not his upper back. (*Id.*).

The accident occurred at approximately 7:30 a.m. (Tr.14). Another worker, Mike Davis, approached Petitioner. (*Id.*). Petitioner reported the accident to Respondent on the same day. (*Id.*). Petitioner did not continue to work and went to Chiropractor Bergbower three hours after the accident. (Tr.15). Bergbower referred Petitioner to a walk-in clinic, where Petitioner was prescribed medications, which provided a little relief, but Petitioner still had pain. (Tr.16).

Petitioner saw Karen Huddleston on August 23, 2022, then Dr. Nardone on October 10, 2022. (Tr.18). Petitioner underwent a strength test. (Tr.19). Petitioner saw APRN Heather Heicher at Sarah Bush Lincoln Pain Management on November 7, 2022. (*Id.*). Petitioner had a

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lumbar injection on December 8, 2022 which provided a little relief for thirty days. (*Id.*). Before the injection, Petitioner's pain was 6 ½ to 7/10. (Tr.20). After the injection, Petitioner's pain was 3 ½ to 4/10. (*Id.*).

Petitioner saw Huddleson on January 16, 2023. (Tr.20). Huddleston prescribed Tramadal and Flexeril. (*Id.*). Petitioner had a little relief from the medications, for a few hours after taking each pill. (Tr.21).

Petitioner saw Dr. Mitry on February 27, 2023 for an injection. (Tr.22). The injection provided thirty days of relief, a little less than the prior injection. (*Id.*). Petitioner saw Dr. Mitry on June 9, 2023 and had visits with Huddleston in the interim. (*Id.*). The June 9, 2023 injection provided less relief, perhaps two and one-half weeks. (Tr.23).

There were two Huddlestons at Casey Family Medical Clinic, Karen and Ashley. (Tr.23). Petitioner was personally examined by one of them in each visit. (Tr.24).

Petitioner understands that he needs another injection prior to being a candidate for cauterizing the nerves. (Tr.25). Since his August 18, 2023 visit, Petitioner has had monthly visits to Casey Family Medicine. (*Id.*). Petitioner's last visit prior to arbitration was September 16, 2024. (*Id.*). Petitioner was recommended off work in each medical visit. (*Id.*). Casey Family Medicine was and is Petitioner's primary care medical provider. (*Id.*).

Each of Petitioner's visits at Casey Family Medicine was for his back. (Tr.26). Petitioner was never taken off work for any condition other than his back. (*Id.*). At the time of arbitration, Petitioner was taking Gabapentin, Tramadol, Cyclobenzaprine, Amitriptyline, and Diclofenac. (*Id.*).

Petitioner had been taking those medications for more than a year prior to arbitration. (Tr.27). Petitioner gets a few hours of relief, perhaps four to six hours, with each pill, then the pain returns. (*Id.*). Petitioner's base line back pain is 5 1/2 / 10. (*Id.*). Petitioner has some range of motion issues but does stretches. (Tr.28). Sometimes Petitioner can touch his toes. (*Id.*).

At the time of arbitration, Petitioner had difficulty playing ball with his children. (Tr.28). Petitioner put items in the middle of his refrigerator to avoid bending. (*Id.*). Petitioner got a smaller tea pitcher. (*Id.*). Petitioner has difficulty using the restroom and installed a chair in his shower. (*Id.*). Petitioner does not play with his dogs like he used to. (*Id.*). Petitioner needs help from his wife to change the propane tank on the grill. (*Id.*).

Petitioner had no difficulties before the accident. (Tr.29). Petitioner performed athletic activities, such as running, lifting weights, and walking fast. (*Id.*). Petitioner no longer performs those activities. (*Id.*).

Petitioner wants to undergo more injections and wants to undergo a cervical MRI scan. (Tr.30). Petitioner has two children, ages ten and eight, who are special needs. (*Id.*).

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Petitioner saw Dr. VanFleet for an independent medical examination on October 27, 2023. (Tr.31). Dr. Van Fleet spent fifteen minutes with Petitioner. (Tr.32).

B. Petitioner's Medical Records

The first medical record in evidence was for Petitioner's visit with Chiropractor Bergbower on August 11, 2022. (Pet.Exh.#5). That medical record reflects a history of Petitioner's back pain since a work accident earlier that morning. (*Id.*). Bergbower performed chiropractic treatments on August 11, 12, 15, 17, 18, and 22, 2022. (*Id.*).

Petitioner went to Sarah Bush Lincoln Medical Clinic on August 11, 2022. (Pet.Exh.3, Exh.2). The record reflects a history of Petitioner's low back pain following the work accident earlier that morning. (*Id.*). Petitioner's pain was in his back and right buttock. (*Id.*). Petitioner complained of back spasms. (*Id.*). Petitioner had seen a chiropractor. (*Id.*). The Sarah Bush medical provider diagnosed back pain and recommended medications. (*Id.*).

Petitioner began treating at Casey Family Medicine on August 23, 2022. (Pet.Exh.3, Exh.3). The record reflects a history of Petitioner's August 11, 2022 accident. (*Id.*). Petitioner had seen a chiropractor and a walk-in clinic. (*Id.*). Nurse Huddleston diagnosed back pain, recommending off work, medications, and a lumbar MRI scan. (*Id.*).

Petitioner underwent the lumbar MRI scan on August 31, 2022. (Pet.Exh.#3, Exh.4). There was no comparison study. (*Id.*). The report indicated a mild L5-S1 spondylosis and a posterior central disc protrusion with annular tear. (*Id.*).

Petitioner saw Dr. Nardone, a back surgeon, on October 10, 2022. (Pet.Exh.#3, Exh.5). Dr. Nardone diagnosed chronic low back pain with left sciatica. (*Id.*). Dr. Nardone wrote that Petitioner was not a surgical candidate. (*Id.*). Dr. Nardone recommended physical therapy and a left S1-2 transforaminal epidural steroid injection, causally connecting Petitioner's symptoms and need for medical treatment to the August 11, 2022 accident.

Petitioner returned to Casey Family Medicine on October 12, 2022. (Pet.Exh.#3, Exh.3). Petitioner had seen a surgeon, who recommended physical therapy and injections. (*Id.*). Huddleston recommended off work and medications. (*Id.*). Petitioner returned to Casey Family Medicine on November 3, 2022. (*Id.*). Petitioner had seen Dr. Nardone a month earlier and will return after a November 22, 2022 low back injection. (*Id.*). Petitioner's pain was moving up his back, so Huddleston recommended a thoracic MRI scan. (*Id.*).

Petitioner went to Dr. Mitry's clinic on November 7, 2022. (Pet.Exh.#3, Exh.6). Dr. Mitry diagnosed lumbar radiculopathy, low back pain, and thoracic radiculopathy. (*Id.*). Dr. Mitry recommended a lumbar transforaminal epidural steroid injection on the left at S1-2. (*Id.*). Dr. Mitry noted that the thoracic MRI was scheduled for November 16, 2022. (*Id.*).

Petitioner underwent a thoracic MRI scan on November 16, 2022. (Pet.Exh.#3, Exh.7). The study indicated mild degenerative changes with no acute findings. (*Id.*).

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Petitioner returned to Dr. Mitry on December 8, 2022. (Pet.Exh.#3, Exh.8). Dr. Mitry performed a transforaminal epidural steroid injection at S1-2 on the left. (*Id.*).

Petitioner returned to Casey Family Medicine on January 16, 2023. (Pet.Exh.#3, Exh.3). Petitioner had no relief from the injection. (*Id.*). Petitioner was scheduled for a second injection for February 27, 2023. (*Id.*). Petitioner had pain on both sides, attributing the right-sided pain to sleeping wrong. (*Id.*). The doctor diagnosed thoracic and lumbar intervertebral disc disorder, recommending off work and medications. (*Id.*).

Petitioner returned to Dr. Mitry on February 2, 2023. (Pet.Exh.#3, Exh.9). Petitioner said the injection did not help at all. (*Id.*). Petitioner had low back pain with pain and numbness on the left into his ribs and abdomen. (*Id.*). Dr. Mitry recommended transforaminal epidural steroid injections on the left at L4-5 and L5-S1. (*Id.*). Petitioner was supposed to get a second surgical opinion. (*Id.*). Dr. Mitry diagnosed mild lumbar spondylosis at L5-S1 and a posterior central disc protrusion with annular tear. (*Id.*).

Petitioner went to Casey Family Medicine on February 13, 2023. (Pet.Exh.#3, Exh.3). Petitioner had one back injection, with no relief. (*Id.*). Petitioner was scheduled for another injection for February 27, 2023. (*Id.*). Huddleston recommended off work and medications. (*Id.*).

Dr. Mitry performed transforaminal epidural steroid injections on the left at L4-5 and L5-S1 on February 27, 2023. (Pet.Exh.#3, Exh.10). On March 13, 2023, Huddleston noted that Petitioner's back was a little better and that Petitioner was treating at a pain clinic. (Pet.Exh.#3, Exh.3). Huddleston recommended off work and medications. (*Id.*).

Respondent sent Petitioner for an independent medical examination with Dr. Beatty, a neurosurgeon, on March 16, 2023. (Pet.Exh.#4). Dr. Beatty diagnosed possible disc fragments moving, causing radicular symptoms. (*Id.*). Dr. Beatty causally related the symptoms, and the diagnosis, to Petitioner's August 11, 2022 accident. (*Id.*). Dr. Beatty recommended an updated lumbar MRI and an EMG study of the lower extremities, as well as a twenty-five pound lifting restriction. (*Id.*).

Petitioner returned to Casey Family Medicine on April 13, 2023. (Pet.Exh.#3, Exh.3). Petitioner's low back pain was worse than in the prior visit. (*Id.*). Petitioner was better after the recent injection and will be going to the pain clinic in June, 2023. (*Id.*). Huddleston recommended off work and medications. (*Id.*).

Petitioner underwent the updated lumbar MRI scan on April 20, 2023. (Pet.Exh.#3, Exh.11). The findings in that MRI were identical to the earlier lumbar MRI scan. (*Id.*).

Petitioner saw Huddleston on May 15, 2023. (Pet.Exh.#3, Exh.3). The medications were helping. (*Id.*). Petitioner was scheduled for an EMG/NCV study for June 15, 2023. (*Id.*).

Petitioner saw Dr. Mitry on June 9, 2023. (Pet.Exh.#3, Exh.12). Petitioner had three weeks of relief following the recent injection and had 50% relief after six weeks. (*Id.*). Dr.

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Mitry recommended repeat injections at L4-5 and L5-S1. (*Id.*). Dr. Mitry also referred Petitioner for urological evaluation for pelvic complaints. (*Id.*).

Petitioner returned to Huddleston on June 13, 2023. (Pet.Exh.#3, Exh.3). Petitioner had two injections at the pain clinic, without relief. (*Id.*). Petitioner wanted a second surgical opinion, as Dr. Nardone earlier determined that Petitioner was not a surgical candidate. (*Id.*).

Petitioner underwent an EMG/NCV study with Dr. Collins on June 24, 2023. (Pet.Exh.#3, Exh.13). Dr. Collins read the study to be normal. (*Id.*). Dr. Collins recommended thoracic and cervical MRI scans. (*Id.*).

Petitioner returned to Huddleston on July 13, 2023. (Pet.Exh.#3, Exh.3). Petitioner was scheduled for more injections in two months. (*Id.*). Petitioner again asked to be referred to another surgeon. (*Id.*). Huddleston recommended Dr. Stephani at Union Hospital. (*Id.*).

Petitioner saw Dr. Ballinger, a urologist, on July 19, 2023. (Pet.Exh.#3, Exh.14). Dr. Ballinger noted that a CT scan of Petitioner's pelvis showed possible gastritis and an indeterminate hepatic nodule. (*Id.*). Dr. Ballinger recommended that Petitioner should follow up with a primary care doctor or a gastroenterologist. (*Id.*).

On August 14, 2023, Huddleston noted that Petitioner was scheduled to return to the pain clinic. (Pet.Exh.#3, Exh.3). Petitioner returned to Dr. Mitry on August 18, 2023. (Pet.Exh.#3, Exh.15). Petitioner had 50% improvement from the June 9, 2023 injections for a few weeks. (*Id.*). A urologist diagnosed prostatitis. (*Id.*). Dr. Mitry diagnosed lumbar and thoracic radiculopathy, left facet arthritis, and left hip pain. (*Id.*). Dr. Mitry noted that the cervical MRI scan had been denied. (*Id.*).

Petitioner saw Huddleston on September 15, 2023. (Pet.Exh.#3, Exh.3). Petitioner had pain, numbness, and stiffness. (*Id.*). Petitioner had not had repeat injections because they were denied by workers' compensation. (*Id.*). Petitioner had an upcoming IME. (*Id.*). On October 17, 2023, Huddleston noted that Petitioner was scheduled for an IME on October 27, 2023 and that there was no scheduled visit for Petitioner to return to the pain clinic. (*Id.*).

Petitioner underwent an independent medical examination with Dr. VanFleet at Respondent's request on October 27, 2023. (Resp.Exh. #1). Petitioner has returned to Huddleston monthly since October 17, 2023. (Pet.Exh.#3, Exh.3; Pet.Exh.#6). Huddleston has recommended off work and medications in each visit. Petitioner's last medical visit prior to arbitration, with Huddleston, was on September 16, 2024. (Pet.Exh.#6).

C. Dr. Mitry Evidence Deposition

Dr. Mitry testified in an evidence deposition on January 22, 2024. (Pet.Exh.3). Dr. Mitry practiced at Sarah Bush Lincoln Health. (P.5). Dr. Mitry specialized in pain management. (P.6). Prior to 2006 or 2007, Dr. Mitry was an operating room anesthesiologist and converted to pain management. (*Id.*). Dr. Mitry treated spinal conditions every day and treated lumbar and thoracic radiculopathy. (*Id.*).

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23 WC 005900

Dr. Mitry noted Petitioner's August 11, 2022 accident. (P.8). Dr. Mitry noted that Petitioner underwent a lumbar MRI on August 31, 2022. (P.11). The study showed mild lumbar spondylosis most pronounced at L5-S1, a posterior central disc protrusion with annular tear, and mild bulges at L4-5 and L5-S1. (P.12). Dr. Mitry testified that a disc protrusion is an early herniation. (P.13).

As Petitioner's symptoms began after the work accident, Dr. Mitry testified that Petitioner's condition was causally related to the August 11, 2022 accident. (P.15). Petitioner's pain and numbness in the back of the thigh fit the findings on the MRI. (P.17). Dr. Mitry noted that Petitioner underwent a transforaminal epidural steroid injection at S1-2. (P.18). Dr. Mitry testified that facet joints are subject to traumatic injury. (P.19).

Dr. Mitry agreed with Dr. Nardone that Petitioner's work injury caused his symptoms. (P.20). The thoracic MRI showed multi-level facet hypertrophy. (P.21). After the December 8, 2022 injection, Petitioner's straight leg raising on the left was significantly less than on the right. (P.24). Dr. Mitry recommended that Petitioner should be off work. (P.26). Dr. Mitry testified that Petitioner's accident may have aggravated Petitioner's thoracic condition. (P.26).

Dr. Mitry noted that Dr. Collins had recommended a cervical MRI. (P.33). Dr. Mitry explained that cervical narrowing, demyelinating disease, or structural abnormality may result in symptoms lower down. (P.33-34).

Dr. Mitry attributed Petitioner's annular tear at L5-S1 to trauma. (P.41). Dr. Mitry explained that medial branch blocks are not long-term solutions. (P.42). Dr. Mitry recommended radio frequency ablations. (*Id.*). Dr. Mitry testified that Petitioner's accident was not related to any hip condition. (P.46).

Dr. Mitry's last visit with Petitioner was on August 18, 2023. (P.48). Petitioner was not at maximum medical improvement at that time. (*Id.*).

Dr. Mitry disagreed with Dr. VanFleet's recommendation that Petitioner was not in need of further medical treatment and that no current condition was related to Petitioner's accident. (P.51). Dr. Mitry agreed with Petitioner's primary care doctor that Petitioner should be off work. (P.53).

On cross examination, Dr. Metry testified that he was board certified in internal medicine, anesthesiology, and pain management but was not a surgeon. (P.53). Dr. Mitry testified that he deferred to orthopedic and neurosurgical surgeon opinions and recommendations for spine treatment. (P.54).

Dr. Mitry testified that people can have annular tears and have no symptoms. (P.54). Regarding the recommendation for the cervical MRI, Dr. Mitry testified that the concern for that recommendation was to rule out multiple sclerosis, which Dr. Mitry testified was not a work-related condition. (*Id.*).

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D. Dr. VanFleet Evidence Deposition

Dr. VanFleet testified in an evidence deposition on May 8, 2024. (Resp.Exh.#1). Dr. VanFleet Fleet was a board certified orthopedic surgeon who specializes in back surgery. (P.6). Dr. VanFleet does approximately 250 to 300 back surgeries per year. (Pp.8-9).

Dr. VanFleet performed an independent medical examination at Respondent's request on October 27, 2023. (P.8). Dr. VanFleet diagnosed Petitioner with a resolved lumbar strain. (P.12). Dr. VanFleet noted that Petitioner was a malingerer. (*Id.*).

Dr. VanFleet reviewed the lumbar MRI's. (P.13). The studies showed an annular tear and disc protrusion, which Dr. VanFleet testified were degenerative in nature. (*Id.*). There was no change in comparing the MRI from August 31, 2022 to the MRI of April 20, 2023. (P.14). The June 24, 2023 EMG was normal in result. (P.15). Petitioner did not need a cervical MRI, and even if Petitioner needed a cervical MRI, it would not be related to this case, which involved a back injury. (P.17).

Dr. VanFleet gave five reasons why Petitioner was a malingerer. (P.18). Petitioner had exaggerated responses. (*Id.*). Petitioner complained of discomfort to superficial palpation, which is not anatomic. (*Id.*). Petitioner complained of a nonanatomic pain with truncal rotation. (*Id.*). Petitioner complained of low back pain with axial compression to his head and shoulders, which are not related to the low back. (*Id.*).

Dr. VanFleet explained that the most significant reason to support the finding that Petitioner was a malingerer was that Petitioner gave different efforts and results when Petitioner was distracted and not distracted during the examination. (P.18). If Petitioner's symptoms were legitimate, Petitioner would demonstrate the same effort and result on examination when distracted and when not distracted. (*Id.*). Dr. VanFleet testified that Petitioner's efforts and results greatly deviated when distracted and when not distracted during the examination. (*Id.*).

On cross examination, Dr. VanFleet elaborated on his observation that Petitioner demonstrated a great deviation in effort and result when distracted and when not distracted. (P.34). Dr. VanFleet testified that it is not common for treating doctors to implement that particular examination technique. (*Id.*). Dr. VanFleet testified that none of Petitioner's treating medical records indicated that any of Petitioner's doctors, nurses, or therapists wrote that was a technique that any of them utilized. (*Id.*). On the contrary, Petitioner's treatment records indicated that each doctor, nurse, and therapist simply took Petitioner's word that he had symptoms. (*Id.*).

III. Conclusions of Law

The Arbitrator incorporates the above-mentioned Findings of Fact into the Conclusions of Law. The Arbitrator finds that Petitioner reached maximum medical improvement for the effects of the August 11, 2022 accident by October 27, 2023, the date of Dr. VanFleet's IME.

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23 WC 005900

The Arbitrator notes that Dr. VanFleet is the most credentialed doctor involved in this case. Huddleston is a nurse. Dr. Mitry is a pain specialist but testified in his evidence deposition that he defers to spine surgeons, such as Dr. VanFleet. The Arbitrator further notes that Dr. Mitry has not seen Petitioner since August 18, 2023 and therefore would not be able to comment on Petitioner's condition when Dr. VanFleet saw Petitioner on October 27, 2023.

The Arbitrator is particularly swayed by Dr. VanFleet's explanation, in his evidence deposition, regarding the physical examination techniques that Dr. VanFleet utilized and that are not noted anywhere in Petitioner's treatment records. Coupled with Dr. VanFleet's unmatched credentials in this case, and Dr. Mitry's deference to spine surgeons such as Dr. VanFleet, Dr. VanFleet had the most factual foundation due to utilizing those examination techniques than any of Petitioner's treating medical providers.

Dr. VanFleet testified that Petitioner was at maximum medical improvement on October 27, 2023 and was able to return to work without restrictions at that time. The Arbitrator finds that all medical and temporary total disability benefits after October 27, 2023 are denied.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	24WC026574
Case Name	Brayan E. Perez v. Avient- Clariant Master Batch Inc
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	25IWCC0511
Number of Pages of Decision	23
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	Alexandra Broderick
Respondent Attorney	Daniel J Levato

DATE FILED: 12/23/2025

/s/ Maria Portela, Commissioner

Signature

24WC026574

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STATE OF ILLINOIS)

) SS.

COUNTY OF COOK)

☐ Affirm and adopt (no changes)☒ Affirm with changes☐ Reverse☐ Modify☐ 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

BRAYAN PEREZ,

Petitioner,

vs.

NO: 24WC026574

AVIENT CLARIENT MASTER BATCH 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, temporary total disability and 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, but makes clarifications as outlined 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).

The Commission finds that Petitioner's accident arose out of and in the course of his employment because he was exposed to a risk distinctly associated with his employment under the first and third categories outlined in *McAllister v. IWCC*, 2020 IL 124848, which stated:

a risk is distinctly associated with an employee's employment if, at the time of the occurrence, the employee was performing (1) acts he or she was instructed to perform by the employer, (2) acts that he or she had a common-law or statutory duty to perform, or (3) acts that the employee might reasonably be expected to perform incident to his or her assigned duties. *Caterpillar Tractor*, 129 Ill. 2d at 58; see also *The Venture—Newberg-*

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Perini, Stone & Webster v. Illinois Workers' Compensation Comm'n, 2013 IL 115728, ¶ 18, 376 Ill. Dec. 823, 1 N.E.3d 535; *Sisbro*, 207 Ill. 2d at 204.

McAllister at ¶ 46. The Court continued:

Caterpillar Tractor prescribes the proper test for analyzing whether an injury "arises out of" a claimant's employment, when a claimant is injured performing job duties involving common bodily movements or routine everyday activities. *Sisbro* and *Caterpillar Tractor* make it clear that common bodily movements and everyday activities are compensable and employment related if the common bodily movement resulting in an injury had its origin in some risks connected with, or incidental to, employment so as to create a causal connection between the employment and the accidental injury. *Sisbro*, 207 Ill. 2d at 203 (citing *Caterpillar Tractor*, 129 Ill. 2d at 58). *Caterpillar Tractor* does not require a claimant to provide additional evidence establishing that he was exposed to the risk of injury, either qualitatively or quantitatively, to a greater degree than the general public, once he has presented proof that he was involved in an employment-related accident. *Caterpillar Tractor*, 129 Ill. 2d at 58.

...

Once it is established that the injury is work related, *Caterpillar Tractor* does not require claimants to present additional evidence for work-related injuries that are caused by common bodily movements or everyday activities. Therefore, we hold that *Adcock* and its progeny are overruled to the extent that they find that injuries attributable to common bodily movements or routine everyday activities, such as bending, twisting, reaching, or standing up from a kneeling position, are not compensable unless a claimant can prove that he or she was exposed to a risk of injury from these common bodily movements or routine everyday activities to a greater extent than the general public.

Id. at ¶ 64.

In the case at bar, Petitioner was instructed to traverse the stairs by virtue of the fact that his job required him to work on both floors, which is a distinctly employment related risk under the first *McAllister* category. Similarly, traversing the stairs is an activity that Petitioner would reasonably be expected to perform incident to his or her assigned duties under the third *McAllister* category. Therefore, we do not need to engage in a neutral-risk analysis to determine whether Petitioner was exposed to the risk of stairs to a greater degree than the general public.

Finally, the Commission strikes, on page 8, the citation to *Flex-N-Gate Logistics v. IWCC*, 2020 IL App. (4th) 190467WC-U because it is a Rule 23 Order filed prior to January 1, 2021. *Ill. S. Ct. Rule 23*.

All else is affirmed and adopted.

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IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 11, 2025 is hereby affirmed and adopted with the clarifications noted above.

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.

DECEMBER 23 2025

/s/ Maria E. Portela

SE/

/s/ Marc Parker

O: 11/20/25

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/s/ Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION
DECISION SIGNATURE PAGE

Case Number	24WC026574
Case Name	Brayan E. Perez v. Avient- Clarient Master Batch Inc
Consolidated Cases	
Proceeding Type	19(b) Petition Remand Arbitration
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	19
Decision Issued By	Daniel Swanson, Arbitrator

Petitioner Attorney	Alexandra Broderick
Respondent Attorney	Daniel J Levato

DATE FILED: 2/11/2025

/s/ Daniel Swanson, Arbitrator
Signature

THE INTEREST RATE FOR THE WEEK OF FEBRUARY 11, 2025 4.19%

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)

Brayan Perez

Employee/Petitioner

v.

Avient Clariant Master Batch Inc.

Employer/Respondent

Case # **24** WC **26574**

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 **Daniel Swanson**, Arbitrator of the Commission, in the city of **Chicago**, on **1/10/25**. 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, **7/17/24**, 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 **\$41,600.00**; the average weekly wage was **\$800.00**.

On the date of accident, Petitioner was **28** 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 **\$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**Medical Expense Award**

Respondent shall pay Petitioner directly for the following outstanding gross medical services, pursuant to the medical fee schedule and Sections 8(a) and 8.2 of the Act: \$21,330 to Advocate Good Samaritan Facility (PX 8); \$8968 Grandview Health (PX 9); \$784.16 to Persistent RX (PX 10); \$24,000 to River North Pain Management (PX 11); \$4500 to Western Touhy Anesthesia (PX 11); \$18,677.56 to Lakeshore Surgery Center Facility (PX 11); \$570 to Lakeshore Surgery Center Physicians (PX 11); \$1829.40 to Delaware Physicians (PX 11); \$13,101.78 to Lakeshore Open MRI (PX 11); \$2179 to Matrix Medical (PX 12); \$1120 to G & T Ortho (PX 13).

Temporary Total Disability Award

Respondent shall pay Petitioner temporary partial disability benefits of \$533.33 for 21 $\frac{2}{7}$ weeks, commencing 8/15/24 through 1/10/25, as provided in Section 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.

Daniel Swanson

Signature of Arbitrator

February 11, 2025

BRAYAN PEREZ,	)	
	)	
Petitioner,	)	
	)	
v.	)	
	)	Case No. 24WC0026574
AVIENT CLARIENT MASTER BATCH, INC.,	)	
	)	
	)	
Respondent.	)	

This matter proceeded to hearing on January 10, 2025 in Chicago, Illinois before Arbitrator Daniel Swanson on Petitioner’s Request for Hearing pursuant to Section 19b under the Illinois Workers’ Compensation Act “Act.”

The issues in dispute include accident, causal connection, medical expenses and temporary total disability benefits. (Arbitrator's Exhibit 1).

Petitioner was employed by Respondent as a machine operator. Petitioner testified that he operated a “Strudel” machine. (Transcript at page 14). Petitioner’s duties included operating the machinery, monitoring production, and cleaning the machines. Several of the machines he was tasked with working on were located on the second floor. In order to access the second floor, he

was required to go up and down the stairs. He had to use a specific set of stairs to access these machines, and three people used this specific set of stairs. (Transcript at page 15). Each shift, which was 1 day a week, 5 days a week, required him to go up and down the stairs at least 8 times a shift (Transcript at page 15).

Prior Medical Condition

The Petitioner testified that he had no history of back, right knee or head complaints prior to the fall on the stairs, which occurred on July 17, 2024. (Transcript at page 13).

Accident

On July 17, 2024 Petitioner was on the second floor, where he was inspecting the levels of product on the machines (Transcript at page 41) and was returning to his other duties on the first floor. Petitioner testified that he had started going down the stairs, had his right hand on the right handrail, and had a clear folder with a list of the orders to fulfill taped around his left wrist (Transcript at page 30). As he was descending the stairs, he got dizzy, attempted to grab the left handrail with his left hand but was unable to do so. He fell down the approximately 10 stairs and woke up in the ambulance (Transcript at page 16). On cross-examination, Petitioner testified that he had an order form in a clear folder in his hand. (Transcript at pages 30-31). On re-direct examination, Petitioner clarified that the order form in the clear folder in his hand was taped to his wrist with safety tape, which “possibly” may have gotten in the way while he was reaching for the railing to the stairs when he felt dizzy and fell. (Transcript at pages 34-35).

Further on cross-examination, Petitioner denied taking a double dose of his anxiety medication before his shift on July 17, 2024. Also, the Petitioner was forthright in testifying that he was involved in a car accident in which he fell asleep at the wheel about a month before the July 17, 2024 fall on the stairs at work. Petitioner sustained no physical injuries during the motor vehicle accident, but he was hospitalized for in-patient mental health care. (Transcript at pages 11-12).

There was no medical evidence or expert opinion presented that clearly demonstrated that the fall resulted from an internal, personal origin as a result of a prior automobile accident or any adverse side effect from taking medication for anxiety and depression.

Summary of Medical Record

The Petitioner was taken from the scene via ambulance to Advocate Good Samaritan Hospital on July 17, 2024. The West Chicago Ambulance Report reflected that the cause of injury is a fall from stairs and steps (PX 1.) At the hospital it was noted that he had lost consciousness (PX 2). Petitioner presented a consistent history of dizziness followed by a fall down the stairs, and complained of headaches, dizziness, pelvic pain, and right knee pain. Petitioner was subsequently sent by the Respondent to Concentra not for treatment, but rather for a company physical. He was sent for the same fitness for duty physical that he had prior to being hired. The Concentra reflect that it was determined that Petitioner was unable to work as he was unable to meet the physical requirements of the job.

When Petitioner arrived at Advocate on July 17, 2024 via ambulance, It was noted that Petitioner had a history of anxiety and depression. Petitioner reported that he takes anxiety medicine every 8 hours and had taken a dose of anxiety medication around 10:30pm before his shift began. Petitioner underwent a head CT that was negative for ant acute traumatic injury; a right knee x-ray that revealed no fracture or dislocation; and a pelvis x-ray that revealed no fracture. Petitioner was diagnosed with a head contusion, pelvic contusion, right knee contusion, and right knee abrasion, and discharged without any noted work restrictions. (Px2, p.5-61).

Petitioner was next seen by Edward Neuroscience Institute on September 13, 2024. Petitioner testified that he was sent there by Human Resources (Transcript at page 19). He testified that he was also given a form titled Neurologist clearance form (PX 4, page 54) to give to the doctor to fill out by HR. (Transcript at page 19). The doctor felt that Petitioner was unable to return to

work and meet his job duties at that time. He was diagnosed by Dr. Buckhold with post concussive syndrome likely a result of the work accident. He recommended medication and that Petitioner remain off work.

Petitioner was seeing Dr. Buckhold of Edward Neuroscience institute for only his head injuries, and he sought out treatment with Grandview for treatment of his other body parts on September 27, 2024 (PX 5). At his initial visit, he complained of pain in his head, neck, thoracic and lumbar spine, ribs, and right knee. He was placed off work, recommended physical therapy, and referred for MRIs of the brain, lumbar, cervical and right knee. He underwent the MRIs on October 18, 2024. The MRIs were not significant except for the MRI of the lumbar spine which revealed at L4/5 & L5/S1 2-3 mm posterior central disk protrusion which indents the ventral surface of the thecal sac with bilateral neuroforaminal narrowing exacerbated by facet arthrosis and the MRI of the right knee which revealed a horizontal medial meniscal tear involving the posterior horn extending to the midbody region (PX 6).

Petitioner was seen for a follow up with Dr. Buckhold on October 18, 2024 noting continued headaches (PX 4). He was diagnosed with post concussive syndrome and migraine without aura, prescribed medication, and continued off work.

On October 6, 2024, Dr. Gavin Ryan of Grandview referred Petitioner for a pain management consultation (PX 5). Petitioner was referred for a pain management consult with Dr. Vargas, whom he first saw on November 6, 2024 (PX 6). He diagnosed the Petitioner with lumbar radiculopathy, lumbar axial back pain, and lumbar facet syndrome. Dr Vargas also noted that Petitioner presented with knee pain as a result of the work injury and referred him for an orthopedic consult. Dr. Vargas noted that the low back axial pain, was not uncommon for the mechanism of injury that the patient sustained.

Petitioner was seen for an orthopedic consult on November 8, 2024 by Dr. Thomas Poepping of G&T Orthopedics (PX 7). He noted the Petitioner was a 28 year-old male who had a fall down a flight of steps at work, and injured his right knee at that point. He diagnosed the Petitioner with right knee pain, gave him an injection, and placed him off work. He was seen for a follow up with Dr. Poepping on December 6, 2024, noting improvement from the injection. He was released full duty in so far as the right knee only and asked to return on an as needed basis.

Petitioner was seen by Dr. Buckhold on November 22, 2024 (PX 4) noting improvement in his headache symptoms. He was returned to work full duty for the post-concussion and migraines, but to discuss existing restrictions with pain management. He was further asked to follow up in 3 months.

Dr Vargas performed both a diagnostic and therapeutic block on the Petitioner on November 14, 2024, and again on December 5, 2024. He noted 50-60% improvement, and therefore a 3rd injection was recommended. Petitioner underwent the 3rd injection on December 19, 2024.

Petitioner's Current Condition

The Petitioner testified that his pre-existing anxiety has gotten worse after the fall on the stairs on July 17, 2024 because of the lack of money. (Transcript at page 23).

On December 6, 2024, Dr. Poepping discharged the Petitioner for the right knee after improvement in his condition as a result of three injections administered. (Transcript at page 22).

The Petitioner did not testify regarding how his neck and back condition has changed his life. However, the Arbitrator notes that he has not been discharged from care by his treating physicians or reached maximum medical improvement.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). 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 demeanor of the witness and any external inconsistencies with his/her testimony. Where a claimant's testimony is inconsistent with his/her 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).

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 witness testimony. O'Dette v. Industrial Commission, 79 Ill.2d 249, 253 (1980); Hosteny v. Workers' Compensation Commission, 397 Ill. App. 3d 665, 674 (2009). 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 ILWC 004187 (2010).

In the case at hand, the Arbitrator observed Petitioner during the hearing and finds him be a credible witness. Petitioner was direct and forthright in answering questions. The Arbitrator compared Petitioner's testimony with the totality of the evidence submitted and did not find any material contradictions that would deem the witness unreliable.

(C) In support of the Arbitrator’s decision regarding whether an accident occurred that arose out of and in the course of Petitioner’s employment by Respondent, the Arbitrator makes the following conclusions of law:

The Arbitrator find that Petitioner sustained an accident that arose of out of and in the course of his employment on July 17, 2024.

The Arbitrator notes that there was no medical evidence or medical opinion presented that clearly demonstrated that the fall on July 17, 2024 resulted from an internal, personal origin as a result of a prior automobile accident or any adverse side effect from taking medication for anxiety and depression.

On July 17, 2024 Petitioner was on the second floor, where he was inspecting the levels of product on the machines (Transcript at page 41) and was returning to his other duties on the first floor. Petitioner testified that he had started going down the stairs, had his right hand on the right handrail, and had a clear folder with a list of the orders to fulfill taped around his left wrist (Transcript at page 30). As he was descending the stairs, he got dizzy, attempted to grab the left handrail with his left hand but was unable to do so. He fell down the approximately 10 stairs and woke up in the ambulance (Transcript at page 16).

In order to determine whether a claimant’s injury arose out of his employment, we must first categorize the risk to which he was exposed. The risks to which an employee may be exposed are categorized into three groups: (1) risks distinctly associated with employment; (2) risks personal to the employee, such as idiopathic falls, and (3) neutral risks that have no particular employment or personal characteristics. *Illinois Consolidated Telephone Co. v. Industrial Comm’n*, 314 Ill.App.3d 347, 352, 247 (2000) (Rakowski, J., concurring).

Although traversing stairs is a neutral risk, the Petitioner in the instant case ascended and descended the stairs 8 times per shift to feed material into the “strudel” machine on the second floor. Brayon Perez had to traverse stairs in the exercise of his employment duties more often

than the general public. The Petitioner was performing an act he would reasonably have been expected to perform incidental to his job duties given that he was required to traverse stairs in order to fill the “strudel” machine with product on the second floor.

Significantly, the Flex-N-Gate Logistics v. Ill. Workers’ Comp Comm’n 2010 IL. App. (4th) 190467WC-U is an unpublished Appellate Court Rule 23 Decision cited for persuasive value as the facts and legal analysis are strikingly similar to the case at bar. The Claimant was a truck driver who transported trailers between facilities and brings paperwork to the facilities shipping and receiving office at each location. During the third stop of the day, he fell while ascending stairs to the office. He was carrying paperwork but testified that he did not know what caused the fall, but he may have missed a step. There were no defects on the stairs and only seven steps. On average Claimant goes up and down steps during a workday 8 to 10 times per day. The Appellate Court cited McCallister, and found that the accident was a compensable employment risk because Claimant was injured while performing an act he would reasonably be expected to perform incident to his assigned job duties. Moreover, the Appellate Court noted that the shipping and receiving desk was where Claimant dropped off paperwork from his prior trip and received orders and paperwork for his next trip, and he was required to ascend stairs to reach the shipping and receiving desk. Therefore, in the same way as the case at bar, traversing those stairs was connected with what he had to do in fulfilling his job duties. “Thus, walking up the stairs at the facility was an act that the Claimant might reasonably be expected to perform incident to his assigned duties.”

Furthermore, injuries arising from a condition personal to the claimant can be compensable if the employment increases the risk of injury. In Village of Villa Park v. Illinois Workers' Compensation Commission, 2013 IL App (2d) 130038WC, the evidence showed that that the employer village required its community service officer to traverse stairs in the police station a minimum of six times per day. Those facts supported a finding that the officer's falling accident arose out of his employment under an increased-risk exception to the general rule of non-compensability for injuries resulting from a personal risk when the employment placed him in a position of greater risk of falling because of the frequency with which he was required to traverse the stairs. That constituted an increased risk on a quantitative basis from that to which the general public was exposed.

In the instant case, Petitioner had started descending the stairs during the first hour of his shift on July 17, 2024, his right hand was on the handrail, he got dizzy, attempted to grab the left handrail but was unable to do so, and fell down the stairs. Similar to Village of Villa Park, the Petitioner here was placed at a greater risk of falling because of the frequency for which he ascended and descended the stairs. Petitioner testified that he would ascend/descend the stairs at least 8 times a day, 5 times a week. Petitioner testified that he got dizzy when he was attempting to descend the stairs a 3rd time on 7/17/24 when he fell down the approximate 10 stairs. He was at a greater height, the second floor, when he fell down the stairs and ultimately was at an increased risk. Only 3 people had access to this set of stairs. His hand was on the right handrail and he attempted to grab the left handrail when he fell down the stairs. The Village of Villa Park Court found 6 times a day of going up or down the stairs to be sufficient to place an individual at an increased risk of falling down the stairs. Here, Petitioner would go up and down the stairs at least 8 times a day. Similarly to Village of Villa Park, Petitioner's employment

placed him in a position of greater risk of falling because of the frequency with which he was required to traverse the stairs. Therefore, Petitioner's accident arose out of his employment.

Petitioner was also at an increased risk of falling down the stairs as a result of the clear folder containing the order of product that was wrapped around his left wrist. Petitioner testified that on the day of the accident his right hand was on the railing, and that he tried to grab the railing with his left hand but he was unable to do so. As part of his job, he had a list of orders in a plastic folder tied to his wrist. The folder tied to his left wrist, is an impediment to him grabbing the handrail with his left hand. The folder was taped to his wrist, and then hung down (Transcript at page 35). Petitioner testified that this folder could get in the way as he tried to grab the handrail on the stairs (Transcript at page 35). The clear folder taped to his left wrist listed the orders he was to verify for the machines he operated on the second floor. Therefore, the Petitioner was also at an increased risk when ascending and descending the stairs due to the clear folder that was taped to his left wrist, and thus the accident arose out of the employment.

At the time of the accident, Petitioner was performing his job duties as a machine operator during the hours of his employment. This accident must be analyzed through the lens of McAllister. McAllister v. Illinois Workers' Compensation Comm'n, 2020 IL 124848. An injury "arises out of" employment when "the injury had 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." A risk is incidental to the employment when it belongs to or is connected with what the employee has to do in order in fulfilling his job duties. Accordingly, an injury arises out of an employment-related risk (i.e., a risk "distinctly associated with" and "incidental to" his employment) if, at the time of the occurrence, the employee was performing acts he was

instructed to perform by his employer, acts which he 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." Here, Petitioner was going up the stairs to put the product into the machine and verify the order (Transcript at page 14). Petitioner testified that some of the actual machines are on the first floor, but the product is put into the machine from the second floor (Transcript at page 40). These were part of his job duties as a machine operator, and job duties that would be expected of one doing that type of job. Further, the accident report submitted by Respondent indicates Petitioner fell down the stairs while walking into the mixing room. Petitioner was clearly performing duties that he was instructed to perform and ones that he would be expected to perform incident to his assigned duties, and therefore under McCallister he sustained an accident that arose out of and in the course of employment.

The Arbitrator had the opportunity to observe the Petitioner's demeanor and found him to be a credible witness. The Arbitrator finds that on July 17, 2024, an accident occurred that arose out of and in the course of the Petitioner's employment with the Respondent. Petitioner credibly testified that on that date the Petitioner was descending the stairs when he got dizzy and fell down the stairs. Petitioner was at an increased risk due to the fact due to the quantitative number of times he ascended and descended the stairs, as well as due to the clear folder that was taped to his left wrist. Further, this was an incidental risk connected with Petitioner's employment. The Arbitrator therefore finds Petitioner sustained an accident that arose out of and in the course of his employment on July 17, 2024.

(F) In support of the Arbitrator's decision regarding whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions of law:

The Arbitrator took into account Petitioner's testimony at Arbitration and deemed him to be a forthright and reliable witness. The Arbitrator finds Petitioner met the burden of proof and established his head, back, cervical, and right knee condition of ill-being is causally related to the 7/17/24. work accident.

In finding causal connection, the Arbitrator takes into account the chain of events, the consistency of Petitioner's complaints of right knee pain, and the Reliable and persuasive opinions of Dr. Buckhold, Dr. Vargas, and Dr. Poepping.

It is well-established law that proof of prior sound health and change immediately following and continuing after an injury may demonstrate 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 a causal connection between work duties and a condition may be established by a chain of events. This includes the Petitioner's ability to perform duties before the date of the accident and inability to perform the same duties following that date. Id.

Petitioner testified that he had no history of head, neck, back, or right knee injury prior to July 17, 2024 (Transcript at page 13). Petitioner testified that he had a motor vehicle accident approximately one month prior to the work accident of July 17 2024, but that he suffered no physical injuries (Transcript at page 12). He was able to complete his work duties without issue for the approximate one month after his return prior to the work accident. Furthermore, the Arbitrator notes that the Respondent did not present an IME to dispute causal connection.

Petitioner was seen by Dr. Buckhold of Edward Neurosciences Institute (PX 4) who diagnosed the Petitioner with post concussive syndrome and migraine without aura and stated "is likely related to his injury as he fell down the stairs" (PX 4 at 44).

Petitioner was also evaluated by Dr. Vargas who diagnosed Petitioner with lower back pain syndrome, lumbosacral discogenic and radiculopathy, lumbosacral axial facet pain syndrome and right knee pain. Further he noted that the initial complaints of thoracic and cervical pain had now resolved (PX 6 at 17). Dr Vargas noted that the Petitioner's axial facet pain syndrome was consistent with the mechanism of injury the patient sustained (p. 16) and that the knee was a result of the injury (p. 17).

Dr. Poepping treating the Petitioner for his right knee, noted the MRI revealed a meniscal tear and diagnosed him with right knee pain, and noted that "the patient is a 28 year-old male who had a fall down one flight of steps at work on July 17, 2024. He injured his right knee at that point." (PX 7).

Respondent presented no evidence to dispute causal connection, other than inferring that there was a personal idiopathic cause for the fall. The Respondent has not submitted an independent medical examination in support of the idiopathic or personal condition theory of defense. The Arbitrator therefore relies upon the reliable opinions of Dr. Buckhold, Dr. Vargas, and Dr. Poepping, and finds Petitioner's current condition of ill-being to be causally related to the July 17, 2024 work incident.

(J) In support of the Arbitrator's decision whether the medical services that were provided to the Petitioner were reasonable and necessary, and whether Respondent paid all appropriate charges for all reasonable and necessary services, the Arbitrator makes the following conclusions of law:

The Arbitrator finds that the medical expenses admitted were for reasonable, related and necessary treatment based upon the totality of the credible evidence.

Further, having established both accident and casual connection, the Arbitrator awards all medical bills. Respondent has presented no basis to deny medical bills, as there is no IME or utilization reviews.

Pursuant to Section 8.7(i)(3) of the Act, once the utilization review process is invoked by Respondent, “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.” The issue of causal connection has already been addressed, therefore, there is no dispute as to the reasonableness and necessity of the care rendered. The Arbitrator notes that Respondent has not offered a Section 12 or Utilization Review opinion into evidence to challenge the reasonableness or necessity of the medical treatment and expenses admitted into evidence.

The Arbitrator therefore finds all the medical bills to be reasonable and necessary and awards al the following gross medical bills pursuant to the fee schedule:

(PX 8) Advocate Good Samaritan Facility, \$21,330 ;

(PX 9) Grandview Health, \$8,966;

(PX 10); Persistent RX, \$784.15;

(Group PX 11) UnisLink:

(a) River North Pain Management Consultants , \$24,000;

(b) Western Touhy Anesthesiology, \$4500;

(c) Lakeshore Surgery Center Facility, \$18,677.66;

(d) Lakeshore Surgery Center Physicians, \$570;

(e) Delaware Physicians,,LLC., \$1829.40;

(f) Lakeshore Open MRI, \$13,101.78:

(PX 12) Matrix Medical, \$2,179,

(PX 13) G & T Orthopedics, \$1120.

Moreover, Respondent shall pay Petitioner directly the outstanding medical services awarded above, pursuant to the medical fee schedule and Sections 8(a) and 8.2 of the Act: The Arbitrator also notes that this is a 19(b), and that those medical bills that have been incurred but not yet received, the issue of those bill has been reserved by Petitioner, and Respondent had no objection.

(K) In support of the Arbitrator's decision regarding the amount owed for temporary total disability benefits, the Arbitrator makes the following conclusions of law:

The Arbitrator finds Petitioner satisfied his burden of proof and awards TTD benefits from August 15, 2024 through January 10, 2025, a period of $21\frac{2}{7}$ weeks at a TTD rate of \$533.33 totaling \$11,352.31. In doing so, he notes that the parties stipulated that there was no claim for TTD for the period of July 18, 2024 through August 14, 2024, and no claim for a credit either for this four week period, as Petitioner was paid his usual salary by Respondent.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	22WC004540
Case Name	Joy Ming-Wilson v. Maxim Healthcare Group
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	25IWCC0512
Number of Pages of Decision	19
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	Molly Price
Respondent Attorney	Joseph Cervantez

DATE FILED: 12/24/2025

/s/Maria Portela, Commissioner
Signature

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)
☐ Modify	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOY C. MING-WILSON,

Petitioner,

vs.

NO: 22WC004540

MAXIM HEALTHCARE GROUP,

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, temporary total disability, medical expenses and nature and extent, and being advised of the facts and law, affirms and adopts, with the following addition, the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission notes that Petitioner filed a "Motion to Dismiss Respondent/ Appellant's Petition for Review..." on June 30, 2025, claiming that Respondent did not file an authenticated transcript by the Return Date on Review of May 2, 2025. Petitioner argues that Respondent was not diligent in pursuing its Review and the Commission no longer has jurisdiction. Petitioner relies on a CompFile printout which indicates that the "Transcript Authentication Page" was "Modified" on "5/9/2025 9:54 AM." *P's Motion Exhibit 1 at 13.*

The Commission finds that Petitioner misunderstands the significance of that "modified" date because CompFile clearly reflects that Respondent filed the transcript authentication page on March 3, 2025, almost two months prior to the Return Date on Review. The authentication page contained the signatures of both attorneys, as required. However, in addition to uploading the authentication page, the CompFile system also has a transcript status field, intended to be used internally by Illinois Workers' Compensation Commission clerical staff, to change the status from "Pending Authentication" to "Authenticated." Currently, this field can also be changed by end users, but it has no legal significance. For example, if a party uploads an authentication page with only one attorney's signature but incorrectly changes the transcript status to "Authenticated," this

does not mean that the transcript was, in fact, properly authenticated. Conversely, if a party uploads a properly authenticated transcript with all required signatures but the status is not changed to “Authenticated,” this does not mean that the transcript was not authenticated and filed in a timely manner.

Therefore, the Commission finds that Respondent timely filed the transcript authentication page on March 3, 2025. The “modified date” of May 9, 2025, when the transcript status was changed to “Authenticated,” is a strictly clerical CompFile function with no legal significance. Petitioner’s “Motion to Dismiss...” is hereby denied.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 14, 2025, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner’s “Motion to Dismiss Respondent/Appellant’s Petition for Review...” is denied.

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.

DECEMBER 24 2025

/s/ Maria E. Portela

SE/

/s/ Marc Parker

O: 11/6/25

49

/s/ Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION
DECISION SIGNATURE PAGE

Case Number	22WC004540
Case Name	Joy Ming-Wilson v. Maxim Healthcare Group
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	16
Decision Issued By	Bradley Gillespie, Arbitrator

Petitioner Attorney	Molly Price
Respondent Attorney	Sarah Hocking

DATE FILED: 2/14/2025

/s/Bradley Gillespie, Arbitrator
Signature

THE INTEREST RATE FOR THE WEEK OF FEBRUARY 11, 2025 4.19%

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
 PETITIONER'S PROPOSED ARBITRATION DECISION**

JOY C. MING-WILSON
 Employee/Petitioner

Case # **22** WC **004540**

v.

Consolidated cases: **N/A**

MAXIM HEALTHCARE GROUP
 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 **BRADLEY GILLESPIE**, Arbitrator of the Commission, in the city of **MT. VERNON**, on **DECEMBER 11, 2024**. 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 **\$2,866.01 for Tricare's subrogation interest.**

FINDINGS

On the date of accident, **December 17, 2021**, 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 **\$60,803.60**; the average weekly wage was **\$1,169.30**.

On the date of accident, Petitioner was **30** 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 **\$0.00** for TTD, **\$0.00** for TPD, **\$0.00** for maintenance, and **\$4,586.78 (medical)** for other benefits, for a total credit of **\$4,586.78 (medical)**.

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 \$59,131.55 to Air Evac Lifeteam for date of service 12/17/2021, \$125.00 to Deaconess Health System for date of service 12/17/2021, \$180.96 to Mercy Clinic Primary Care/Dr. Devabhaktuni for dates of service 12/21/2021 and 12/29/2021, \$2,948.00 to United Physicians Group for dates of service 3/24/2022 through 4/18/2023, \$17.98 to Diagnostic Imaging Associates for date of service 11/10/2022, \$2,238.41 to the Orthopedic Surgery Center of Creve Coeur for date of service 3/15/2023 and \$1,827.96 to Zynex Medical for dates of service 4/26/2023 through 9/26/2023, as provided in Section 8(a) of the Act.

Respondent shall pay \$2,866.01 to Petitioner for Tricare's subrogation interest.

Respondent shall pay Petitioner temporary total disability benefits of \$779.53/week for 17 weeks, commencing December 18, 2021, through January 2, 2022 and January 13, 2022 through April 25, 2022, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of \$701.58/week for 62.5 weeks, because the injuries sustained caused a 12.5% 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.

Bradley D. Gillespie
Signature of Arbitrator, Bradley Gillespie

February 14, 2025

Petitioner was assigned to work at Communicare - Harrison Healthcare Center (hereinafter "Harrison Healthcare") in Corydon, Indiana from November 24, 2021, through January 5, 2022, and Respondent received pay for from the facility for Petitioner so doing. (RX 6 and Tr. p. 15) Respondent received \$75.00 an hour with a minimum of forty-eight (48) hours per week for hours worked by Petitioner at the Harrison Healthcare. (RX 6). If Petitioner was not utilized during said time frame by Harrison Healthcare, then Respondent would receive fifty percent (50%) of the amount due to Respondent for the remainder of the term. *Id.* Harrison Healthcare was not to cancel and/or terminate Petitioner. *Id.* Additionally, Harrison Healthcare was not allowed to recruit, hire, or employ Petitioner for a period of twelve (12) months following the date Petitioner last worked a shift for Harrison Healthcare or Harrison Healthcare would owe Respondent damages. (RX 4)

For the week of December 13, 2021, at Harrison Healthcare, Petitioner worked Monday, December 13, 2021, through 6:00 a.m. on Friday, December 17, 2021. (RX 4) She stayed at a hotel on December 16, 2021, due to the fact that her home was four hours away and she had a shift that night (Tr. pp. 15-16, 51; PX 11) On December 17, 2021, Petitioner was in a car accident driving home from work in which she sustained injuries. (Tr. pp. 16-17) At the time of the accident, Petitioner was traveling home after her travel assignment. (Tr. pp. 29, 100) On the date of the accident, Petitioner could have stayed at the hotel after her shift but she was not required to do so. (Tr. pp. 105, 107).

Petitioner was transferred from the scene of the accident via helicopter to Deaconess Midtown Campus Hospital in Evansville, Indiana on the date of the injury. (PX 1, p. 2) She stated that she did lose consciousness. (PX 2, p. 31) She complained of headache, left shoulder pain, bilateral elbow pain, bilateral hip pain, left knee pain and neck pain. (PX 2, pp. 31, 43) She described her pain as severe, continuous and constant and stated that her pain was aggravated by any attempted movement. (PX 2, pp. 31, 89) Dr. Colby Dorroh noted that Petitioner had tenderness to her left shoulder, bilateral elbows, and left knee. (PX 2, p. 34) X-rays of Petitioner's right shoulder, left shoulder, right elbow, left elbow, and left knee were negative for fractures. (PX 2, pp. 34-35) CT scans of Petitioner's head, cervical spine, chest, abdomen, pelvis, thoracic and lumbar spine were negative. (PX 2, pp. 35-37) Ms. Jennifer Lampert, NP noted that Petitioner had multiple abrasions to her right arm and face and that shards of glass were removed from multiple abrasions on Petitioner's arm. (PX 2, p. 41) Ms. Lampert also noted that Petitioner had a laceration to her upper lip and right thumb just below the IP joint. *Id.* Ms. Lambert cleansed Petitioner's right arm, face, neck upper lip and right thumb with peroxide and sterile normal saline and closed her lacerations with Dermabond glue. *Id.* Dr. Dorroh diagnosed motor vehicle collision, lip laceration and laceration of right thumb. (PX 2, p. 41) Dr. Dorroh administered a Dilaudid injection, prescribed Flexeril and Norco and placed Petitioner off work until December 24, 2021. (PX 2, pp. 32-33, 72, 102)

On December 21, 2021, Petitioner sought treatment from Dr. RamaDevi Devabhaktuni at Mercy Clinic Primary Care in St. Louis, Missouri. (PX 3, pp. 1-2) She complained of glass in her right ear, dizziness, lightheadedness, and pain in her knees and back with walking. (PX 3, p. 40) Dr. Devabhaktuni noted that Petitioner had a paraspinal spasm to her back and stiffness in her back when walking (PX 3, p. 8) She noted that Petitioner had multiple superficial lacerations on her left elbow and right knee. *Id.* Dr. Devabhaktuni diagnosed motor vehicle accident, lip laceration, laceration of right thumb and multiple abrasions and placed Petitioner off work. (PX3, pp. 9, 19)

Petitioner returned to Dr. Devabhaktuni on December 29, 2021. She complained of hip pain. (PX 3, p. 36). Dr. Devabhaktuni noted that Petitioner had pain in her right hip on the lateral side. (PX 3, p. 38). She diagnosed motor vehicle accident and right hip pain and ordered an x-ray of Petitioner's right hip (PX 3, p. 39) Petitioner was allowed to return to work on January 3, 2022. (PX 3, p. 51) On January 11, 2022, Dr. Devabhaktuni referred Petitioner to see Dr. Thomas Lee for her back pain. (PX 3, p. 52)

On January 13, 2022, Petitioner sought treatment from Dr. Lee at Pain and Rehabilitation Specialists in Chesterfield, Missouri. (PX 4, p. 3) She complained of ongoing pain in her low back, neck and shoulder. *Id.* She reported that she tried to work after her primary doctor released her, but she was crying in pain. *Id.* Dr. Lee noted that Petitioner had tenderness to her mid to lower cervical spine as well as decreased extension, flexion, and rotation (PX 4, p. 4) He noted that Petitioner had contralateral trapezial pain with rotation. *Id.* Dr. Lee noted that Petitioner had decreased flexion and extension with torso range of motion and had pain and tenderness in her low lumbar region. *Id.* X-rays of Petitioner's cervical spine showed hypermobility in extension at C4-5 and C5-6. Dr. Lee noted that he wanted to rule out cervical and lumbar disc derangement and ordered MRI scans of Petitioner's cervical and lumbar spine. *Id.* He also referred Petitioner to physical therapy, prescribed Meloxicam and Tizanidine and placed her off work. (PX 4, p. 4)

Petitioner completed a total of nine (9) physical therapy sessions at Athletico Physical Therapy - South City in St. Louis, Missouri from January 21, 2022, through March 1, 2022. (PX 5, pp. 9-32) On March 1, 2022, she reported that she had stiffness and soreness after sitting for long periods and that she was avoiding lifting anything heavier than her laundry basket. (PX 5, p. 28) Mr. Christopher Dollenmeyer, PT noted that Petitioner was only able to lift 40 lbs. out of the 120 lbs. required for her job. (PX5, pp. 28-29)

On March 24, 2022, Petitioner returned to Dr. Lee. She complained of constant low back pain and excruciating pain with bending. (PX 4, p. 5) Dr. Lee noted that Petitioner showed levels of movement consistent with restricted motion (PX4, p. 5). Dr. Lee diagnosed cervical and lumbar sprain and wanted to rule out disc derangement (PX4, p. 5). Dr. Lee changed Petitioner's medication from Tizanidine to Baclofen and kept her off work (PX4, p. 5).

Petitioner returned to Dr. Lee on April 25, 2022. She complained of low back and neck pain and reported that she had difficulty traveling (PX4, p. 6) Dr. Lee noted that Petitioner had limitations in extension of her lumbar spine as well as limitations in her cervical spine, especially with extension and rotation to the right. *Id.* Dr. Lee diagnosed probable cervical and lumbar disc derangement. *Id.* Dr. Lee instructed Petitioner to continue taking Baclofen and Meloxicam and once again recommended the MRI scans. (PX4, pp. 4, 6) Dr. Lee allowed Petitioner to return to work on April 26, 2022, doing less strenuous work. (Tr. p. 22 and PX 4, p. 8)

On October 24, 2022, Petitioner returned to Dr. Lee, and reported that her back pain was persisting. (PX 4, p. 7) She stated that she had difficulty standing due to her pain. *Id.* Dr. Lee once again noted that Petitioner had movement patterns consistent with restrictions. (PX 4, pp. 5, 7) Dr. Lee noted that he wanted to rule out lumbar disc displacement and once again ordered an MRI of Petitioner's lumbar spine. (PX 4, pp. 6-7) He noted that work comp may have to be

bypassed to obtain the MRI. (PX 4, p. 7) Dr. Lee instructed Petitioner to continue taking Meloxicam and Baclofen and prescribed Lidoderm patches. *Id.*

Petitioner had an MRI taken of her lumbar spine at St. Luke's Hospital on November 10, 2022. (PX 6, p. 7) The MRI showed a disc bulge at L5/S1 containing an annular fissure and marrow edema surrounding a developing acute Schmorl's node along the inferior endplate of L5 (PX 6, pp. 7-8)

On December 2, 2022, Petitioner returned to Dr. Lee. (PX 4, p. 8) She reported that she was still having severe and constant back pain despite engaging in less strenuous work, physical therapy, and home exercises. *Id.* Petitioner's physical exam remained unchanged. (PX 4, pp. 7-8) Dr. Lee reviewed Petitioner's MRI of her lumbar spine from November 10, 2022, and noted L5-S1 protrusion with annular signal alteration. (PX 4, p. 8) Dr. Lee diagnosed L5-S1 annular tear with protrusion and possible cervical disc displacement. *Id.* Dr. Lee referred Petitioner to Dr. Helen Blake for an L5-S1 epidural injection midline. *Id.*

Dr. Helen Blake performed an L5-S1 interlaminar epidural steroid injection (ILESI) with fluoroscopy at the Orthopaedic Surgery Center of Creve Coeur in Creve Coeur, Missouri on March 15, 2023. (PX 7, p. 4) Petitioner's postoperative diagnosis was lumbar radiculopathy. *Id.*

On April 18, 2023, Petitioner returned to Dr. Lee. (PX 4, p. 9) She complained of ongoing symptoms and reported that the injection had not provided much relief. *Id.* She stated that she was only able to work two (2) 12-hour shifts per week because of her pain. *Id.* Dr. Lee noted that Petitioner had movement patterns consistent with restrictions and protected motion. *Id.* Dr. Lee noted that Petitioner had failed conservative treatment and nothing short of surgery was going to resolve Petitioner's symptoms (PX 4, p. 9) He recommended surgery and prescribed an interferential device for pain management. *Id.*

Petitioner testified that despite trying physical therapy, injections, and a pain device for her injuries, she still has stiffness and pain in her back. (Tr. p. 23) She reported that it is hard to do almost anything with her back because of her pain. *Id.* She is unable to stand or sit for long periods of time. (Tr. pp. 24-25) At trial, Petitioner was clearly uncomfortable due to driving and having to sit in a chair while testifying. (Tr. pp. 23-24) Petitioner also testified that she avoids lifting as much as possible and has to squat instead of bend because of her pain. (Tr. pp. 25-26) If she moves or twists quickly, then she experiences low back pain. (Tr. p. 25) She has problems sleeping and feels sleep deprived because she cannot lay on her back too long without her pain device or a heating pad. (Tr. p. 26) She testified that she has purchased two (2) new mattresses to try and relieve her back pain while sleeping. *Id.* When it is cold outside, her back is stiff and tight and feels like it is locked up like a board. *Id.* She testified that she has ongoing pain in her neck and left shoulder. (Tr. pp. 24, 28) Petitioner stated that her left shoulder feels like someone is pulling on it. (Tr. p. 28)

As for household chores, Petitioner stated that she has to do her laundry downstairs because it is heavy and she has difficulty taking her laundry upstairs. (Tr. p. 24) She can only take her laundry upstairs if her son is there to help. *Id.* She testified that she cannot mop or sweep, and it takes her longer than it used to clean her house. (Tr. p. 27) Petitioner is unable to take out the trash

anymore and cannot lift cases of bottled water. (Tr. p. 25) As for hobbies, she stated that she used to do makeup for clients, but because of her pain she cannot do more than two (2) clients a day. (Tr. p. 24) Petitioner also used to model, but because she can no longer wear high heels for long periods of time this has become impractical (Tr. p. 27)

Petitioner stated that she now works at a nursing facility by the name of Chestnut Rehab as a PRN for 2-3 shifts a week. (Tr. pp. 27-28) She receives less pay at this job than she did with Respondent, but it is easier and less strenuous. *Id.* Prior to the accident on December 17, 2021, she was healthy and had no symptoms. (PX 4, p. 3)

On cross examination, Petitioner stated that she had a personal recruiter that was employed by Respondent that would reach out to her about different travel assignments. (Tr. pp. 45-46, 103) She took into consideration where the travel assignments were, what the wages were and what the stipend was when she applied for them. (Tr. pp. 43-45) She did not receive any other stipends when she worked for Respondent besides a housing and meal stipend, the value of which was controlled by Respondent. (Tr. pp. 34-38, 44) Respondent did not book hotels for Petitioner or mandate specific hotels for her to stay during assignments. (Tr. p. 42) Respondent did not make meal arrangements for her or instruct her as to a particular route to take to, or home from her travel assignments. (Tr. pp. 42, 104).

However, Petitioner was not given a choice of when she would like to work or that her shifts were from 6:00 p.m. to 6:00 a.m. at Harrison Healthcare in Corydon, Indiana. (Tr. pp. 46-47) There were times when she did not get off at 6:00 a.m. and worked overtime. (Tr. p. 49) She typically worked a four shift block and on the week of December 13, 2021, she worked Monday, December 13, 2021, through Friday, December 17, 2021. (Tr. 48-49, 51). On December 16, 2021, she stayed at a hotel before she went in to work at 6:00 p.m. that night and then finished her shift at 6:00 a.m. on December 17, 2021. (Tr. p. 50) After that shift ended, she essentially started her weekend. (Tr. pp. 51-52) She likely checked out of her hotel the day prior, on December 16, 2021, as she did not have to report to work the night of December 17, 2021. (Tr. p. 51)

She is unsure of the exact time she left Harrison Healthcare the morning of December 17, 2021, and believed she did not go to her hotel room but headed straight home. (Tr. p. 52). Petitioner determined the route she would take to get home that day and obeyed all of the speed limits on the roads she traveled going home. (Tr. p. 52) She does not remember the accident on the morning of December 17, 2021, or how fast she was driving at the moment of the accident, but only remembers waking up at the hospital afterwards. (Tr. pp. 52-53). She did not remember how the accident occurred. (Tr. p. 53)

Petitioner testified that she did have trouble sleeping or insomnia and was taking Amitriptyline nightly before her accident when she was in nursing school. (Tr. pp. 54-55). On January 16, 2020, a year before the accident, she had an immunization reaction that began as right hip pain. (Tr. pp. 59-60) She also had minimal tenderness to her left lateral shoulder around the healing injection site. (RX 8, p. 2) Dr. Tyler Mork diagnosed an adverse effect of vaccine-likely the TDAP vaccine and gave Petitioner IT band stretches to perform for her hip pain. (RX 8, pp. 2-3) On December 18, 2021, Petitioner guided her husband in typing an email that was sent to her recruiter. (Tr. p. 62) She does not dispute what was typed in said email (Tr. pp. 62-63) Said email

notes that Petitioner was in a terrible accident yesterday, that her car was totaled and that she was airlifted to a hospital in Indiana. (RX 9). The email also notes that Petitioner “didn’t sustain any major injuries but [that she was] in a lot of pain” and that “[her] face and left knee [were] swollen” and that the “doctors had to glue [her] lip, thumb and wrist together” (RX9). Petitioner would let her recruiter know in a couple days how she was feeling after following up with her primary physician, but the doctor from the hospital believed that she could return back to work within one to two weeks. (RX 9).

On redirect, Petitioner stated that she did not have any trouble driving home and had never lost consciousness before her accident on December 17, 2021. (Tr. pp. 68-69) She was not taking her insomnia medication, Amitriptyline, after July of 2021 and was doing fine without it. (Tr. pp. 69-71) Dr. Devabhaktuni switched her from Amitriptyline to Trazodone for her insomnia on July 30, 2021, but after that she was not taking anything for her insomnia. (Tr. pp. 72-73)

Respondent’s first witness, Ms. Addie Mae Cain, testified that she was a truck driver driving for Midwest Express on Interstate 64 in Illinois at about 6:57 a.m. on December 17, 2021, and that there was a dash cam video taken that date which showed two (2) views, one of her driving and one of the road in front of the truck. (Tr. 75, 77-79) She testified that the dash cam video from her truck was a fair and accurate representation of the accident on December 17, 2021, and of her memory of the accident. (Tr. pp. 78-79) A red vehicle was coming pretty fast and hit the side of her tire, pushed out her bumper and went to the side. (Tr. pp. 77-79) Ms. Cain went down to the red vehicle to make sure that the person was okay, and they were groggy and trying to move and get out of the vehicle. (Tr. p. 83) She told them not to move *Id.* Besides this, Ms. Cain did not have any further discussions with the driver of the red vehicle. (Tr. p. 84) On cross examination, Ms. Cain confirmed that the video only showed her speed and not the speed that Petitioner was going. (Tr. p. 85) She admitted that she did not know the speed Petitioner was traveling. (Tr. pp. 85-86)

Next, Respondent’s counsel called Illinois State Trooper Joshua D. Kiefer to the stand. (Tr. p. 90) He testified that he got called to the scene of a motor vehicle accident on December 17, 2021, at approximately 7:57 a.m. Central Standard Time and that the accident involved a passenger car and a truck-tractor semi-trailer. (Tr. pp. 90-91) He stated that he reviewed the dash cam video from Ms. Cain’s truck after the accident to determine the cause of the accident and that the video was a fair and accurate representation of what he saw on the day of the accident (Tr. pp. 92-93) Illinois State Trooper Kiefer stated that Petitioner was the driver of the red car and was listed as Unit 1 on the traffic crash report. (Tr. pp. 91-92) He opined that Petitioner was going at least 85 miles an hour at the time of the accident and that she traveled around 140 miles in an hour and eleven (11) minutes. (Tr. pp. 94-96 and RX 2, p. 1) He was not able to talk to Petitioner on the date of the accident because she was in the process of being transported for medical care. (Tr. p. 93) Illinois State Trooper Kiefer gave Petitioner two citations for the accident on December 17, 2021. (RX 7, p. 1) One for improper overtaking on the left and operating a vehicle with cancelled, suspended, or revoked Illinois registration. (RX 7, p. 5)

On cross examination, Illinois State Trooper Kiefer stated that he was not present at the time of the accident and thus, he could not say for certain how fast Petitioner was traveling. (Tr. pp. 97-98) He also did not record on the traffic crash report how fast each of the vehicles were traveling at the time of the accident. (Tr. p. 97) The citation for operating a vehicle with cancelled,

suspended or revoked Illinois registration was amended/reduced to stopping, standing or parking outside a business or residence district. (PX 12, pp. 2-3). The citation for improper passing on the left was dismissed. (PX 12, pp. 4).

CONCLUSIONS OF LAW

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

“The general rule is that an injury incurred by an employee in going to or returning from the place of employment does not arise out of or in the course of employment, and hence, is not compensable.” *Venture-Newberg-Perini v. Ill. Workers’ Comp. Comm’n*, 1 N.E.3d 535, 539, 376 Ill. Dec. 823, 827 (2013). An exception applies to a traveling employee. *Chicago Bridge & Iron v. Industrial Comm’n*, Ill. App. 3d 687, 693, 618 N.E.2d 1143, 1148, 188 Ill. Dec. 573, 578 (5th Dist. 1993). A traveling employee is an employee “who is required to travel away from his employer’s premises in order to perform his [or her] job” *Id.* at 694, 1148, 578. Furthermore, there is no difference between an “employee who is continuously traveling and one who travels to a distant job location” *Wright v. Industrial Com.*, 62 Ill. 2d 65, 69, 338 N.E.2d 379, 381.

After determining that an employee is a traveling employee, then it must be determined whether the traveling employee’s activity when he/she was injured is compensable. *Venture-Newberg-Perini v. Ill. Workers’ Comp. Comm’n*, 1 N.E.3d 535, 539-540, 376 Ill. Dec. 823, 827-828 (2013). The Court has found that three (3) categories of acts are compensable: “(1) acts the employer instructs the employee to perform; (2) acts which the employee has a common law or statutory duty to perform while performing duties for his employer; (3) acts which the employee might be reasonably expected to perform incident to his assigned duties.” *Id.* at 540, 828. Under the third category, the test is whether the employee’s act was reasonable “and whether it might normally be anticipated or foreseen by the employer.” *Wright v. Industrial Com.*, 62 Ill. 2d 65, 69-70, 338 N.E.2d 379, 381. “It would be obviously unreasonable to say that a traveling employee has the protection of the [Workers’ Compensation] Act only when in the physical act of performing selling or other duties and only in the course of a normal business day.” *Id.* at 71, 382.

In *Venture-Newberg-Perina*, the claimant, a union worker, took a temporary position with Venture approximately 200 miles from his home due to lack of available work in his local area. *Venture-Newberg-Perini v. Ill. Workers’ Comp. Comm’n*, 1 N.E.3d 535, 537, 376 Ill. Dec. 823, 825 (2013). He relocated to a nearby motel for the job and was injured in a motor vehicle accident on his way to work. *Id.* The Court found that the claimant was not a traveling employee because (1) he was not a permanent employee of Venture or working for Venture on a long-term exclusive basis; (2) nothing in his contract required him to travel out of his union’s territory and instead, he made the personal decision to do so because he felt the pay outweighed the personal cost of traveling, (3) he was not directed by Venture to travel away from this work site to another, but rather he merely traveled from the premises to a residing location; and (4) Venture did not reimburse him for his travel expenses nor did it assist him in making his travel arrangements. *Id.* at 541-542, 829-830. Additionally, the Court determined that the claimant’s accident did not occur within the course and scope of his employment, because his course or method of travel was not determined by the demands and exigencies of the job, but rather by his personal preference. *Id.* at

543, 831. The claimant was free to choose his own route to work and Venture did not reimburse him for travel expenses or time spent traveling. *Id.*

In comparison to *Venture-Newberg-Perina*, the Court found that the claimant in *Wright* was traveling employee and that his motor vehicle accident arose out of the scope of his employment. *Wright v. Industrial Com.*, 62 Ill. 2d 65, 69-71, 338 N.E.2d 379, 381-382. The claimant's job required that he travel to out-of-state locations and remain there for 5 to 6 months. *Id.* at 67, 380. When he traveled out-of-state, "he was paid on an hourly basis for a 40-hour work week, and received \$15 per diem for expenses in addition to an allowance for the mileage" *Id.* He was injured in a motor vehicle accident approximately 6 miles from his motel when he was either returning from a possible business errand or from some type of recreational outing. *Id.* at 67, 71, 380, 382. The Court noted that even if the claimant was returning from some sort of recreational outing, it was not unreasonable or unforeseeable and that it is expected that an employee working out of town will seek some type of recreational activity on his days of rest. *Id.* at 71, 382.

In *Chicago Bridge & Iron*, "[t]he claimant . . . [worked] exclusively for [his] employer and was periodically required to travel to work sites in other [s]tates." *Chicago Bridge & Iron v. Industrial Comm'n*, Ill. App. 3d 687, 688-689, 618 N.E.2d 1143, 1145, 188 Ill. Dec. 573, 575 (5th Dist. 1993). After each of the jobs were completed, then the claimant was terminated from the payroll. *Id.* The claimant was contacted by his employer by telephone in Illinois and offered the job in Pine Bend, Minnesota. *Id.* at 691, 1147, 577. He was told his pay and that he would receive mileage in the amount of 30 cents per mile. *Id.* The claimant was in a motor vehicle accident and injured after he left his motel and was on his way to the job site. *Id.* at 689, 1145, 575. The appellate court agreed that if it had not been for the claimant being terminated after each job, they would have little difficulty characterizing him as a traveling employee. *Id.* at 694, 1149, 579. In spite of this, the appellate court considered claimant's long-standing, exclusive employment with his employer and the purpose of the Workers' Compensation Act, which "is to provide financial protection for injured workers through prompt and equitable compensation", and found that the claimant was a traveling employee. *Id.*

Petitioner falls under the traveling employee exception. Petitioner was required to travel away from Respondent's premises in Omaha, Nebraska (Arb. Ex. 2, p. 1). In her employment with Respondent, she had travel assignments in Mt. Sterling, Illinois, Council Bluffs, Iowa and Corydon, Indiana. Additionally, Petitioner, unlike the claimant in *Venture*, was a permanent employee of Respondent and had been working for Respondent on a long-term exclusive basis. She had been working for Respondent for five (5) months exclusively and was not terminated after each travel assignment (Tr. 12, 67-68). Respondent was also the only one that could terminate Petitioner and required that the facility Petitioner worked for not recruit, hire, or employ her for a period of one year after her last day worked for the facility. Furthermore, Petitioner received a weekly travel stipend to pay for housing, meals and travel similar to the \$15 per diem in the case of *Wright* and was informed by Respondent of suggested hotels where she could stay.

Respondent, however, argues that Petitioner had her choice of travel assignments and that Respondent did not book hotels for her or mandate which hotels she stayed in. While this is true, Respondent irrefutably knew that Petitioner would have to travel and stay overnight away from

her home during the assignments. This is evidenced by the fact that they compensated her with the above-mentioned weekly stipend to cover such travel costs. Furthermore, were the Petitioner expected to commute daily she would have a six (6) hour commute per shift worked in addition to her minimum twelve (12) hour shifts. This type of commute could not reasonably be practical or expected by Respondent particularly if they expected their employees to perform to the best of their abilities. In addition, Petitioner had no choice in when she worked her shifts, instead being required to work shifts on four consecutive days further adding to the unlikelihood of an expected daily commute.

In *U.S. Indus., Prod. Mach. Div.*, the claimant had finished working when he drove up into the mountains in a different direction from his job site and he fell asleep, causing his vehicle to strike a monument. *U.S. Indus., Prod. Mach. Div. v. Indus. Comm'n*, 40 Ill. 2d 469, 471, 240 N.E.2d 637, 639. The Court found that this action was clearly unanticipated, unforeseeable, and unreasonable. *Id.* at 475, 641.

In contrast, in *David Wexler*, the claimant was in a motor vehicle accident when he was headed back to his motel. It was Memorial Day, and he was wearing a short-sleeved sport shirt and had golf clubs and fishing equipment in his vehicle. *David Wexler & Co. v. Industrial Com.*, 52 Ill. 2d 506, 507-508, 288 N.E.2d 420-421 (1972). The Court found that the employer did not seek to restrict the private activities of the claimant and that it was reasonable for an employee to engage in reasonable private conduct when away from home on a holiday. *Id.* at 511, 422.

The claimant in *Bradley Printing Co.* attended a scheduled sales meeting and then was returning to his vacation home when he was fatally injured in a motor vehicle accident. *Bradley Printing Co. v. Industrial Com.*, 187 Ill. App. 3d 98, 100-101, 543 N.E.2d 116, 117, 134 Ill. Dec. 833, 834. The Court found that the claimant's activities on the date of his accident were foreseeable and reasonable because his employer knew of his commute to Chicago to conduct business as well as his vacation home and he did not embark upon a course of conduct incompatible with his work at any time after the sales meeting and prior to the automobile accident. *Id.* at 103-104, 119, 836.

Petitioner's actions at the time of her accident were reasonable and foreseeable and in turn, compensable. While Respondent did not instruct Petitioner what route to take home from her travel assignment, Respondent knew that Petitioner lived in St. Louis, Missouri and that she would have a commute home from her travel assignment. Respondent also controlled and only provided a set amount for a weekly travel stipend for Petitioner to stay near her travel assignment and did not require that she stay through her weekends. Thus, it was reasonable and foreseeable that when Petitioner's weekly stipend ran out, she would have to go home. Similar to this case, the claimant in *David Wexler* was returning to his home, albeit his vacation home. Additionally, Petitioner traveling home was reasonable and foreseeable given the fact it was her weekend and especially given the proximity to the holidays. Furthermore, Petitioner was traveling directly home and not going elsewhere like the claimant in *U.S. Indus., Prod. Mach. Div.* She was exactly where her employer could expect her to be on December 17, 2021, traveling home from a week of her travel assignment.

Respondent argues that Petitioner was going 20 miles per hour above the speed limit before the accident and in doing so, was engaging in unreasonable and unforeseeable conduct and/or

conduct that took her outside the scope of her employment. However, “it has long been recognized that one of the objectives of the Workers’ Compensation Act was to do away with the defenses of contributory negligence or assumed risk.” *Stembridge Builders v. Industrial Comm’n (Zepeda)*, 263 Ill. App. 3d 878, 881, 636 N.E.2d 1088, 1090, 201 Ill. Dec. 656, 658 (2nd Dist. 1194). “Excessive speeding, standing alone, does not, as a matter of law, disqualify an employee from coverage” *Id.* Only speeding that amounts to willful and wanton conduct instead of mere negligence can prohibit an employee from receiving benefits, and speeding grossly fast for the conditions amounts to such. *Id.* at 881-882, 1090-1091, 658-659.

In *Stembridge Builders*, the claimant was swerving to pass another vehicle in the left-hand lane when he lost control of his vehicle and his vehicle flipped over several times. *Id.* at 879-880, 1089, 657. The claimant was going 25 to 30 miles per hour above the speed limit. *Id.* at 879, 1089, 657. The appellate court ruled that the claimant was still within the scope of his employment in that the surrounding circumstances, that it was a clear day, the sun was shining, and the road was straight, flat and dry, did not suggest his conduct was willful and wanton. *Id.* at 882-884, 1091-1092, 659-660.

Here, there is no solid evidence of how fast Petitioner was driving on the date of the accident and even if one accepts that Petitioner was driving 20 miles per hour above the speed limit per Illinois State Trooper Kiefer’s testimony. Petitioner was not driving as fast as the claimant in *Stembridge Builders*. Furthermore, the dashcam video and traffic crash report shows that it was a clear day, the road was dry, and Petitioner was not in a zone where she could not pass when the accident took place on December 17, 2021. (RX 5 and RX 7, p. 1) Based on the totality of the evidence, the Arbitrator finds and concludes that Petitioner’s accident on December 17, 2021, arose out of and in the course of her employment with Respondent. Petitioner is found to be a traveling employee, and her actions were reasonable and foreseeable in that she was traveling home following her last shift for the week.

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

Circumstantial evidence, especially when entirely in favor of the Petitioner, is sufficient to prove causal nexus between an accident and the resulting injury, such as a chain of events showing a claimant’s ability to perform manual duties before accident and decreased ability to still perform immediately after accident. *Pulliam Masonry v. Indus. Comm’n*, 77 Ill.2d 469, 397 N.E.2d 834 (1979); *Gano Electric Contracting v. Indus. Comm’n*, 260 Ill.App.3d 92, 96-97, 197 Ill. Dec. 502, 631 N.E.2d 724 (1994); *International Harvester v. Indus. Comm’n*, 93 Ill.2d 59, 666, Ill. Dec. 347, 442 N.E.2d 908 (1982).

Petitioner reported symptoms in her neck and left shoulder on the date of the accident and reported issues with her back four (4) days later. She had no issues with her neck or back prior to the accident on December 17, 2021, and Petitioner’s medical records corroborate this. Respondent only offered into evidence a medical record from January 16, 2020, a year before the accident, that Petitioner had minimal tenderness in her left shoulder after a vaccination, but nothing else. Thus, the medical records wholly support that all care and treatment was a direct result of her injury and its sequela. Additionally, Petitioner was able to work for Respondent prior to her motor vehicle accident on December 17, 2021, but was unable to work afterwards due to her symptoms.

Respondent provided no evidence that Petitioner's condition was not causally related to her accident on December 17, 2021. There was no Section 12 examination and no contrary medical evidence suggesting that Petitioner's condition was otherwise unrelated to her December 17, 2021, motor vehicle accident. Based upon the totality of the evidence, the Arbitrator finds and concludes that Petitioner's current condition of ill-being in her neck, left shoulder and back are causally related to her accident on December 17, 2021.

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?

O. Is Petitioner entitled to reimbursement of \$2,866.01 in medical expenses paid by Tricare?

The right to be compensated for medical costs associated with work-related injuries is at the very heart of the Workers' Compensation Act. *Hagene v. Derek Polling Const.*, 388 Ill.App.3d 380, 383, 902 N.E.2d 1269, 1273 (2009)

Petitioner submitted unpaid medical expenses in the amount of \$66,469.86 as Petitioner's Exhibit 9. Given the conclusions on accident and causation and the uncontradicted evidence that the medical services provided to Petitioner were reasonable and necessary, Respondent shall pay \$59,131.55 to Air Evac Lifeteam for date of service 12/17/2021, \$125.00 to Deaconess Health System for date of service 12/17/2021, \$180.96 to Mercy Clinic Primary Care/Dr. Devabhaktuni for dates of service 12/21/2021 and 12/29/2021, \$2,948.00 to United Physicians Group for dates of service 3/24/2022 through 4/18/2023, \$17.98 to Diagnostic Imaging Associates for date of service 11/10/2022, \$2,238.41 to the Orthopedic Surgery Center of Creve Coeur for date of service 3/15/2023 and \$1,827.96 to Zynex Medical for dates of service 4/26/2023 through 9/26/2023, as provided in Section 8(a) of the Act and in accordance with medical fee schedules.

In addition to the above, Petitioner submitted a ledger of medical expenses that Tricare paid in the amount of \$2,866.01 in Petitioner's Exhibit 9 (PX9, pp. 2-3) "[T]here are three requirements which must be established before credit [and a hold harmless] can be awarded under § 8(j). First, group insurance must have paid medical benefits; second, the employer paid into the group policy; and third, the group policy must preclude medical payments for injuries sustained in work-related accidents." *Keith Yarmer v. City of Chicago*, 17 IL. W.C. 2053, 19 I.W.C.C. 0333, 2019 WL 3531337 (Ill. Indus. Com'n June 28, 2019). "As the claimant has the burden of proving all the elements of his or her claim, the employer has the burden of proving that it is entitled to credit under § 8(j)." *Id.*

In this matter, the record only addresses the first criterion, that group insurance paid some medical expenses. There is nothing in the record establishing either of the other criteria *i.e.*, that the employer paid into the policy, and that the policy precludes payments for medical expenses associated with work-related conditions of ill-being. Rather, Tricare's insurance was provided through Petitioner's husband, Robert Wilson (PX 9, p. 16) In light of the above, Respondent shall pay \$2,866.01 to Petitioner for Tricare's subrogation interest.

K. What temporary benefits are in dispute? – TTD benefits

Petitioner testified and the medical records reflect that she was placed off work from December 18, 2021, through January 2, 2022, and January 13, 2022, through April 25, 2022, by her medical providers and Respondent did not dispute this. (Tr. pp. 18, 22). Thus, Respondent shall pay Petitioner temporary total disability benefits of \$779.53/week from December 18, 2021, through January 2, 2022, and January 13, 2022, through April 25, 2022, or a total of 17 weeks, as provided in Section 8(b) of the Act.

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

While consideration is not given to any single enumerated factor as the sole determinant, the Arbitrator relies on the following five factors pursuant to 820 ILCS 305/8.1(b).

- i. **Level of Impairment:** No permanent partial disability impairment report and/or opinion was submitted into evidence. No weight is given to this factor.
- ii. **Occupation:** Petitioner testified that she worked as a traveling nurse at the time of the accident and now works as a nurse at a nursing facility. Despite the fact that she still works as a nurse and has returned to work, she stated that her current job is easier and less strenuous than her previous job with Respondent. She is not required to travel, which she has difficulty doing due to her back pain. Additionally, the medical records show that Dr. Lee only released Petitioner to work doing less strenuous work and if Petitioner was to go back to her regular traveling duty, then Dr. Lee noted that she would require additional treatment (PX4, p. 6). Moderate weight is given to this factor.
- iii. **Age:** Petitioner was 30 years old at the time of the accident and is currently 33 years old (ARBX1 and ARBX2). Because Petitioner was younger in age than most employees at the time of the accident, she will have to live and work with her symptoms for a longer period of time than most other employees. She will likely have a disability for a significant portion of her working years and expected natural life. As a result, moderate weight is given to this factor.
- iv. **Earning Capacity:** Petitioner testified that she receives less pay at her current job than she did working with Respondent. Some weight is given to this factor.
- v. **Disability:** Petitioner's residual symptoms in her back/lumbar spine, neck/cervical spine and left shoulder are corroborated by the medical records and in turn, objective evidence. Petitioner is unable to stand or sit for long periods of time, avoids lifting as much as possible, has to squat instead of bend and has difficulty sleeping because of her back pain. If she moves or twists quickly, then she also has back pain. Three (3) of the medical providers have found that Petitioner has symptoms in her back. Dr. Devabhaktuni noted that Petitioner had a paraspinal spasm to her back and stiffness in her back when walking. Dr. Lee noted that Petitioner had decreased flexion and extension with torso range of motion and had pain and tenderness in her low lumbar region. Mr. Christopher Dollenmeyer, PT noted that Petitioner was unable to lift the

required amount to do her job. Besides the clinical findings of the above treating providers, Petitioner's lumbar spine MRI from November 10, 2022, showed disc bulge at L5/S1 containing an annular fissure and marrow edema surrounding a developing acute Schmorl's node along the inferior endplate of L5. Additionally, at the last visit with Dr. Lee on April 18, 2023, almost a year and a half out from the accident, he noted that Petitioner had movement patterns consistent with restrictions and protected motion in her lumbar spine. On the same date, he also opined that surgery was the only thing that was going to cure Petitioner's current symptoms. Petitioner has not had surgery, and so it stands to reason that she would have residual issues in her lumbar spine.

Petitioner also has neck pain and stated that her left shoulder feels like someone is pulling on it. On January 13, 2022, and April 25, 2022, Dr. Lee noted that Petitioner had tenderness to her mid to lower cervical spine as well as decreased extension, flexion, and rotation. X-rays of Petitioner's cervical spine showed hypermobility in extension at C4-5 and C5-6. Furthermore, it is clear that both Petitioner and Dr. Lee were focused on resolving Petitioner's lumbar spine symptoms first, even though, Dr. Lee's last note did not Petitioner's residual cervical spine and left shoulder issues. On April 25, 2022, Dr. Lee opined that Petitioner's low back pain was more bothersome and he continued to diagnose possible cervical disc displacement through the last date he seen Petitioner (PX 4, pp. 6, 9).

Because of the ongoing symptoms that Petitioner continues to experience and the fact that these symptoms impact her activities at and outside of work, significant weight is given to this factor. The Arbitrator places more weight on this factor.

Based on the factors cited in Section 8(1)(b) of the Act and the record taken as a whole, Petitioner sustained a loss of use of the body as a whole from the accident and permanent partial disability to the extent of 12.5% loss of use of the body as a whole pursuant to §8(d)(2) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	23WC017479
Case Name	Robert Lewis v. Prairie Farms Dairy DBA East Side Jersey Dairy Inc.
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	25IWCC0513
Number of Pages of Decision	19
Decision Issued By	Raychel Wesley, Commissioner

Petitioner Attorney	David Galanti
Respondent Attorney	Matthew Terry

DATE FILED: 12/24/2025

/s/ Raychel Wesley, Commissioner

Signature

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)
☐ Modify	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT LEWIS,

Petitioner,

vs.

NO: 23 WC 17479

EAST SIDE JERSEY DAIRY, 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, medical expenses, prospective medical care, and temporary total disability, and being advised of the facts and law, changes the Decision of the Arbitrator by correcting clerical errors, but otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission 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 (1980).

The Commission corrects clerical errors in the "Order" section and "Conclusions of Law" section in the Decision of the Arbitrator. Therein, the Arbitrator awarded temporary total disability benefits from September 13, 2021 to January 19, 2022. The Arbitrator found that this period equaled "19 3/7 weeks." *Decision of the Arbitrator, p.2, 14*. We strike "19" in the temporary total disability period awarded, and replace it with "18," so that the number of weeks awarded for temporary total disability benefits reflects the correct period of "18 & 3/7ths weeks."

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 January 27, 2025, as changed above, 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 the Petitioner on account of said accidental injury.

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 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 \$28,700. 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.

DECEMBER 24 2025

RAW/wde

/s/ Raychel A. Wesley

O: 11/5/25

/s/ Carolyn M. Doherty

43

/s/ Frank J. Soto

ILLINOIS WORKERS' COMPENSATION COMMISSION
DECISION SIGNATURE PAGE

Case Number	23WC017479
Case Name	Robert Lewis v. Prairie Farms Dairy DBA East Side Jersey Dairy Inc.
Consolidated Cases	
Proceeding Type	19(b) Petition Remand Arbitration
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	16
Decision Issued By	Dennis OBrien, Arbitrator

Petitioner Attorney	David Galanti
Respondent Attorney	Matthew Terry

DATE FILED: 1/27/2025

/s/ Dennis OBrien, Arbitrator
Signature

THE INTEREST RATE FOR THE WEEK OF JANUARY 22 2025 4.17%

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)

Robert Lewis
 Employee/Petitioner

Case # **23** WC **017479**

v.

Consolidated cases: _____

East Side Jersey Dairy, 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 **Dennis O'Brien**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **11/19/2024**. 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, **09/10/2021**, 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 **\$42,071.12**; the average weekly wage was **\$809.06**.

On the date of accident, Petitioner was **54** 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 **\$7,863.64** for TTD, **\$0** for TPD, **\$0** for maintenance, and **\$0** for other benefits, for a total credit of **\$7,863.64**.

Respondent is entitled to a credit of **all amounts paid by its group health insurance carrier** under Section 8(j) of the Act.

ORDER

Petitioner sustained an accidental injury which arose out of an in the course of Petitioner's employment by Respondent on September 10, 2021.

Petitioner's medical condition, a full thickness tear of the right supraspinatus/rotator cuff, is causally related to the accident of September 10, 2021.

Petitioner was temporarily totally disabled as a result of the accident from September 13, 2021 to January 19, 2022, a period of 19 3/7 weeks at a rate of \$539.37 per week.

The following bills introduced into evidence in Petitioner's Exhibit 6 are related to Petitioner's full thickness tear of the right supraspinatus/rotator cuff injury, are reasonable and were necessitated to treat or cure Petitioner's injuries suffered in this accident, and are to be paid pursuant to Sections 8(a) and 8.2 of the Act:

- 1. The March 20, 2024 MRI bill of HSHS St. Joseph Hospital for the MRI of Petitioner's right shoulder (PX 6 p.2)**
- 2. The out of pocket expenses paid by Petitioner, identified in the Midwest Bone and Joint Surgery bill as "Pt Pmts" (PX 6 p.5-6) and HSHS Holy Family Health Center (PX 6 p.9), which are to be repaid to Petitioner to the limit set out in Sections 8(a) and 8.2 of the Act.**

Respondent is entitled to credit under Section 8(j) of the Act for any amounts of said bill which have been paid by its group health insurance carrier.

Petitioner is entitled to prospective medical treatment as recommended by Dr. Ungacta, to wit, an arthroscopic repair of the Petitioner's right supraspinatus/rotator cuff tear, but based upon Dr. Ungacta's testimony that he did not know whether he intended to be practicing medicine after 2024, this surgery can be performed by the orthopedic surgeon of Petitioner's choice.

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

January 27, 2025

FINDINGS OF FACT:**Petitioner**

Petitioner testified that on Friday, September 10, 2021, he worked for Respondent as a utility cooler worker, and was manually loading two bosseys, which he explained were racks of milk weighing close to 800 pounds each, onto a trailer, when he felt pain in his right shoulder. He said he felt this pain in his right shoulder when pulling the carts with his hands located slightly below chest level and extending outwards. Petitioner noted that he had a steroid injection to the right shoulder from Dr. Weimer a couple of years prior to the date of accident, and had not followed up with the doctor following those injections, and Dr. Weimer had not recommended surgery to him at that time. (T.19-24)

Petitioner was asked a number of times, in different ways whether he was having difficulties with his right shoulder before September 10, 2021. The arbitrator noted Petitioner looked confused by these questions. He was ultimately asked the question in a manner that was not confusing, and he said he had not had difficulties with the right shoulder prior to the date of accident. (T.23-26)

Petitioner said he finished his shift on September 10, 2021, and reported the incident the next day, about 24 hours after it occurred, as it had become intensely worse. He said he had not reported it earlier as he thought he had just sprained something. Petitioner said that after he reported the accident he was told to by the company to go to Med Express to have it checked out. He said Med Express then referred him to see an orthopedic surgeon, and he went and saw Dr. Weimer. He said Dr. Weimer ordered an MRI. (T.26-28)

Petitioner testified that on December 20, 2021, he saw Dr. Rotman for an examination at the request of Respondent. (T.28-29)

Petitioner said that on the referral of his family practitioner, he saw Dr. Lieb and Dr. Ungacta, that they were much closer to his house, and he did not have to drive to Town and Country or Belleville for treatment. Petitioner said that as of the date of arbitration he was still having pain daily, he understood Dr. Ungacta wanted to perform surgery on his right shoulder, and wanted to have that surgery. He said he had not injured his right shoulder in any manner since the date of this accident. (T.29,31)

Petitioner testified that as of the date of arbitration he was no longer working for Respondent, he was now working for the Collinsville School District. (T.32)

On cross examination Petitioner said that Dr. Weimer performed an injection on his shoulder in March of 2020, and that injection worked. He said he returned to see Dr. Weimer in August of 2020, with right shoulder complaints. (T.32-33)

Petitioner testified that he did not report this accident on the actual date of the accident, a Friday, as he figured he had pulled something and would give it time to see if it would self-heal. He acknowledged that he had been taught to report any injury before the end of the shift. He said he thought he reported the accident the next day. He agreed that on that Saturday morning, the morning after this accident, he felt pain in his shoulder when he rolled over onto it. (T.33-34)

Petitioner said that he worked as a tractor-trailer driver between May of 2022 and March of 2023. He said he also worked for Highland School District. He testified that he applied to work for the Collinsville School District in March of 2023. (T.35-36)

Petitioner said he had treated with Dr. Weimer prior to this date of accident, that a year or so before this accident he saw Dr. Weimer for his right shoulder, but Dr. Weimer also treated his left shoulder, performing surgery on the left shoulder, and he had a good result from that surgery. He said he then saw Dr. Weimer after this September 10, 2021 accident, on October 12, 2021, on the referral of Med Express. /he said he did not continue treating with Dr. Weimer after that date as the doctor had told him that he could not do anything for him. He said Dr. Weimer had gotten the MRI and told him that he needed surgery. He said he was then seen by Dr. Rotman. (T.36-39)

When asked why he did not return to Dr. Weimer after being examined by Dr. Rotman, Petitioner said Dr. Weimer had wanted to do surgery, and Petitioner said he could not do anything, it had to be referred by the insurance company. (T.39)

Petitioner said he saw Dr. Ungacta in July of 2023, and Dr. Ungacta recommended physical therapy. Petitioner said he did not get the physical therapy due to his work schedule. When asked why he did not get the physical therapy after seeing Dr. Ungacta again on November 8, 2023, he said it was because of his work schedule, he was “volunteered forced” to work double shifts, earning overtime. When asked how many double shifts he worked from July 2023 to November 2023, he said it varied. He said he also did not yet have insurance for the first couple of months in the job, both his schedule and his lack of insurance prevented him from getting the physical therapy. He said he had to wait a month or two to get insurance from the school district. When reminded that he started working for the school district in March of 2023 and the physical therapy was not recommended until July of 2023, he said he would have had the insurance for the physical therapy. He said the school’s wage records would refer to the school records in regard to how much money he made during that period of time. (T.39-42)

Petitioner said he was not aware that Dr. Ungacta was not board certified, or that he might not be practicing after 2024. He said if Dr. Ungacta was not practicing he would find a doctor who was board certified to do the right shoulder surgery. (T.43)

Petitioner said his hobbies included hunting, fishing, and biking. He said he tried to bike at least one time per month, and, with a permit, he hunts rabbit and deer, using a 20 gauge shotgun for rabbit hunting and either a compound bow or the shotgun for deer hunting. He said the shotgun has a recoil, that he uses both the right and left side to shoot it, and he had not used it since September of 2021. (T.44-46)

Petitioner testified that the bossey carts are on wheels, and that he would push or pull the 790 to 800 pound carts to get them rolling. (T.46)

On redirect examination Petitioner said he stood by everything he wrote on the incident report about what happened on the day of this accident, Respondent Exhibit 9, page 2. He said he had not shot the shotgun since the date of this accident, and he could not fire a pistol with his right hand, as he had tried to do so and experience pain in the superior anterior portion of his right shoulder. (T.47-49)

Tova Sarpy

Ms. Sarpy was called as a witness by Respondent. She testified that East Side Dairy was a subsidiary of Prairie Farms, that prior to May of 2020 she had performed HR and workers' compensation work for East Side Dairy, and she was employed by Prairie Farms as a regional environmental health and safety specialist beginning in 2022. She explained how to read Respondent Exhibit 4-1, an attendance printout for Petitioner, noting what columns signified the date worked, which indicated when he began work, as well as which columns showed his starting and stopping his 30-minute lunch, as well as which column for clocking out at the end of a shift. She indicated what the check in and out times for Petitioner were on September 11, 2021. (T.51-55)

Ms. Sarpy said employees were to report accidents to their supervisor or come upstairs to the office to report an accident if between 8:00 a.m. and 5:00 p.m. She said they could send a text message to their supervisor if the supervisor was not available, and employees had also used a call-in line to make the report. (T.54-56)

On cross-examination Ms. Sarpy testified she had probably worked with Respondent counsel to create Respondent's exhibits. She said the incident report stated that bad wheels caused the accident. She said her job on the leadership team was to advocate for the employee who is injured or had a near miss or other situations that required workers' compensation to be involved, not to keep costs down. She said she facilitates the paperwork, makes sure the paperwork is correct, and submits it to their corporate office, who sends it to the claims adjuster. She said she also facilitates employees' return to work, and receives doctor notes from the employees, sending those to the appropriate people. She said that since 2022 she did proactive training to help prevent incidents and accidents, keeping injuries low. (T.56-59)

Ms. Sarpy said Respondent was using Med Express as the company referred doctor at the time of this accident, as it was a good facility. She said that facility felt Petitioner needed to see an orthopedic surgeon for his right shoulder. She agreed that Petitioner exhibit 1, page 1 indicated Med Express made a referral to an orthopedic surgeon. (T.56-62)

MEDICAL EVIDENCE

Pre-September 10, 2021 Medical Records

Petitioner was seen by Nurse Practitioner (NP) Barnhart at HSHS Medical Group – St. Elizabeth's on March 12, 2020, complaining of bilateral shoulder pain, saying his right shoulder had been bothering him for about one month, and his left shoulder pain starting in November of 2019. He denied any trauma causing these problems. The pain increased with elevation and would awaken him from sleep. The pain was in the anterior superior portions of both shoulders. He noted he worked in a warehouse where he had to lift heavy objects, and he had a ten pound limit on lifting with his left arm. Examination of the right shoulder showed some loss of range of motion, positive empty can, crossarm and impingement tests and full strength. X-rays of the right shoulder demonstrated mild to moderate arthritis of the right acromioclavicular joint. Diagnoses on this date were impingement syndrome of right shoulder, arthritis of the right acromioclavicular joint, and chronic left shoulder pain. Physical therapy

was offered, but declined. A cortisone injection for his right shoulder impingement was provided. A ten pound weight restriction for the right arm was offered, but declined, Petitioner saying his declining it was because of his job. If he did not improve, he was to call back and an MRI would be ordered. (RX 2 p.36,38,55-56)

On June 22, 2020, Petitioner was seen by NP Joliff at HSHS Holy Family Health Center, for a follow up for hypertension. He also complained of epigastric symptoms. He noted that he was having pain in his left shoulder again, saying it had “mostly been the right shoulder but now it is the left.” He said he wanted to go back to the orthopedist for more injections. He also mentioned some heel complaints he had experienced a few months earlier. Physical examination on that date revealed he had normal range of motion, but no swelling, tenderness or deformity. Neither shoulder was mentioned in the diagnoses for that day. (RX 3 p.1,3-4)

Petitioner was again seen at HSHS Medical Group – St. Elizabeth’s on August 6, 2020, this time by Dr. Weimer. On this occasion he was complaining of bilateral shoulder pain, left worse than right. He said the prior cortisone shot had worked for a couple of months, but the pain on the left had become more severe in the last couple of weeks. Both left and right shoulders had positive Jobses and empty can tests, as well as negative crossarm and positive impingement tests. Strength was normal on both sides. An MRI was ordered for the left shoulder, but not the right. That MRI, conducted the same day, found a partial thickness tear of the supraspinatus tendon in the left shoulder, suspected adhesive capsulitis of the shoulder, moderate acromioclavicular arthritis, but no findings for impingement. Diagnoses were impingement syndrome on both the left and the right shoulders, and osteoarthritis of both the left and the right shoulders. Dr. Weimer after reviewing the MRI recommended left shoulder arthroscopic decompression and rotator cuff repair. (RX 2 p.77-78,82-84)

Post-September 10, 2021 Medical Records

Petitioner was seen by NP Korte at MedExpress on September 12, 2021. He was complaining of right shoulder pain which had started the preceding Friday night. Petitioner advised NP Korte that he was pulling a cart at his job three days earlier when he felt a pain in his shoulder, and the pain became worse the morning before he was seen after rolling on his shoulder while sleeping. Petitioner on physical examination had full, but painful range of motion during flexion, extension, and internal rotation testing of the right shoulder. X-rays revealed mild arthritis. The assessment was pain in the right shoulder, he was told to elevate the arm as much as possible. He was to follow up on September 15, 2021. He was given a no work slip and restrictions were given of no pulling, reaching, or overhead reaching, and no lifting or carrying with the right arm. (PX 1 p.11-12,14; PX 2 p.7)

Petitioner was seen by Physician Assistant (PA) Ianitelli at MedExpress on September 15, 2021. He noted no improvement since last seen despite his having been taken off work, with continuing decreased range of motion due to pain. Physical examination showed continuing and additional limitations in range of motion due to pain, as well as reduced strength. His right A/C joint was tender to palpation. The assessment remained the same, and Petitioner was given a referral to see an orthopedist

within a week, though no specific name was noted, and a request for authorization was forwarded to CCMSI. (PX 1 p.6-10)

Petitioner was seen by NP Curtis at MedExpress on September 22, 2021. At that time he complained of 9/10 right shoulder pain. Physical examination showed limited extension, which was painful, and Petitioner had glenohumeral joint tenderness. Petitioner was judged to have full shoulder strength against resistance. The assessment at that time remained the same, pain in the right shoulder, and it was again recommended that he follow up with a specialist. Restrictions were given of modified duty, with no pulling, reaching, or overhead reaching, and no lifting or carrying with the right arm. Petitioner was not to operate heavy equipment. (PX 1 p.1-2,4-5)

Dr. Weimer saw Petitioner on October 12, 2021, with a history of right shoulder complaints after pulling a rack of milk and having a sudden onset of pain. He noted he had previously treated Petitioner's left shoulder. He said he had seen Petitioner for this same right shoulder "going back to 2020," resulting in a subacromial cortisone injection in March of 2020 which "helped up until this injury." Physical examination showed some reduction in range of motion, reduced strength, and a positive Jobe's test. He suspected this was a traumatic rotator cuff tear secondary to the injury described to him, as well as "his underlying impingement. He ordered an MRI of the shoulder, and it was performed that same day and was interpreted by Dr. Weimer to show a near full-thickness anterior supraspinatus rotator cuff tear, as well as impingement at the acromioclavicular joint. Dr. Weimer was of the opinion that this was an acute tear, and he recommended an arthroscopy with a medial subacromial decompression, a distal clavicle excision and a repair of the 1 cm full-thickness anterior supraspinatus rotator cuff tear. Dr. Weimer restricted Petitioner from work at that time. (PX 2 p.3; PX 3 p.2,6)

A second MRI of the right shoulder was performed on November 11, 2021, and it was interpreted by the radiologist to reveal a full-thickness to near full-thickness tear of the anteriormost fibers of the supraspinatus tendon. Some bursal fibers were possibly still intact. An associated small volume of fluid was also seen in the subacromial/subdeltoid bursa, and mild to moderate osteoarthritis of the acromioclavicular joint was also seen. (PX 2 p.2,4)

On December 20, 2021, Respondent had Petitioner examined at its request by Dr. Rotman. His findings and opinions are contained in the summary of his deposition, below.

On January 18, 2022, Petitioner was seen by NP Comrie at HSHS Holy Family Health Center to get a return to work note after being off for right shoulder pain, saying "work comp determined his shoulder pain is not a work related issue. He noted that he would require surgery, but he had to have a partial nephrectomy first, which was scheduled for February 25, for a lesion on the right kidney which was believed to be renal cell carcinoma. He noted he still had right shoulder pain, and was taking Tylenol as needed. That day's diagnoses were essential hypertension and chronic right shoulder pain. A return to work order was issued. (PX 4 p.1,3-5)

Petitioner was seen by Dr. Leb of Midwest Bone and Joint Surgery on August 23, 2022, with complaints of right shoulder pain of 3/10 intensity. He gave a history of the pain beginning on September 10, 2021 while moving bossey racks onto a trailer. When examined, Petitioner had reduced range of motion of the right shoulder, 4+/5 rotator cuff strength, with pain, and positive Neer/Jobs/ Hawkins signs

for impingement. X-rays that day were negative for bony abnormalities other than some indications of AC arthritis. A right shoulder ultrasound showed a full thickness tear of the anterior supraspinatus. Physical therapy, medication and additional testing were ordered and Dr. Leb's assessment that day was right shoulder pain due to a probable rotator cuff tear. He noted Petitioner had not had his right shoulder treated for over a year prior to this accident, had the September 10, 2021 accident, and had been symptomatic ever since that time. He noted Petitioner was now working maintenance for a school but was having pain with lifting and overhead work. He believed Petitioner's injury was work related. Petitioner was to be seen on an as-needed basis. (PX 5 p.9-10)

Petitioner saw Dr. Ungacta at Midwest Bone and Joint Surgery on July 27, 2023, complaining of 7/10 right shoulder pain. Petitioner said it was painful to lift his arm above his head or behind his back. His right shoulder physical examination revealed some decrease in range of motion, reduced rotator cuff strength, and impingement. Nine x-rays of the right shoulder were taken, along with one of the neck, showing no significant abnormalities, and an ultrasound of the right shoulder was also performed, and showed an intact rotator cuff. A Kenalog injection was then performed on the right shoulder in the subacromial space. (PX 5 p.6- 7)

Petitioner saw Dr. Ungacta again on November 8, 2023. At this time Petitioner said his pain was 9/10. He reported difficulty sleeping and wanted to know what else could be done. Numerous shoulder and arm x-rays, and cervical x-rays, were performed and revealed no significant abnormalities. Another ultrasound was performed, and the findings were the same as on August 23, 2022. An MRI was ordered. Petitioner was to return after the MRI was performed. (PX 5 p.3-5)

A third MRI of the right shoulder was performed on March 20, 2024, and while it had a limited evaluation due to motion during the test, the radiologist deemed it to reveal a tear of the supraspinatus tendon, with a 3.7 cm tendon retraction. Degenerative changes were also seen about the humeral head, and the anterior fibers of the infraspinatus tendon appeared to be torn, along with thinning of the posterior fibers of the same tendon. (PX 2 p.1)

Petitioner was again seen by Dr. Ungacta, on April 2, 2024. He was complaining of 9/10 pain, and located on the lateral side of the right shoulder. Petitioner gave a history of experiencing right shoulder pain while he was loading a trailer. Physical examination found reduced range of motion, reduced rotator cuff strength, and positive Neer, Jobs and Hawkins tests for impingement. It was noted that Petitioner had received a right shoulder injection two years prior to his work related injury of September 10, 2021. Dr. Ungacta noted that in his opinion Petitioner's right shoulder pain was due to his work injury of September 10, 2021. Physical therapy, medication and additional testing were ordered. (PX 5 p. 1)

DEPOSITION TESTIMONY OF DR. MICHAEL ROTMAN

Dr. Rotman was deposed as a witness by Respondent. He testified that he was board-certified in orthopedic surgery, with a specialty in the upper extremity. Dr. Rotman said Petitioner gave him a history of pain in his right shoulder after an accident of September 10, 2021, while loading and pulling bossey carts. Dr.

Rotman said he reviewed numerous medical records which had been provided to him by Respondent, summarizing them in his report and portions of them in his testimony. He then described his physical examination findings of that day, , which included no atrophy, a reduction to about 80 to 90 percent of his strength, and good motion, though he had a slight loss of ability to reach behind his back. (RX 1 p.4-5,9-13)

Dr. Rotman said it appeared Petitioner had pain from a small rotator cuff tear, based upon his physical examination. He did not believe this was caused by Petitioner's work, noting he had the same complaints on the opposite, left, side in 2020 when treated by Dr. Weimer, and of having had problems for over a year. He did not believe pulling on the carts was an acute injury, and was not like a fall or doing repetitive overhead work over a period of time. Dr. Rotman believed Petitioner would benefit from a shoulder surgery to remove bone spurs that were digging into the rotator cuff, and, if needed, a repair of the rotator cuff, as the need to repair a small tear cannot be determined until the surgeon looked at it during the surgery. (RX 1 p.14-16)

Dr. Rotman testified the MRI of March 20, 2024, showed Petitioner's rotator cuff tear had gotten quite large and might not be repairable. (RX 1 p.17)

On cross examination, Dr. Rotman agreed that after the September 10, 2021 accident, Dr. Weimer examined Petitioner and recommended surgery, as had he upon examining Petitioner. He said Dr. Weimer was a competent orthopedic surgeon for shoulder disorders. He said ultrasounds were good diagnostic tools for rotator cuff tears, dependent on the skill of the person performing the test. He said it was not uncommon for orthopedic surgeons to personally perform ultrasounds of the shoulder. (RX 1 p.18-21,23)

DEPOSITION TESTIMONY OF DR. FELIX UNGACTA

Dr. Ungacta was deposed as a witness by Petitioner. He testified that he was an orthopedic surgeon who had previously been board-certified but had allowed his certification to lapse on December 31, 2023, as he is unsure whether he will continue to practice medicine after 2024. He noted Dr. Leeb had been an employee of his in the past. His testimony reference Petitioner's office visits, history, complaints, physical examination findings and diagnoses was consistent with the medical summaries, above. Dr. Ungacta testified that during Petitioner's visit of July 27, 2023, he injected his right shoulder. (PX 7 p.3-14)

Dr. Ungacta testified his diagnosis on July 27, 2023 was possible partial thickness rotator cuff tear. He said Petitioner returned on November 8, 2023, and said the injection had not helped enough, Petitioner was describing his pain as 9/10 on that date. Dr. Ungacta's diagnosis as of this date was a full thickness rotator cuff tear, and he recommended arthroscopic surgery. He ordered an MRI of the right shoulder at that time, as it would help determine if there was a tear of the labrum, and would assist him in preparing for the surgery. He said that MRI was performed on March 20, 2024, and it showed progression of the rotator cuff tear, the tear was larger than it had been seen to be in the 2021 MRI. He said once a rotator cuff is torn, it can progress with activities of daily living. He said that Petitioner had failed conservative treatment and continued to be symptomatic, which is why he felt it was time for surgical intervention. Dr. Ungacta testified that the work Petitioner was doing with milk crates contributed to his symptoms of pain in the shoulder. He said the latest MRI showed Petitioner's tendon had retracted 3.7 cm, but it was not retracted so far it could not be repaired, though it would take a good deal of skill to perform the repair. He said if authority to perform the surgery was ordered by the arbitrator, another ultrasound would be required prior to surgery. (PX 7 p.14-19,21)

On cross examination, Dr. Ungacta testified he had previously treated Petitioner in 2014, for low back and hip pain. He said there was no way to determine from an MRI how long a rotator cuff had been torn. Dr. Ungacta said he did not believe Petitioner had received the physical therapy which had been prescribed. When asked what procedures he would perform on Petitioner if the surgery was ordered, Dr. Ungacta said he would at least perform a rotator cuff repair, but there was a high likelihood anchors would need to be used, though he did not know how many. He said he had not seen Petitioner since April 2, 2024. Dr. Ungacta said activities of daily living could make a rotator cuff symptomatic, as could rolling on a shoulder while sleeping. (PX 7 p.24-25,29,30-32)

ARBITRATOR CREDIBILITY ASSESMENT

Petitioner seemed confused at times while he was testifying, and he did not appear to listen closely to questions being asked, or wait for the questions to be finished before answering. When questions were repeated or when he was instructed to listen to or wait for the questions to be concluded, his answers were more appropriate. He did not appear to be trying to avoid questions, or refuse to answer them. Most of Petitioner's testimony was corroborated by contemporaneous medical records. Some of his answers were impeached on cross examination, such as his explanation that he did not get his physical therapy as he did not yet have insurance with his present employer, and then, when dates were pointed out to him, he admitted he would have had health insurance. Similarly, the wage records for Collinsville CUSD 10, his employer during the period of time Petitioner was prescribed physical therapy and did not get it, contradicted Petitioner's other explanation for why he did not get the physical therapy, that he was working double shifts during that period of time and did not have time to get the therapy. The wage records show Petitioner's weekly pay stayed the same, or very similar, in amount, from mid-June 2023 through December of 2023, with only one paycheck, of August 25, 2023, being larger. No persuasive explanation for his not getting the therapy was ever supplied by Petitioner. The Arbitrator therefore finds Petitioner to have been generally, but not fully, credible.

Ms. Sarpy appeared to answer in a straightforward manner, answering all question put to her by both attorneys in a direct manner, and at times indicating the limits of her job and her not dealing with some matters due to her having held two positions at different times. The Arbitrator finds Ms. Sarpy to have been a credible witness.

CONCLUSIONS OF LAW

In support of the Arbitrator's decision relating to whether an accident occurred which arose out of an in the course of Petitioner's employment by Respondent on September 10, 2021, the Arbitrator makes the following findings:

The findings of facts, above, are incorporated herein.

The summaries of medical evidence and deposition testimony, above, are incorporated herein.

The Arbitrator's Credibility assessments, above, are incorporated herein.

Petitioner's testimony as to the actions of September 10, 2021, his pulling wheeled carts weighing approximately 800 pounds onto a trailer, and, while doing so, he felt pain in his right shoulder, was uncontradicted. While he did not report the incident immediately to his supervisor, as required by company policy, the Workers' Compensation Act does not require immediate reporting of the incident, §6 of the Act states that the employee shall advise the employer "as soon as practicable, but no later than 45 days." Petitioner explained that he waited to see if it would just go away, and testified that he did so two days later, on September 12, 2021. That testimony is corroborated by Respondent's Workers' Compensation Claim Form, showing it was reported to Supervisor Paula Powell on that date, and the handwritten Employee's Accident / Incident Report filled out and signed by Petitioner on September 12, 2021. (RX 9 p.1-2) Petitioner's history at MedExpress that same date was consistent with Petitioner's testimony of how the accident occurred and those forms. No contradictory evidence was admitted into evidence.

The Arbitrator finds that the Petitioner sustained an accidental injury which arose out of an in the course of Petitioner's employment by Respondent on September 10, 2021. This finding is based upon the testimony of Petitioner, Respondent Exhibit 9, and the medical records of MedExpress of September 12, 2021.

In support of the Arbitrator's decision relating to whether Petitioner's current condition of ill-being, rotator cuff tear of the right shoulder, is causally related to the accident of September 10, 2021, the Arbitrator makes the following findings:

The findings of fact, above, are incorporated herein.

The summaries of medical evidence and deposition testimony, above, are incorporated herein.

The Arbitrator's Credibility assessments, above, are incorporated herein.

The findings in regard to accident, above, are incorporated herein.

While Petitioner had made right shoulder complaints on March 12, 2021, saying they had started one month earlier. That was diagnosed as impingement, not rotator cuff tear, and an injection was given for impingement. On June 22, 2021 Petitioner was seen for hypertension follow up, as well as epigastric and heel complaints, also mentioning that he had bilateral shoulder pain, but his left shoulder was worse than his right shoulder. No diagnoses for shoulder problems were contained in the medical records of that date. Petitioner was seen on August 6, 2021 for bilateral shoulder pain, again, left worse than right, and an MRI of the left shoulder was ordered. No MRI of the right shoulder was ordered. The diagnoses for August 6, 2021 was impingement syndrome of both the left and right shoulders. Dr. Weimer recommended left shoulder arthroscopic surgery on this date. No recommendation for right shoulder surgery was made. No mention or diagnoses in regard to the right shoulder rotator cuff was made on any of these three dates.

Petitioner's complaints at MedExpress on September 12, 2021, two days after this accident, were limited to the right shoulder, and Petitioner had painful range of motion of the right shoulder. He was taken off work at that time. Three days later, again at MedExpress, Petitioner had continued decrease in range of motion of the right shoulder, with pain. He was to be referred to an orthopedist, and no mention of changes in work

restrictions were made. When next seen, twelve days after this accident, on September 22, 2021, Petitioner had 9/10 right shoulder pain, was given modified duty restrictions, and was to follow up with a specialist.

Petitioner saw Dr. Weimer on October 12, 2021, an MRI of the right shoulder was performed and it showed a near full-thickness anterior supraspinatus rotator cuff tear of the right shoulder. Dr. Weimer wrote that this was an acute tear, and recommended an arthroscopic rotator cuff tear at that time and restricted Petitioner from work.

Dr. Rotman, Petitioner's examining physician, agreed Petitioner appeared to have pain from a small rotator cuff tear based on his examination of Petitioner, but did not feel it was causally connected, based upon his having shoulder complaints on the left side for over a year, and his belief that pulling on the cart would not tear the rotator cuff, while a fall or repetitive overhead work would. He did believe Petitioner would benefit from surgery, however, and a repair of the rotator cuff depending on what the surgeon saw while performing the surgery.

Dr. Leb first saw Petitioner on August 23, 2022, with a consistent history of accident, reduced right shoulder range of motion, reduced right rotator cuff strength, and an ultrasound examination which showed a full thickness tear of the anterior supraspinatus. He did not believe Petitioner had been treated for right shoulder problems for a year prior to this accident. Dr. Leb believed Petitioner's right shoulder injury was work related.

Dr. Ungacta began treating Petitioner on July 27, 2023, and the right shoulder ultrasound he performed on that date was interpreted by him to not indicate a torn rotator cuff. He injected the subacromial space of the right shoulder on that date. On November 8, 2023 another negative ultrasound was performed, and an MRI was ordered. It was done on March 20, 2024, and it showed a tear of the supraspinatus and a 3.7 cm retraction of the tendon. Dr. Ungacta on that date, and in his later deposition, stated that Petitioner's right shoulder condition and pain were due to the work injury of September 10, 2021.

The Arbitrator finds that Petitioner's medical condition, a full thickness tear of the right supraspinatus/rotator cuff, is causally related to the accident of September 10, 2021. This finding is based upon the testimony of Petitioner, the treating medical records, both prior to and subsequent to the date of accident, and the opinions of Dr. Leb and Dr. Ungacta. The Arbitrator notes Dr. Leb was of the erroneous belief that Petitioner had not had his right shoulder treated in the year prior to this accident, but the Arbitrator further notes that Petitioner had not been diagnosed with any right rotator cuff complaints in the year prior to this accident, that prior treatment was for subacromial impingement syndrome. **The Arbitrator further finds that the chain-of-events also support a finding of causal connection.** This finding is based upon Petitioner's un rebutted testimony to a pre-accident state of asymptomatic good health in the right rotator cuff, his having an accident on September 10, 2021, and his immediately after said accident having sudden pain, immediate medical treatment and new diagnoses based on diagnostic testing and physical examinations. Certi-Serve, Inc. vs. Industrial Commission, 101 Ill.2d 236,244 (1984) It is noted that no MRIs of the right shoulder had been recommended or performed prior to the date of this accident, Petitioner had not been restricted from work due to right shoulder pain prior to the date of this accident, and no surgery to the right shoulder had been recommended or performed prior to the date of this accident.

In support of the Arbitrator's decision relating to what temporary benefits Petitioner is entitled to as a result of the accident of September 10, 2021, the Arbitrator makes the following findings:

The findings of fact, above, are incorporated herein.

The summaries of medical evidence and deposition testimony, above, are incorporated herein.

The Arbitrator's Credibility assessments, above, are incorporated herein.

The findings in regard to accident and causal connection, above, are incorporated herein.

Petitioner claimed to have been temporarily totally disabled as a result of this accident from September 13, 2021 through January 19, 2022, a period of 18 3/7 weeks. Respondent at arbitration denied liability for this period of disability on the basis of causal connection, but did not dispute the period of the disability. Petitioner's condition of ill-being has been found compensable, as noted above.

The Arbitrator finds that Petitioner was temporarily totally disabled as a result of the accident from September 13, 2021 to January 19, 2022, a period of 19 3/7 weeks at a rate of \$539.37 per week. This finding is based upon the testimony of Petitioner, the restrictions place upon Petitioner by his medical treaters, the finding of causal connection between Petitioner's condition of ill-being and the accident of September 10, 2021, and the stipulation by Respondent at arbitration.

In support of the Arbitrator's decision relating to whether the medical services that were provided to Petitioner were reasonable and necessary as a result of the Accident of September 21, 2021, the Arbitrator makes the following findings:

The findings of fact, above, are incorporated herein.

The summaries of medical evidence and deposition testimony, above, are incorporated herein.

The Arbitrator's Credibility assessments, above, are incorporated herein.

The findings in regard to accident, causal connection, and temporary total disability, above, are incorporated herein.

Medical bills were introduced in Petitioner Exhibit 6. Page 1 of that exhibit is a list, not a bill, and is not considered in this finding, except to the extent that it notes that Petitioner is only seeking payment for two bills, and out-of-pocket expenses paid by Petitioner.

The Arbitrator finds that the following bills introduced into evidence in Petitioner's Exhibit 6 are related to Petitioner's full thickness tear of the right supraspinatus/rotator cuff injury, are reasonable and were necessitated to treat or cure Petitioner's injuries suffered in this accident, and are to be paid pursuant to Sections 8(a) and 8.2 of the Act:

- 3. The March 20, 2024 MRI bill of HSHS St. Joseph Hospital for the MRI of Petitioner's right shoulder (PX 5 p.2)**

- 4. The out of pocket expenses paid by Petitioner, identified in the Midwest Bone and Joint Surgery bill as “Pt Pmts” (PX p p.5-6) and HSHS Holy Family Health Center (PX 6 p.9), which are to be repaid to Petitioner to the limit set out in Sections 8(a) and 8.2 of the Act.**

This finding is based upon the medical records introduced into evidence and the testimony of Petitioner and Dr. Ungacta.

Respondent is entitled to credit under Section 8(j) of the Act for any amounts of said bill which have been paid by its group health insurance carrier.

In support of the Arbitrator’s decision relating to whether Petitioner is entitled to any prospective medical treatment, the Arbitrator makes the following findings:

The findings of fact, above, are incorporated herein.

The summaries of medical evidence and deposition testimony, above, are incorporated herein.

The Arbitrator’s Credibility assessments, above, are incorporated herein.

The findings in regard to accident, causal connection, temporary total disability, and medical bills, above, are incorporated herein.

Multiple MRIs identified Petitioner’s right supraspinatus as being partially torn, full thickness torn, and even torn with a 3.7 cm retraction. Dr. Weimer noted that the first MRI approximately one month after this accident, revealed an acute tear of the rotator cuff. Dr. Ungacta testified that over time tears of the rotator cuff would progress. Considerable time has passed since the date of this accident. Dr. Weimer, Dr. Ungacta, and even Respondent’s examining physician, Dr. Rotman, testified that arthroscopic surgery to repair Petitioner’s right rotator cuff was reasonable and necessary, and would benefit Petitioner, though Dr. Rotman did not believe it was caused by this accident and questioned whether it was possible, given the amount of retraction of the tendon. Dr. Ungacta felt that the repair was possible.

The Arbitrator finds that Petitioner is entitled to prospective medical treatment as recommended by Dr. Ungacta, to wit, an arthroscopic repair of the Petitioner’s right supraspinatus/rotator cuff tear, but based upon Dr. Ungacta’s testimony that he did not know whether he intended to be practicing medicine in 2024, this surgery can be performed by the orthopedic surgeon of Petitioner’s choice.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	22WC013581
Case Name	Rose Burris v. City of Cairo
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	25IWCC0514
Number of Pages of Decision	38
Decision Issued By	Stephen Mathis, Commissioner, Kathryn Doerries, Commissioner

Petitioner Attorney	Thomas Rich
Respondent Attorney	Patrick Keefe

DATE FILED: 12/29/2025

/s/Stephen Mathis, Commissioner

Signature

DISSENT

/s/Kathryn Doerries, Commissioner

Signature

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)
☐ Modify	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROSE BURRIS,

Petitioner,

vs.

NO: 22 WC 013581

CITY OF CAIRO,

Respondent.

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 causal connection, medical expenses, and prospective medical care, and being advised of the facts and law, corrects the Decision of the Arbitrator as stated below and otherwise affirms the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission identifies a scrivener's error on the first line of the final paragraph of the Decision at Page 6. The Commission strikes "February 2" and replaces with "February 3".

All else if affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of \$456.90 per week for a period of 2 2/7 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 reasonable and necessary medical services outlined in Petitioner's group exhibit, as provided in Sections §8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay for the

prospective treatment recommended by Dr. Bradley and Dr. Gornet, including but not limited to, right total knee arthroplasty and lumbar spine disc replacement.

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. Respondent shall hold Petitioner harmless from any claims by providers of 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 any additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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.

December 29, 2025

O: 11/04/25

SJM/msb

044

/s/ Stephen J. Mathis

Stephen J. Mathis

/s/ Amylee H. Simonovich

Amylee H. Simonovich

DISSENT

I respectfully dissent from the opinion of the majority and would partially reverse the Decision of the Arbitrator. While I agree with the majority's decision affirming the award for prospective medical benefits regarding the right knee arthroplasty recommended by Dr. Bradley, I disagree with the Arbitrator's causation finding for the lumbar spine condition and would vacate the prospective medical benefits awarded for the lumbar disc replacement recommended by Dr. Gornet.

It is undisputed Petitioner had a pre-existing condition involving chronic low back pain and radiating bilateral lower extremity symptoms which required extensive treatment including repeated diagnostic imaging and pain management over a period of many years, culminating in the placement of a trial intrathecal morphine pump in mid-October of 2021, a little over three months before the work accident on February 3, 2022. It is also uncontroverted that Petitioner was a candidate for lumbar spine surgery prior to the accident. Claimants seeking benefits under the Act bear the burden to prove all elements of their claims by a preponderance of the evidence, including that a causal connection exists between the condition of ill-being and the work accident. *Tazewell County vs. Illinois Workers' Compensation Comm'n*, 2025 IL App (4th) 230754WC, PP24-25. In

cases involving preexisting conditions, the claimant must prove “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. vs. Industrial Comm’n*, 207 Ill. 2d 193, 205-206, 797 N.E.2d 665 (2003). The accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was a causative factor in the resulting condition of ill-being. *Id.*

Where, as in the present matter, a claimant’s pre-existing condition was already symptomatic before a work accident, causation may only be found if the evidence establishes that the work accident caused further deterioration. See *Schroeder vs. Illinois Workers’ Compensation Comm’n*, 2017 IL App (4th) 160192WC. In *Schroeder*, the Court ruled that the salient factor is not the precise previous condition; it is the resulting deterioration from whatever the previous condition had been. *Schroeder*, 2017 IL App (4th) 160192WC at P26. In such cases, evidence showing a diminished ability to work, structural change, or worsening symptoms after a work accident can support finding an aggravation. In *Schroeder*, supra, the Court determined the Commission properly found an aggravation of a pre-existing symptomatic condition where the claimant became unable to work after the accident. See *Schroeder* 2017 IL App (4th) 160192WC at PP30-31. In *Tazewell*, supra, the Appellate Court held that a pre-existing condition which “becomes painful” as a result of work related activity rather than a natural progression of the underlying condition is compensable as an aggravation even in the absence of any organic or structural change. *Tazewell County*, 2025 IL App (4th) 230754WC, PP27-31. Though *Tazewell* dealt with an asymptomatic pre-existing condition that became painful after the accident, the Court’s holding would presumably apply to pre-existing conditions that were already symptomatic provided the claimant can present credible evidence that the accident caused worsening symptoms not solely related to the natural progression of the underlying condition.

In the case at bar, Petitioner was working full duty both before and after the accident, with the exception of a stipulated 2-2/7 weeks period following her medial meniscus repair by Dr. Bradley on July 6, 2023. Dr. Gornet testified he recommended Petitioner continue working full duty over the course of multiple treatment visits. (PX16 at 12, 14, 15, 18) Respondent’s section 12 physician, Dr. O’Boynick, also documented Petitioner’s full duty status during his IME in April 2023. (RX1 at 20) Clearly, the lumbar spine condition did not diminish Petitioner’s ability to work for Respondent and her work status cannot form a basis for finding an aggravation. The Arbitrator found, however, that the accident caused both a structural change as well as a worsening of Petitioner’s symptoms in relation to the claimed lumbar spine injury. I disagree with both findings.

Following her arthroscopic knee surgery, Dr. Bradley referred Petitioner to Dr. Gornet for further evaluation of her cervical and lumbar spine. Petitioner then underwent an MRI of the lumbar spine on December 15, 2022. (PX10 at 4-5) That MRI showed protrusions at L4-L5 and L5-S1, with annular tears in both discs, along with mild to moderate bilateral foraminal stenosis and mild central canal stenosis at L4-L5, and mild foraminal stenosis at L5-S1. The radiologist also noted disc bulging at L3-L4 with right and left foraminal protrusions resulting in moderate right-greater-than-left foraminal stenosis. Dr. Gornet reviewed the MRI and it was his assessment that the lumbar spine MRI was consistent with disc injuries at L3-4, L4-L5, and L5-S1, with high intensity zone signal changes and annular tears at both L4-L5 and L5-S1. (PX11 at 5) As reflected

in the Arbitrator's findings, Dr. Gornet became aware Petitioner had previously undergone an MRI of the lumbar spine and asked Petitioner to obtain the older scan.

Dr. Gornet referred Petitioner to Dr. Blake for injections which failed to provide sustained relief. On April 12, 2023, Dr. Gornet performed a discogram at two levels, L3-L4 and L4-L5. Dr. Gornet did not test the L5-S1 level as he evidently believed the L5-S1 disc required surgery and the discogram was intended to ascertain whether the adjacent two levels also required surgical intervention. The discogram resulted in concordant pain at L4-L5. (PX11 at 7) A post-discogram CT scan showed a right paracentral annular tear and 5.5 mm protrusion, resulting in ventral dural displacement with moderate right-greater-than-left foraminal stenosis at L4-5. (PX12 at 3) The CT also showed left paracentral protrusion with no stenosis at L5-S1. The CT scan report was silent regarding annular tear at the L5-S1 level; however, the radiologist noted the contrast material was seen only in the nuclear cavities at L3-L4 and L4-L5, suggesting the contrast material was not injected at that level. (PX12 at 3) Dr. Gornet saw Petitioner for follow-up on May 25, 2023, and indicated it was his opinion that the accident aggravated her pre-existing condition and recommended disc replacement at L4-L5 and L5-S1.

At Respondent's request, Dr. O'Boynick performed a section 12 examination on April 18, 2023. He reviewed voluminous medical records which he later described during his deposition as a stack of records measuring about 4½ to 5 inches tall. (RX1 at 7) Dr. O'Boynick's IME report set forth a detailed summary of Petitioner's past medical history including prior diagnostic imaging reports and medical records commencing on November 4, 2008 and ending October 13, 2021. Dr. O'Boynick also reviewed the radiology report for the MRI ordered by Dr. Gornet. Based on his review of the medical records and imaging reports, which documented pre-existing pathology at L4-L5 and L5-S1 with a past history for chronic back pain and radiculopathy, placement of a trial intrathecal morphine pain pump three months before the accident, and similar symptoms following the accident, Dr. O'Boynick opined it was unlikely Petitioner had aggravated, exacerbated, or altered her chronic L5 radiculopathy in the work accident. Dr. O'Boynick noted, however, that he had not seen the imaging for the prior studies and therefore was unable to perform a comparison.

On May 25, 2023, Dr. Gornet saw Petitioner for follow-up and noted Petitioner had a previous MRI on August 5, 2021. Dr. Gornet indicated the older MRI showed disc pathology at L4-L5 and L5-S1 and given this radiographic appearance he believed the accident aggravated her underlying condition. (PX11 at 12) As mentioned, Dr. Gornet formally recommended disc replacement at those levels.

Dr. O'Boynick subsequently had an opportunity to review the imaging from the prior MRI performed on August 5, 2021, which he described in his addendum report. (RX1, deposition exhibit #3) Both the initial report and the addendum report, attached as exhibits to the deposition transcript, were admitted into evidence by agreement of Petitioner's attorney. (RX1 at 9) Dr. O'Boynick performed a "side by side comparison" of the before and after MRI studies and focused on the two disc levels where Dr. Gornet had recommended disc replacement. Regarding the L4-L5 level, Dr. O'Boynick noted there appeared to be no change to the disc protrusion and no change in the appearance of the annular tear based on the sagittal cuts. Dr. O'Boynick further noted the T2 weighted axial cuts likewise demonstrated there was no change in the appearance of the L4-5 disc herniation across the two studies. Dr. O'Boynick also noted there was no evidence of

increased compression at this level. Regarding the L5-S1 level, Dr. O'Boynick noted the disc protrusion appeared to have *decreased* in size between the August 5, 2021 study and the December 15, 2022 study. Dr. O'Boynick further noted the annular tear at that level appeared "more visible" on the December 15, 2022 MRI. The axial cuts confirmed the L5-S1 protrusion had improved during the intervening period between the two studies.

Dr. O'Boynick indicated his prior opinion regarding the lack of causation remained unchanged. He noted that the pre and post injury lumbar MRI studies demonstrated minimal change across L4-L5 and L5-S1 and the medical records documented a long history of low back pain and bilateral lower extremity radiculopathy requiring medical and interventional management prior to the injury date. (RX1, deposition exhibit #3)

Dr. Gornet testified he compared the MRI studies taken before and after the accident and agreed the older MRI did show disc pathology at both L4-L5 and L5-S1 but it was his opinion that there was an aggravation. (PX16 at 19) Dr. Gornet did not, however, offer any testimony delineating any differences or changes between the before and after MRI studies. Later on direct examination, Dr. Gornet testified he believed the work accident caused an aggravation of the pre-existing condition because Petitioner's lumbar spine condition was "*more tolerable prior to that*" work accident. (Emphasis added.) (PX16 at 21) Reading Dr. Gornet's deposition testimony in its entirety, it appears that Dr. Gornet pinned his causation opinion on Petitioner's subjective reporting of worsening symptoms after the accident. Dr. O'Boynick, on the other hand, unequivocally reaffirmed during his deposition that it was his opinion there were no structural changes when he compared the MRI studies performed before and after the accident. (RX1 at 16) Accordingly, I would find there was no reliable evidence of a structural change in Petitioner's lumbar spine pathology.

The Arbitrator found otherwise, however, placing great reliance on Dr. O'Boynick's statement in his addendum report wherein he noted the annular tear in the L5-S1 disc appeared "more visible" on the December 15, 2022 MRI. The Arbitrator characterized this statement as an admission by Dr. O'Boynick and interpreted the statement as evidence of a post-accident structural change. I view the statement differently. The statement that the annular tear at L5-S1 was more visible must be read not in isolation but in conjunction with his concluding written opinion and subsequent deposition testimony, which both indicate he found no significant structural changes. I view Dr. O'Boynick's statement regarding the enhanced visibility of the annular tear in the post-accident MRI as more likely representing a descriptive term for the diagnostic quality of the imaging, or in the alternative, the annular tear might have become more visible in 2022 by reason of the reduced size of the disc protrusion at that level. I do not believe we can take this statement out of context and find the enhanced visibility noted by Dr. O'Boynick as evidence of a change in the pathology.

In any event, even assuming there was some change in pathology, it was Petitioner's burden to prove that any such change was due in part to the work accident and was not solely from the natural progression of the pre-existing condition. Given Dr. Gornet's vague testimony, I would find there was no credible medical opinion supporting a change in pathology due to the accident. Accordingly, in order to show an aggravation, Petitioner was therefore required to prove by a preponderance of the credible evidence that the accident worsened her symptomology. As

mentioned, the Appellate Court noted in *Tazwell County*, supra, that the absence of structural or organic change is not dispositive when determining whether an accident has aggravated a pre-existing condition. Though Dr. Gornet testified it was his belief the work accident caused an aggravation because Petitioner's lumbar spine condition was "more tolerable" before the work accident, I find Dr. Gornet's opinion unpersuasive given the past treatment history and prior complaints and his testimony, discussed in greater detail below, admitting he had no recollection of Petitioner ever disclosing to him she had bilateral low back pain going into the buttocks and both legs in 2021.

Returning to Dr. O'Boynick's IME report, the prior treatment records were quite extensive and documented a past history for chronic back pain with lower extremity symptoms. (RX1, deposition exhibit #2) The prior medical records contained an MRI report of the lumbar spine, dated November 4, 2008, which was ordered for a clinical history of back pain and left leg pain. Per the radiological findings, there was no focal disc herniation or significant nerve root encroachment at that time; however, there was mild lumbar spondylosis with a mild broad-based disc bulge at L4-5 and a mild broad-based disc bulge at L5-S1. The records further revealed that an EMG test performed on November 14, 2008, demonstrated findings consistent for acute left L5 radiculopathy. On November 24, 2008, a physician assistant documented low back pain and left hip pain. On February 11, 2009, Petitioner completed a pain diagram on which she indicated midline lumbar pain and thoracolumbar pain extending down to the belt line and radiating outward along with *right* anterior thigh pain. Petitioner underwent another MRI of the lumbar spine on April 30, 2014, which showed degenerative disc signal changes at L4-5, as well as a herniated disc at L4-5 that was new since the prior study. The April 2014 report further indicated facet disease and mild spinal stenosis. The April 2014 MRI report also noted a diffuse disc bulge at L5-S1 with degenerative facet disease changes.

On November 14, 2014, Petitioner complained of back pain with radiating pain down *both legs, worse in the right leg*, along with numbness and burning in her feet. A nurse practitioner noted Petitioner had a "greater than one year" history of increasing back pain with radiation into the legs bilaterally. There was also mention of a second EMG performed in April 2014 which showed chronic L5 radiculopathy. The nurse practitioner also documented decreased sensation to light touch involving the L5 nerve distribution. Therapy and medication were recommended and an updated MRI was to be considered if no improvement. Dr. O'Boynick commented that this November 14, 2014 progress note indicated a second EMG showed chronic L5 radiculopathy on the right. (RX1, deposition exhibit #2 at page 10)

The medical records further revealed Petitioner received two epidural steroid injections directed at the left L5-S1 level on December 11, 2014, and January 2, 2015. Petitioner then received a third epidural steroid injection directed at the right L5-S1 level on January 15, 2015. Petitioner was next seen on January 26, 2015 with continuing symptoms. Petitioner also complained of tripping over her own feet. A physician assistant noted the first injection was effective, the second injection was mildly effective, and the third injection was ineffective. The physician assistant further noted Petitioner had left greater than right bilateral lower extremity symptoms consistent with an S1 pattern. An MRI of the lumbar spine was recommended.

On March 31, 2020, Petitioner was seen for her cervical spine condition, during which a

nurse practitioner also examined Petitioner's lower extremities and found diminished sensation to light touch in the left L5 and S1 distributions. The nurse practitioner noted a diagnosis for left-sided lumbar disc disorder with lumbar radiculopathy. Petitioner received another epidural steroid injection on the left at L5-S1 on April 10, 2020.

Petitioner continued treating for her cervical and lumbar spine conditions and underwent a cervical spine fusion on July 23, 2020. Petitioner followed-up post-operatively regarding the cervical spine and on October 6, 2020, the physician assistant noted the Petitioner recently suffered a fall down, landing on her right knee and left shoulder. The physician assistant further noted Petitioner complained of persistent back and neck pain.

Petitioner saw a nurse practitioner on July 29, 2021 with complaints of low back pain and radiating pain down the lower extremities to the feet, described as aching, burning, numbness, pins-and-needles, and stabbing in nature. Petitioner rated her pain as a 6/10 "with medication" that day. On examination, Petitioner exhibited decreased sensation to light touch in the lateral aspect of both legs and feet. The nurse practitioner noted Petitioner walked with an antalgic gait and lumbar flexion produced pain. The treatment plan indicated Petitioner was to follow-up for neurosurgical evaluation after Petitioner obtained the updated MRI. Notably, the nurse practitioner documented Petitioner's reported concern that she may be forced into early retirement due to her back and leg symptoms. Dr. O'Boynick commented that this history was significant as it indicated the pre-existing lumbar spine condition was interfering with Petitioner's activities required for her employment.

Dr. O'Boynick reviewed the report of the MRI of the lumbar spine performed on August 5, 2021. Per the radiology report, this study was ordered due to a history of lumbosacral radiculopathy, chronic lower back pain, and bilateral leg pain. As described by Dr. O'Boynick, the level-by-level description by the radiologist showed L3-L4 mild spinal stenosis, mild foraminal narrowing, a mild disc bulge, and moderate facet arthritis that has worsened since the previous exam. The L4-L5 level revealed mild spinal stenosis, mild bilateral foraminal narrowing, mild disc bulge, a central disc protrusion, and moderate facet arthritis. The L5-S1 level showed mild spinal canal stenosis, patent neuroforamina, and a mild disc bulge with moderate left central protrusion. The overall impression was a worsened appearance of moderate facet arthritis at L3-4 and L4-5 and multilevel degenerative changes without high-grade spinal canal stenosis or neuroforaminal narrowing.

Petitioner returned for evaluation on August 6, 2021 and reported weakness in the lower extremities and poor coordination. Additional complaints included difficulty lifting the left leg and increased pain associated with bending, walking, and sitting. The physician assistant noted mild paresthesia in the *bilateral anterior thighs with decreased sensation in the toes bilaterally* and tenderness involving the spinous processes in the SJ joints bilaterally. The physician assistant also found decreased sensation in the left C8 distribution. It was further noted that Petitioner has had persistent low back pain and bilateral lower extremity pain, left worse than right, since April or May 2021. The physician assistant noted the recent MRI did not show any neurosurgical lesion correlating with the diffuse lower extremity symptoms, prompting an order for a thoracic spine MRI for further assessment.

On August 12, 2021, a nurse practitioner noted Petitioner complained her legs were clumsy and would give way while walking. The documented impression was chronic pain, neuropathy, lumbar spondylosis and disc disorder, thoracic spondylosis, and foraminal stenosis in the cervical spine. The recommended MRI of the thoracic spine remained pending. An MRI report for the thoracic spine, dated August 17, 2021, showed a small T4-T5 disc protrusion without deformity, with multilevel facet hypertrophy.

On August 25, 2021, the nurse practitioner noted the same ongoing complaints without objective neurological deficits. The progress note indicated a neuropsychological evaluation for possible implantable device was under consideration. Dr. O'Boynick found this development significant as indicative of the chronicity and severity of Petitioner's condition.

Petitioner presented to Dr. Reis for evaluation on September 24, 2021. Petitioner complained of pain involving her neck, mid back, and lower back, with numbness and pins-and-needles sensation. Dr. Reis's assessment was chronic pain syndrome. The doctor recommended an intrathecal drug delivery trial. Per a follow-up progress note dated October 12, 2021, Dr. Reis noted Petitioner was undergoing an intrathecal pump trial. He noted the intrathecal space at L3-L4 was entered and intrathecal medication including morphine was introduced.

On October 13, 2021, a nurse practitioner noted Petitioner had been provided with 50 mcg of morphine via intrathecal drug delivery. The nurse practitioner noted Petitioner's reported pre-trial pain score was 6/10 and her post-trial score was 3/10. Petitioner reported 50% improvement and indicated she wished to proceed with permanent implantation of an intrathecal pump. The nurse practitioner further noted, however, that Petitioner's trial was impacted by "not going to work to see how my pain was affected." Rather, Petitioner reported her ability to sleep and perform household duties were improved by 50%. The progress note indicated the office would proceed with a predetermination of benefits.

As mentioned, the October 13, 2021 pain management follow-up visit occurred approximately 16 weeks before the work accident. An inference can be drawn that Dr. Reis's office's request for health insurance pre-approval remained pending. On February 3, 2022, Petitioner sustained a non-disputed compensable accident when she slipped and fell on ice at work.

Dr. Gornet testified Petitioner presented him with a copy of Dr. O'Boynick's IME report on August 14, 2023. (PX16 at 20) Dr. Gornet testified he did not dispute that history; however, he disagreed with Dr. O'Boynick on the issue of causation. As mentioned above, Dr. Gornet testified he believed the work accident caused an aggravation of the pre-existing condition because Petitioner's lumbar spine condition was "*more tolerable prior to that*" work accident. (Emphasis added.) (PX16 at 21) On cross-examination, Dr. Gornet testified he was not made aware of the pain pump Petitioner received in October 2021 for her pre-existing neck and back pain until he read Dr. O'Boynick's report. (PX16 at 35) Dr. Gornet testified that Dr. O'Boynick did "a pretty good job of summarizing the massive amount of records that at least he was provided" and further commented that "Dr. O'Boynick's usually pretty good at that." (PX16 at 36) Given the past medical history documented by Dr. O'Boynick, Dr. Gornet agreed Petitioner had a history of chronic right L5 radiculopathy. (PX16 at 39) Dr. Gornet further testified he was not aware that Petitioner's documented complaints in 2021 included bilateral low back pain going down both

buttocks and down both legs. (PX16 at 39) Questioned further about the verbal history given him by Petitioner, Dr. Gornet testified he had no recollection of Petitioner having divulged prior bilateral low back pain going down into the buttocks and both legs with numbness in 2021; she only mentioned that she had significant low back pain in the past. (PX16 at 39-40) Having reviewed one of the older MRI studies, Dr. Gornet agreed Petitioner had pre-existing lumbar spine pathology at the same disc levels. (PX16 at 41)

Dr. Gornet conceded that Petitioner “clearly had symptoms of significance at least in 2021” and he agreed there was no evidence her prior back condition had resolved prior to her work accident. (PX16 at 41-42) Dr. Gornet testified there was no evidence of a prior surgical recommendation either, which was why we “have to rely on, again, the patient’s verbal history regarding her symptomology and whether it’s worse.” (PX16 at 41-42) That being said, Dr. Gornet’s testimony in response to the next question regarding the trial pain pump was notable:

Q. Okay. And would placement of a pain pump in the lumbar spine, would you consider that of significance?

A. What I would say is based on her lumbar spine pathology placement of a pain pump for this particular problem *without trying more mainstream surgery borders on a very close deviation* of something I don't want to state further on the record. (Emphasis added.) (PX16 at 42-43)

In short, Dr. Gornet’s testimony revealed that Petitioner was already a candidate for lumbar spine surgery before the work accident.

Dr. O’Boynick testified that Petitioner’s prior pain was of such severity that Petitioner underwent an intrathecal morphine pump trial in an attempt to alleviate her pain only three months before the accident. (RX1 at 16-17) Dr. O’Boynick testified there were no changes in Petitioner’s symptoms after the accident. (RX1 at 17) Dr. O’Boynick further testified that Petitioner was working full duty when she presented for his examination and saw no reason why she could not continue working full duty at that time. (RX1 at 19-20) Dr. O’Boynick agreed that Petitioner was potentially a surgical candidate; however, he reiterated Petitioner’s low back pain and lumbar radiculopathy were pre-existing and that surgery would be unrelated to the accident.

Based on the medical records documenting the severity and chronicity of Petitioner’s pre-existing complaints and prior treatment, I find Petitioner has failed to prove a credible worsening of her symptoms after the work accident. I further believe Dr. O’Boynick had more information than Dr. Gornet on which to form a more credible opinion. The prior treatment records reviewed by Dr. O’Boynick documented a reported pain rating of 6 out of 10, *with medication*, during a visit on July 29, 2021. (RX1, deposition exhibit #2 at page 13) At trial, Petitioner testified her current back pain was a 6 to 7 on a scale of 1 to 10. (T. 19) More important, Petitioner’s treating spine surgeon, Dr. Gornet, testified on cross-examination that Petitioner was already a candidate for spine surgery prior to the work accident, and the medical records reviewed by Respondent’s IME physician revealed Petitioner had undergone placement of a trial intrathecal pain pump in the lumbar region in October of 2021. On October 13, 2021, approximately 16 weeks before the work accident, it was recorded that Petitioner wished to proceed with permanent implantation of the pain

pump. The last treatment note indicated that Dr. Reis's office would seek pre-approval for the permanent pain pump. I therefore find that Petitioner has failed to provide credible evidence supporting the claimed aggravation or acceleration of her pre-existing lumbar spine condition.

For the above reasons, I partially dissent from the majority's opinion and would reverse the Arbitrator's causation finding for the lumbar spine condition and would vacate the prospective medical benefits awarded for the lumbar disc replacement recommended by Dr. Gornet.

/s/ Kathryn A. Doerries

Kathryn A. Doerries

December 29, 2025

ILLINOIS WORKERS' COMPENSATION COMMISSION
DECISION SIGNATURE PAGE

Case Number	22WC013581
Case Name	Rose Burris v. City of Cairo
Consolidated Cases	
Proceeding Type	19(b) Petition Remand Arbitration
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	27
Decision Issued By	Bradley Gillespie, Arbitrator

Petitioner Attorney	Thomas Rich
Respondent Attorney	Patrick Keefe

DATE FILED: 2/28/2025

/s/ Bradley Gillespie, Arbitrator
Signature

THE INTEREST RATE FOR THE WEEK OF FEBRUARY 25, 2025 4.18%

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)

Rose Burris
 Employee/Petitioner

Case # **22** WC **13581**

v.

Consolidated cases: _____

City of Cairo
 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 **Bradley Gillespie**, Arbitrator of the Commission, in the city of **Mt. Vernon, Illinois**, on **December 11, 2024**. 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, **02/03/2022**, 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 **\$35,360.00**; the average weekly wage was **\$685.35**.

On the date of accident, Petitioner was **65** 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 **\$1,044.34** for TTD, **\$0** for TPD, **\$0** for maintenance, and **\$0** for other benefits, for a total credit of **\$1,044.34**.

Respondent is entitled to a credit of **\$37,276.77** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of \$456.90/week for 2 2/7 weeks, commencing July 6, 2022 through July 21, 2022, as provided in Section 8(b) of the Act.

Respondent shall pay the reasonable and necessary medical services outlined in Petitioner's group exhibit, 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 authorize and pay for the prospective treatment recommended by Dr. Bradley and Dr. Gornet, including, but not limited to, right total knee arthroplasty and lumbar spine disc replacement.

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.

Bradley D. Gillespie

Signature of Arbitrator

February 28, 2025

CT scans of the chest, abdomen and pelvis were performed which showed no acute intrathoracic findings. (PX 3 pp. 13-14) A CT of the cervical spine showed status post ACDF at C4-5, previous interbody fusion at C5-6 and C6-7, status post C4 through T2 posterior fixation, mild C3-4 and moderate C7 through T1 degenerative disc disease, and no evidence of acute osseous injury to the cervical spine. (PX 3 p. 15) A CT of the head showed no evidence of acute intracranial process. (PX 3 pp. 15-16) X-rays of the right elbow and right forearm showed no acute osseous abnormality. (PX 3 pp. 16-17) X-rays of the right knee showed no acute osseous abnormality and mild to moderate tricompartmental osteoarthritis. (PX 3 p.17) An initial musculoskeletal assessment by Renee Hendrickson, RN, showed pain to the right side of Petitioner's body in her hip, right knee, and neck. (PX 3 p. 21)

Petitioner's diagnoses included contusions of the right elbow, right knee, and rib on the right side, pain in the right knee and elbow, cervical disc degeneration in the cervicothoracic region, and cervicalgia. (PX 3 p. 4) She was given a prescription for Tramadol and was instructed to follow up with her physician.

On February 10, 2022, Petitioner presented to Regional Primary Care, where she saw nurse practitioner Emily Greenley. (PX 5 p. 2) NP Greenley noted that Petitioner presented for a work comp visit due to a fall on February 3, 2023. *Id.* She reported symptoms of right shoulder pain which was sharp and radiating. *Id.* Her pain was aggravated by walking and standing, and her symptoms included decreased mobility and swelling. *Id.* Her pain radiated from her right shoulder to her left rib, left hip and down to her knee. (PX 5 p. 2)

On exam, she had diffuse tenderness to her right trapezius and to her anterior right knee. (PX 5 p. 5) She was guarded, and the exam was limited due to pain. *Id.* She reported that her right knee pain was increasing, even with rest. *Id.* A meniscus injury was suspected, and NP Greenley ordered an MRI of the right knee. *Id.* She noted that if same was positive, she would refer to orthopedics. (PX 5 p. 5) The assessments included strain of the right trapezius, neck pain, and acute pain of the right knee. *Id.*

An MRI of the right knee was performed on March 4, 2022, at Cape Radiology Group, which showed a complex tear of the medial meniscus with flap formation and extrusion of the body related to loss of hoop containment with a small parameniscal cyst. (PX 4) There was minimal blunting of the free edge of the lateral meniscus at the posterior horn, tricompartmental osteoarthritis, joint effusion with small loose bodies posteriorly, a popliteal cyst, a low to intermediate grade sprain of the MCL, sprain/partial thickness tear of the adjacent medial patellar retinulum complex, minimal lateral tilt of the patella, mild patellar/quadriceps tendinosis, and subcutaneous edema without drainable fluid collection. *Id.*

Petitioner returned to NP Greenley on March 25, 2022, and reported that her pain was constant, had worsened, and was present in her neck, bilateral shoulders, right arm, right upper back, right mid back, and right hip, with radiation into her right upper arm, right elbow, right

forearm, right wrist, right hand and right thumb. (PX 5 p. 9) It was noted that the onset was seven weeks prior, and she was present for a work comp follow up. *Id.*

On exam, Petitioner had guarded and limited range of motion in her neck due to pain, and pain when her right arm was raised above her head. (PX 5 p. 12) Her neck pain radiated to her bilateral shoulders and arms, right worse than left. (PX 5 p. 14) She reported that her symptoms caused her to have pain when completing her tasks at work. *Id.* She also reported pain in the thoracic spine and right hip, and PA Greenley noted that this might be from the injury to Petitioner's right knee, for which Petitioner was compensating. *Id.* A CT of Petitioner's cervical spine was ordered and it was recommended that she keep the appointment with orthopedics for her knee. *Id.* She was taken off work pending her cervical spine MRI results. (PX 5 p. 14)

On March 31, 2022, Petitioner presented to the Orthopedic Institute of Southern Illinois, where she was seen by PA John Nugent for right knee pain, swelling, and instability. (PX 6 p. 4) She indicated that her symptoms had been acute and traumatic, and began on February 3, 2022 with an injury at work as a result of a fall. *Id.* Her symptoms were constant and unchanged, and she stated that they were moderate to severe. *Id.* Her pain level was at a 7/10 and she described same as aching, sharp and stabbing. *Id.* Under review of symptoms, Petitioner was positive for difficulty walking, headache, paresthesia, back pain, bone/joint symptoms, muscle weakness, and neck stiffness. (PX 6 p. 5)

On exam of the right knee, it was noted that Petitioner ambulated with a slow gait and was protective of her right leg. *Id.* She had discomfort over her buttock, and flexion of the hip and knee, and dorsiflexion of the foot resulted in radiating pain down her leg just past the knee. *Id.* She had discomfort over her lateral thigh, reduced quad strength, crepitus with motion, discomfort with dynamic patellar compression testing, discomfort along the medial aspect of her knee, mild effusion. *Id.* She had old, well-healed arthroscopy portals. (PX 6 p. 5)

PA Nugent's assessment was pain in the right knee, acute low back pain, tear of the medial meniscus of the right knee, and primary osteoarthritis of the right knee. (PX 6 p. 6) His impression was that Petitioner had a fall at work on ice on February 3, 2022, had a rotational injury to her knee, as well as neck, shoulder, back, and right hip complaints. *Id.* He noted that she had a right knee arthroscopy in 2014, recovered from same and did well up until her recent fall. *Id.* He felt that her findings were suggestive of a medial meniscus tear and arthritic complaints. *Id.* He recommended physical therapy and performed an aspiration and injection procedure that day in the office. (PX 6 p. 6) PA Nugent noted that Petitioner's low back and hip complaints were keeping her knee aggravated, and he suggested physical therapy for her back as well as a Medrol dose pack. *Id.* She requested to return to work full duty and was allowed to do so. *Id.* She was instructed to return in four weeks. *Id.*

Petitioner performed physical therapy at Diversified Rehab from April 8 through April 27, 2022. (PX 7 p. 9) At Petitioner's initial therapy examination, she reported that she fell on the ice

on February 3, 2022, and that her entire right side hurt. *Id.* She reported pain in her neck and shoulders, down her back, in her hip, and down her leg. *Id.* She indicated that she had a shot in her knee, which helped for two days. *Id.* It was noted that her right hip pain was constant, sharp, hot and radiating, and she was unable to sleep well or lay on her right side. (PX 7 p. 9)

On April 28, 2022, Petitioner returned to the OISI, where she saw Dr. John Wood. (PX 6 p. 10) He noted that Petitioner had symptoms of right knee pain and pain on the right side, which had been acute and traumatic, and began two months prior with an injury at work. *Id.* Petitioner indicated that her symptoms began as a result of a pivoting motion. *Id.* Dr. Wood's assessment was an acute medial miscal tear that occurred in February with a twisting injury while at work. *Id.* He noted she did have some degenerative changes. (PX 7 p. 12) He indicated that non-operative treatment of medication, ice, bracing, topical agents as well as a cortisone injection had been performed. *Id.* He noted that the injection helped for a couple of days, and physical therapy was not helping. *Id.* He indicated that she had underlying arthritis, but the sharp pain made up for the majority of her pain. *Id.* He felt that an arthroscopy was reasonable for the sharp catching pain, but he indicated the aching pain would persist. (PX 7 p. 12) He indicated that Petitioner might need viscosupplementation or even total knee replacement sooner rather than later. *Id.*

On May 19, 2022, Petitioner presented to the office of Dr. Matthew Bradley with symptoms of right knee and shoulder pain. (PX 8 p. 2) He noted that on February 3, 2022, Petitioner slipped on some ice in a parking lot while at work and described twisting and landing on the anterior aspect of her knee. *Id.* He took the history of her subsequent medical treatment. *Id.* He noted that her shoulder pain had improved since her fall and was mild at that time; however, her right knee pain persisted. *Id.* She reported that in 2014, she suffered a medial meniscus tear, underwent arthroscopy and debridement, and had not had significant knee pain since her recovery, nor had she sought medical attention with regard to her previous meniscus tear since 2014. (PX 8 p. 2)

On exam of the right shoulder, she had positive impingement signs and 4++/5 rotator cuff strength. *Id.* Exam of her right knee showed medial pain to palpation and positive McMurray's testing. (PX 8 p. 3) X-rays of the right knee showed moderate to severe medial joint space narrowing and small osteophytes. *Id.* Dr. Bradley's assessment was right knee medial meniscus tear. *Id.* He indicated that Petitioner had tried and failed nonoperative treatment and had symptoms of mechanical catching and clicking within her knee. *Id.* Surgical intervention in the form of a medial meniscectomy was discussed and planned. (PX 8 p. 3) Dr. Bradley noted that Petitioner could continue to work full duty. *Id.*

On June 27, 2022, Petitioner returned Dr. Bradley and reported right upper extremity numbness, tingling and pain, as well as right groin pain. (PX 8 p. 5) She stated that all her symptoms had been present since her fall on February 3, 2022. *Id.* She felt the right groin pain and the right upper extremity numbness, tingling and burning were worsening. *Id.* She was scheduled to have her right knee scoped the next Wednesday and wanted to be evaluated prior to her knee surgery to be sure there was nothing that needed to be done prior to same. *Id.*

Exam of the right shoulder showed positive impingement signs, and exam of the right hip was positive for groin pain. (PX 8 p. 5) X-rays of the right shoulder showed mild AC joint degenerative disease and cervical hardware. (PX 8 p. 6) X-rays of the right hip showed mild degenerative joint disease. *Id.* Dr. Bradley's assessment was right hip labral tear, right upper extremity radiculopathy and right knee meniscus tear. *Id.* With respect to her right upper extremity pain and burning, he did not believe same was emanating from her shoulder or upper extremity but was likely was coming from her neck. *Id.* He noted that she had a history of multiple neck surgeries. (PX 8 p. 6) He provided a referral to Dr. Matthew Gornet for evaluation of right upper extremity radiculopathy. *Id.*

With respect to the right hip, he felt that her physical examination was consistent with a labral tear and noted that her mechanism of injury was consistent with the same. *Id.* He recommended a right hip injection and indicated that if her pain recurred, consideration would be given to an MRI. *Id.* He did not feel that the diagnoses in her right hip and right upper extremity necessitated delaying her right knee surgery. (PX 8 p. 6)

On July 6, 2022, Petitioner underwent a right knee arthroscopic partial medial meniscectomy, chondroplasty of the medial femoral condyle, and trochlea chondroplasty. (PX 9 pp. 2-4) Intraoperatively, Dr. Bradley noted an oblique tear to the junction of the posterior horn and mid body of the medial meniscus that appeared to be subacute versus chronic, as there was some fraying noted. (PX 9 p. 2) The articular surface of the medial tibial plateau showed grade II changes as well as grade III changes to the medial femoral condyle. *Id.* There was loose flat-type cartilage in the area of the tear at the medial aspect. *Id.* The trochlea showed grade III changes with some fraying of the edges and unstable cartilage. *Id.* There were grade II changes to the lateral tibial plateau and lateral femoral condyle, and intermittent areas of grade III changes were appreciated. (PX 9 p. 2) Dr. Bradley noted that Petitioner required excision of 75% of the mid body and posterior horn of the medial meniscus. *Id.*

Petitioner returned Dr. Bradley on July 21, 2022, and reported that she was doing well following her arthroscopy. (PX 8 p. p. 11) Dr. Bradley recommended several weeks of physical therapy, as Petitioner's quadriceps was weak, and she was having difficulty reaching full extension. (PX 8 p. 12) She felt that she could complete her job requirements without significant pain or risk of injury to herself or others, and he allowed her to return to full unrestricted duty. *Id.*

Petitioner performed postoperative physical therapy on her right knee at Diversified Rehab from August 3, 2022, through September 8, 2022. (PX 7)

On September 12, 2022, Petitioner returned to Dr. Bradley and reported generalized achiness and stiffness in her knee in the morning and after prolonged standing. (PX 8 p. 13) She also had symptoms of right hip and groin pain that had been present since her work accident; however, she felt that everyone had been more focused on her knee. *Id.* She stated that her pain had not changed much and that there were certain positions, such as flexion with internal and

external rotation, that created pain. *Id.* Her greatest concern was the pain in her groin area. *Id.* Dr. Bradley's assessment was right knee inflammation status post arthroscopy and right hip pain. (PX 8 p. 14) An injection was performed to Petitioner's right knee that day in the office and he instructed her to continue with physical therapy. *Id.*

With respect to her right hip, Dr. Bradley noted that same was consistent with a labral tear, and that her mechanism of injury was consistent with this. *Id.* He ordered an MRI of the right hip to evaluate a possible labral tear, as she indicated that her pain had been unchanged since her fall. *Id.* He indicated that her hip x-rays did not show significant degenerative disease or fractures. (PX 8 p. 14) He continued her on full duty work. *Id.*

Petitioner underwent an MRI arthrogram of her right hip on September 19, 2022, which showed enthesopathy of both gluteus minimus and medius tendons at the greater trochanter without evidence of tear, and hamstring origin enthesopathy with intra-substance partial tearing without evidence for retraction. (PX 10 p. 3)

Petitioner returned to Dr. Bradley on October 6, 2022, and reported heaviness with numbness and tingling through her shoulder to her hand. (PX 8 p. 16) She noted this had been present since her slip and fall, but she felt it was coming from her shoulder. *Id.* When further questioned, she stated that she had pain at the base of her neck and upper trapezius. *Id.* He noted that Petitioner's hip pain had changed to a warm feeling going from her low back and buttock area down to her foot. *Id.* She denied interval trauma. (PX 8 p. 16) He reviewed her hip MRI and noted that it showed a strain; however, he did not feel that this explained her symptoms. (PX 8 p. 17) He felt her symptoms were more specific to a central spine type issue in both the right upper and lower extremities. *Id.* He noted that Petitioner thought she injured her shoulder and hip and did not link this to a potential neck or back problem. *Id.* He stated, "We again reviewed the MRI scan of her knee which clearly showed some tears to her meniscus which continues to bother her; however, given her more defined symptoms, this seems to be more central spine related" and he recommended an evaluation with a spine surgeon prior to moving forward with any treatment to her knee or hip. *Id.*

That same day, Petitioner was seen in the office of Dr. Matthew Gornet by physician's assistant Nathan Collins, who noted that she had pain to the base of her neck into her bilateral but more to her right trapezius, as well as to her right shoulder. (PX 11 pp. 2-4) Her symptoms radiated into her right scapula, down her right arm to her elbow, and she had numbness and tingling into her right hand. (PX 11 p. 2) This was accompanied by frequent headaches. *Id.* She also had low back pain central to both sides, hips, and buttocks, but greater on the right with intermittent numbness and tingling down her right leg into her foot. *Id.*

PA Collins noted Petitioner's history of injury on February 2, 2022, when she slipped and fell. *Id.* She reported that she had immediate pain in her neck and back and that when she saw NP Greenley, she reported her neck, shoulder, and hip; however, the focus was on her right knee. *Id.*

She reported that when she saw Dr. Woods, she continued to complain about her neck and low back, but no treatment was ordered. (PX 11 p. 2)

Petitioner admitted to a motor vehicle accident in 2004 which resulted in an anterior fusion in her cervical spine, a second surgery for early adjacent level failure from her first surgery, and a posterior cervical fusion sometime later. (PX 11 pp. 2-3) PA Collins indicated that Petitioner recovered from this and would see her chiropractor for conservative care on an intermittent basis. (PX 11 p. 3) She felt that her last treatment prior to her recent injury was about two years prior. *Id.*

On exam, Petitioner motioned to pain at the base of her neck, as well as in both trapezius and shoulders and right scapula. *Id.* She had a significant reduction in range of motion in her neck in all directions, and with flexion and extension in particular. *Id.* In her low back, she motioned to pain to both sides, hips, and buttocks, but in particular to her right hip, right buttock, and down her right leg into her posterolateral thigh with intermittent numbness and tingling in her foot. *Id.* She had decreased plantar flexion and dorsal flexion on the right at 4/5. *Id.*

PA Collins recommended MRIs of Petitioner cervical and lumbar spine as well as a plain CT of her cervical spine. (PX 11 p. 4) His working diagnosis was potential disc injuries to her cervical and lumbar spine. *Id.* He asked her to obtain the notes from her chiropractor as well as notes from her previous motor vehicle accident and operative notes. *Id.* He noted that assuming her history was correct, he believed her pain and symptoms, at least in their level of severity, were related to her February 3, 2022, accident. *Id.* The visit was discussed with Dr. Gornet. (PX 11 p. 4)

An MRI of Petitioner's lumbar spine was performed at MRI Partners of Chesterfield on December 15, 2022, which showed midline protrusions at L4-5 and L5-S1, larger at L4-5, with midline annular tears/fissures at the caudal aspects of both discs in the midline. (PX 10 pp. 4-5) There was mild to moderate bilateral L4-5 and mild L5-S1 foraminal stenosis with mild central canal stenosis at L4-5. (PX 10 p. 4) At L3-4, there was circumferential disc bulging with right lateral recess foraminal and separate left foraminal protrusions, resulting in moderate right-greater-than-left foraminal stenosis. (PX 10 p. 5) There were bilateral foraminal protrusions at L2-3, larger on the left than the right, resulting in mild to moderate left-greater-than-right foraminal stenosis. *Id.*

An MRI of Petitioner's cervical spine was performed that same day, which showed decompression and instrumentation changes at C4 through T2 without definite residual central canal stenosis. (PX 10 p. 6) There were midline annular tears/fissures and protrusions at C2-3 and C3-4. *Id.* There was mild central canal stenosis with moderate bilateral foraminal stenosis at C3-4 and mild central canal stenosis at C2-3. *Id.* A CT of Petitioner's cervical spine was performed that same day, which showed a solid fusion at C4 through T2 and central protrusions at C2-3 and C3-4 with mild central canal stenosis. (PX 12 pp. 2-3)

Petitioner returned to Dr. Gornet's office that same day with continued symptoms in her neck, right trapezius, and right shoulder, as well as back pain, and in particular to the right buttock, hip, groin, and leg. (PX 11 p. 5) Dr. Gornet noted that Petitioner continued to work for Respondent in the payroll department and that she had a sedentary job. *Id.* He noted that her symptoms related to her February 3, 2022, fall at work. *Id.* He reviewed her CT and MRI and believed there was disc injury at C3-4 above her previous fusion. *Id.* Her fusion appeared to be intact with the exception of the very bottom; however, he did not see lucencies around the screws or hardware breakage. (PX 11 p. 5) He believed that her lumbar spine MRI was consistent with disc injuries at L3-4, L4-5, and L5-S1, more so on the right, associated with high intensity zone signal changes and annular tears at L4-5 and L5-S1. *Id.* He recommended a steroid injection at these levels, and she was referred to Dr. Blake for same. *Id.* Dr. Gornet asked Petitioner to obtain her prior MRI scans taken years ago by Dr. Vaught. *Id.* He noted that her neck treatment was placed on hold. (PX 11 p. 5)

On January 24, 2023, Petitioner underwent an epidural steroid injection on the right at L4-5 with Dr. Helen Blake. (PX 13 p. 2-3) On February 7, 2023, Dr. Blake performed an epidural steroid injection on the left at L5-S1. (PX 13 pp. 4-5)

On March 16, 2023, Petitioner returned to Dr. Gornet, who noted that Petitioner had undergone injections with Dr. Blake; however, same did not provide sustained relief. (PX 11 p. 6) Petitioner's exam was unchanged and Dr. Gornet again noted that her December 15, 2022, MRI showed structural disc pathology of significance on the right with tears at L4-5 and L5-S1. *Id.* He recommended a discogram at L3-4 and L4-5 and noted that if L3-4 was negative, he would likely treat Petitioner at the levels of L4-5 and L5-S1. *Id.* He believed that Petitioner's symptoms and requirement for treatment were related to her accident. *Id.*

On April 12, 2023, Dr. Gornet performed a discogram at L3-4 and L4-5 with facet blocks. (PX 12 p. 3; PX 11 pp. 7-11) The results showed a non-provocative disc at L3-4 and a provocative disc at L4-5 with an annular tear. (PX 11 p. 8) A CT post discogram showed a right paracentral annular tear/fissure and 5.5 mm protrusion, resulting in ventral dural displacement with moderate right-greater-than-left foraminal stenosis at L4-5, left paracentral protrusion with no stenosis at L5-S1, disc bulge with mild to moderate foraminal stenosis at L3-4, and disc bulge with left foraminal protrusion and moderate left-greater-than-right foraminal stenosis at L2-3. (PX 12 p. 3)

Petitioner returned to Dr. Gornet on May 25, 2023. (PX 11 p. 12) He discussed her CT discogram and felt that her accident aggravated her underlying condition at L4-5 and L5-S1. *Id.* He recommended disc replacements at those levels. *Id.* He noted she had seen Dr. O'Boynick for an IME, but he did not have the report. *Id.* He instructed Petitioner to return in two to three months, and hoped surgery would be approved. (PX 11 p. 12)

Petitioner returned to Dr. Gornet on August 14, 2023, and discussed the recommended surgery. (PX 11 p. 13) Petitioner brought the IME from Dr. O'Boynick and asked Dr. Gornet to go through it with her. *Id.* Dr. Gornet acknowledged Dr. O'Boynick's statements regarding

Petitioner's history of previous problems as well as her current illness. *Id.* Dr. Gornet stated that there was no dispute that Petitioner had a pre-existing history of neck and lower back complaints and stated that she disclosed same on her first visit. *Id.* He discussed that the real question was whether Petitioner's slip and fall and striking her head could injure or aggravate her underlying condition. (PX 11 p. 13) Based on her medical records and the fact that she had a significant increase in symptoms, Dr. Gornet felt the answer was yes. *Id.* He noted that Dr. O'Boynick felt Petitioner's right upper extremity symptoms might be part of her work-related fall and Dr. Gornet agreed. *Id.* He noted that Dr. O'Boynick made his decisions without looking at the images. *Id.* He noted that they continued to seek approval for treatment. (PX 11 p. 13)

On November 20, 2023, Petitioner was seen in Dr. Gornet's office by physician's assistant Kyle McLafferty. (PX 11 p. 14) PA McLafferty noted that Petitioner's recommended lumbar disc replacement had not been approved. *Id.* Petitioner felt that her symptoms were slowly progressing, and PA McLafferty noted that a delay in her treatment might impact her overall outcome. *Id.* He noted that her neck was on hold. *Id.* She had complaints of right knee pain, and he referred her back to Dr. Bradley for same. (PX 11 p. 14) He noted that they continued to seek approval for her lumbar disc replacement. *Id.* Her exam remained unchanged, and PA McLafferty noted that Petitioner could continue to work full duty. *Id.* He indicated that her next follow up would be in several months, and the visit was discussed with Dr. Gornet. *Id.*

On December 21, 2023, Petitioner returned to Dr. Bradley for follow up on her right knee. (PX 8 p. 18-20) She reported increasing pain along the medial and central portion of her knee that had been present since surgery and had been getting worse with time. (PX 8 p. 18) Dr. Bradley's assessment was right knee pain with underlying chondrosis and exacerbation of her underlying degenerative disease. (PX 8 p. 20) He indicated that chondrosis was noted at the time of her surgery and that sometimes knee arthroscopy can cause ongoing pain from the underlying degenerative disease. *Id.* He recommended nonoperative treatment, including anti-inflammatories, activity modification, and a steroid injection, and the latter was completed in the office that same day. *Id.* He noted Petitioner could continue to work full duty. *Id.*

Petitioner returned to Dr. Bradley on May 24, 2024, for a follow up of her right knee pain. (PX 8 p. 21) He noted that following her arthroscopy, she never got back to her baseline pain level. *Id.* He stated they had been trying to treat her non-operatively and performed a steroid injection at her last visit, and while this helped on a temporary basis, her pain had since recurred. *Id.* X-rays performed that day showed tricompartmental arthritis, which was moderate-to-severe along the medial joint line and was almost bone-on-bone. (PX 8 pp. 22-23) Her exam showed medial pain to palpation, positive McMurray's with pain, and mild pain or crepitus with patellar compression testing. (PX 8 p. 22)

Dr. Bradley's assessment was post arthroscopic accelerated degenerative disease in the medial-greater-than-lateral knee. (PX 8 p. 23) He stated that Petitioner had significant advancement in her disease with bone-on-bone changes in the medial aspect. *Id.* He stated that she

was getting to a point where total knee arthroplasty would need to be considered. *Id.* Petitioner wished to attempt one more injection to see if she could obtain sustained pain relief from same. *Id.* Dr. Bradley noted that if she could not get greater than three months of sustained pain relief, knee replacement surgery would have to be considered. (PX 8 p. 23) An injection was performed that same day in the office and she was instructed to return in two-and-a-half to three months. *Id.*

Petitioner returned to Dr. Bradley on August 26, 2024, where she reported that her knee continued to worsen. (PX 8 p. 24) Her prior injection provided excellent pain relief, but only for two weeks. *Id.* Petitioner brought an IME by Dr. Nogalski with her, and she was concerned, as she told Dr. Nogalski that she had a steroid injection four days prior and that her knee was feeling quite well, so he did not have an accurate description of her knee. *Id.* She stated that Dr. Nogalski did not highlight same in the report, and she felt that he did not understand how she was doing on a day-to-day basis. *Id.*

Dr. Bradley noted that since Petitioner's surgery in July 2022, she had significant worsening of her degenerative disease with same being now bone-on-bone in the medial aspect of her knee. (PX 8 p. 26) In reviewing her operative report, he noted that she had grade II and III chondrosis, but not full thickness chondrosis. *Id.* However, she now had full thickness chondrosis. *Id.* He stated that she improved after surgery with the catching and clicking but she continued to have persistent pain, and same was supported by her medical records. *Id.* He noted that he never managed to get Petitioner back to her preinjury baseline pain level. (PX 8 p. 26) He did not have anything further to offer Petitioner besides a knee replacement. *Id.* He noted that she was having a difficult time walking secondary to pain and wished to move forward with surgery. *Id.* He reviewed Dr. Nogalski's report and stated that he disagreed with Dr. Nogalski in that Petitioner did not report significant knee problems prior to her injury. *Id.* He stated that since her injury, she had been unable to have any level of significant sustained pain relief. (PX 8 p. 26) He believed she did have pre-existing degenerative disease but had significant worsening of same since her injury at a rate greater than he expected had she not had surgery. *Id.* A right knee total arthroplasty was planned. *Id.*

SECTION 12 REPORT AND DEPOSITION OF DR. O'BOYNICK

At Respondent's request, Petitioner presented to the office of Dr. Christopher O'Boynick on April 18, 2023. (RX 1, Dep. Ex. 2) Dr. O'Boynick noted that on the date of the accident, Petitioner stepped onto the sidewalk to go into the building, fell on her right side, and experienced immediate soreness on the right side of her body after the fall. (RX 1, Dep. Ex. 2, p. 1) She reported that she did not notice pain until a few days later when she presented to the emergency room on February 5, 2022, due to right-sided pain in her neck, right upper extremity, and right lower extremity. *Id.* She reported that she injured her right knee, and that she was trying to protect her left knee following a left total knee arthroplasty. *Id.* She indicated that she made an appointment with a worker's compensation physician because she believed she might have torn something in her right knee, as her symptoms were similar to when she had torn her left meniscus in the past.

Id. She indicated that she notified worker's compensation that she experienced right hip pain; however, she thought this was a result of the tears in her knee. (RX 1, Dep. Ex. 2 p. 1) She described a c-shaped pain in the right hip with radiation into her groin and right lower extremity to her foot and indicated that she had frequent falls and difficulty with stairs. (RX 1, Dep. Ex. 2 pp. 1-2)

Dr. O'Boynick noted that Petitioner underwent surgery to repair the tears in her right knee and that while the pain in the distal portion of the lower extremity resolved, her right lower extremity pain did not improve much following her surgery. (RX 1, Dep. Ex. 2 p. 2) He noted that she described a burning sensation in the right buttock that began sometime after the fall, and that she had undergone injections at the recommendation of Dr. Gornet, which did not provide lasting relief of her lower extremity or back pain. *Id.* Dr. O'Boynick noted that Petitioner also had neck pain. *Id.* She provided a history of a motor vehicle accident several years prior, which was treated with disc replacement. *Id.*

On exam of Petitioner's back, Dr. O'Boynick noted that she had reproducible pain over the right greater trochanter. (RX 1, Dep. Ex. 2 p. 5) Her neck exam showed that she had 25 to 50% in all planes which was limited by pain. (RX 1, Dep. Ex. 2 pp. 5-6) He felt that she showed Waddell's signs. (RX 1, Dep. Ex. 2 p. 6) Her lower extremity examination revealed positive straight leg testing on the right with increased posterior thigh and knee pain radiating into the posterior buttock. *Id.*

Dr. O'Boynick reviewed Petitioner's prior medical records regarding her previous cervical and lumbar treatment and noted that she had a cervical discectomy and fusion at C5-6 and C6-7 in May 2005, and in 2008, she had an anterior cervical discectomy and fusion at C4-5 with hardware removal from C5 to C7. (RX 1, Dep. Ex. 2 p. 9) He noted that she had a right knee partial meniscectomy in July 2014. (RX 1, Dep. Ex. 2 p. 10) He noted that in November 2014, Petitioner presented to NP Riley for back pain that ran through her hips, legs, and feet. *Id.* A lumbar spine MRI from April 2014 showed a small disc bulge at L4-5 with mild central canal and foraminal narrowing and mild spondylosis at L4-5 and L5-S1. *Id.* An EMG nerve conduction study from April 2014 revealed chronic L5 radiculopathy with bilateral numbness and burning in Petitioner's feet. *Id.* Dr. O'Boynick noted that she underwent steroid injections at L5-S1 in December 2014 and that in January 2015, she reported weakness of the right tibialis anterior. (RX 1, Dep. Ex. 2 p. 11)

He noted that in March 2020, Petitioner had posterior neck pain with radiation down the left arm and secondary complaints of lower back pain with radiating into the left leg. *Id.* He noted that in May 2020, after undergoing chiropractic care, cervical traction and injection, Petitioner reached 100% improvement in her neck pain. (RX 1, Dep. Ex. 2 p. 12) In July 2020, Petitioner's pain increased, and she underwent laminectomies, foraminotomies, facetectomies at C7 through T1 and posterior fusion from C4 to T2, and she reported improvement following same. *Id.* He noted that in July 2021, Petitioner's left upper extremity radiculopathy had resolved with minimal

left C8 numbness. (RX 1, Dep. Ex. 2 p. 13) She still had posterior cervical paraspinal pain and requested physical therapy. *Id.* At that time, an MRI of her lumbar spine was ordered due to low back pain. *Id.*

Dr. O'Boynick noted that in August 2021, Petitioner reported back and leg discomfort which radiated to the buttocks, left leg, right knee, and bilateral feet. (RX 1, Dep. Ex. 2 p. 14) It was noted that she had giveaway bilateral leg weakness and was referred to neurophysiologists for an implantable device evaluation. (RX 1, Dep. Ex. 2 p. 15) In October 2021, Petitioner underwent an intrathecal pump trial which resulted in 50% improvement, and she wished to proceed with permanent implantation of a intrathecal pump. *Id.* Her exam at that time showed bilateral arm paresthesias, negative straight leg raises, negative Spurling's, and an antalgic gait. *Id.* There was no cervical thoracic or lumbar tenderness. *Id.*

The next records reviewed by Dr. O'Boynick were from Petitioner's February 5, 2022, emergency department visit following her work accident, and her medical treatment thereafter. (RX 1, Dep. Ex. 2 p. 15) He noted that there was no documentation of lumbar spine complaints until March 31, 2022; however, he indicated that her early treatment records from NP Greenley from February 10, 2022, and March 25, 2022, documented hip symptoms. *Id.*

Dr. O'Boynick opined that Petitioner's diagnoses included cervicalgia, right upper extremity radiculopathy, right-greater-than-left bilateral trapezium pain, right-greater-than-left shoulder pain, and interscapular pain. (RX 1, Dep. Ex. 2 p. 20) He indicated her imaging diagnoses included mild C3-4 spinal stenosis and degenerative disc bulge at C3-4, status-post C4 to T2 instrumented posterior spinal fusion with selective decompression at C7 through T1 and status post C4 to C7 anterior cervical discectomy and fusion. *Id.* With respect to her lumbar spine, her diagnoses included low back pain, right lower extremity pain, radiculopathy, trochanteric bursitis, degenerative changes at L4-5 and L5-S1 with annular tear, and low back pain in the setting of facet arthritis. *Id.*

With respect to her cervical spine, he believed her diagnoses were all pre-existing with the exception of the right upper extremity radiculopathy. *Id.* He stated that the most recent notes in reference to her ongoing cervical complaints was August 25, 2021. (RX 1, Dep. Ex. 2 p. 20) He felt that her right upper extremity radiculopathy was a new diagnosis that might stem or flow from her fall, as there did not appear to be a persistent report of right radicular symptoms in the records he reviewed. *Id.*

With respect to her lumbar spine diagnoses, he noted that she was seeking chronic pain treatments in October 2021 and was recommended for a permanent intrathecal pain medicine delivery device due to her chronic low back pain and bilateral lower extremity pain. *Id.* He noted there was EMG evidence from 2014 of chronic right L5 radiculopathy, and he felt that these correlated with her present symptoms. *Id.* Given her medical history, Dr. O'Boynick felt that her conditions in her lumbar spine were pre-existing. (RX 1, Dep. Ex. 2 p. 20)

He stated that her treatment, including imaging and medications, were reasonable and necessary for the workup of cervical pain in the setting of a fall. (RX 1, Dep. Ex. 2 p. 21) With respect to her lumbar spine, he stated that physical therapy activity modification, medication, and imaging were all reasonable and necessary from the workup of a symptomatic lumbar spine; however, he felt that her complaints were the same as the ones she had pre-injury for which she was seeking pain management. *Id.* He felt there was limited change on her lumbar MRI scan based upon the reports and felt that the steroid injections performed by Dr. Blake were not reasonable or necessary because Petitioner had a pre-existing condition for which she was already seeking treatment with pain management. *Id.*

He felt that Petitioner might require further treatment and workup flowing from her injury with respect to her right upper extremity radicular complaints and indicated that Petitioner might benefit from physical therapy or from a bilateral upper extremity NCV/EMG. (RX 1, Dep. Ex. 2 p. 21) He felt that selective nerve root blocks might be recommended in an attempt to treat her radicular pain. *Id.*

With respect to her remaining diagnoses, he felt that evaluation and treatment directed to her cervical and lumbar spines would be reasonable and necessary, but he did not feel these were causally related to her work injury, as they were pre-existing. *Id.* He felt that she could continue to work full duty as a payroll clerk. *Id.* He noted that he did not have access to nor had he been provided any of the imaging of her cervical or lumbar spine prior to the injury date, and therefore could not perform a direct comparison of the post injury MRIs to those prior to her injury date. (RX 1, Dep. Ex. 2 p.22)

On September 7, 2023, Dr. O'Boynick authored an addendum report. (RX1, Dep. Ex. 3) He stated that he had reviewed Petitioner's March 25, 2020, and October 16, 2020, cervical spine MRIs, her August 5, 2020, and October 16, 2020, cervical spine CT scans, her July 20, 2021 lumbar spine CT scan and her August 5, 2021 lumbar spine MRI scan. *Id.*

He compared Petitioner's August 5, 2021, and December 15, 2022, lumbar MRI scans and felt that there were no changes to the L4-5 protrusion or annular tear. (RX1, Dep. Ex. 3 p. 2) He felt there were minimal changes across L4-5 five and L5-S1. *Id.* He felt the protrusion at L5-S1 improved in the later MRI but admitted that Petitioner's annular tear at L5-S1 appeared to be more visible on the post-accident MRI. *Id.*

He agreed with Dr. Gornet that L4-5 was a pain generator but felt that this level was causative of her pain over the course of her pre-injury treatment. *Id.* He felt that Petitioner's discogram was reasonable and necessary but was not causally related to her work injury because he likely would have suggested it prior to her injury date. (RX1, Dep. Ex. 3 p. 3)

He compared Petitioner's October 16, 2020, and December 15, 2022, cervical MRI scans and felt that there were similar findings at C2-3 and C3-4. *Id.* He stated there appeared to be some change in the right paracentral region at C3-4 with a broad-based but non-compressive disc bulge.

He was unclear if her new diagnosis of right upper extremity radiculopathy was related to the changes. *Id.* He stated that his opinions regarding her cervical and lumbar spine were unchanged from his previous report. *Id.*

Dr. O'Boynick testified via deposition on November 8, 2023. (RX 1) On direct examination, his testimony was consistent with his reports. He performs one to two Section 12 examinations per week at the request of employers. (RX 1 pp. 21-22) He agreed that he did not see any indication of Waddell's signs or malingering in the many pages of medical records he reviewed and admitted that Waddell's signs are not 100% accurate (RX 1 pp. 26-27)

With regard to Petitioner's discogram, he testified that "it would be nice to have a discogram at L5-S1 just to get correlation" but surmised that it was not included in Petitioner's discogram because Dr. Gornet thought the disc problem was going to be surgical no matter what. (RX 1 pp. 34-35)

He testified that if Petitioner failed selective nerve root blocks for her cervical radiculopathy, he would consider a posterior fusion surgery at C3-4. (RX 1 pp. 25-26) With respect to Petitioner's lumbar spine, although he did not agree on causation, he felt that the L4-5 and L5-S1 lumbar disc replacement could provide Petitioner relief of her symptoms. (RX 1 p. 29)

SECTION 12 REPORT AND DEPOSITION OF DR. NOGALSKI

At Respondent's request, Petitioner submitted to a Section 12 examination with regard to her right knee with Dr. Michael Nogalski on May 29, 2024. (RX 2, Dep. Ex. 2) He took the history of Petitioner's February 3, 2022, fall wherein she reported that her right foot went under her and she fell on her right side. *Id.* He noted her subsequent medical treatment. (RX 2, Dep. Ex. 2 pp. 1-2) She reported that after the July 2022 arthroscopic surgery, her pain never stopped and her knee became worse the more she walked on it. (RX 2, Dep. Ex. 2 p. 2) She reported continued pain in her knee and pain from her hip and buttock area down to into her knee and leg, as well as general numbness and pain. *Id.* She indicated she had pain all over the knee and could not localize it to one distinct region. *Id.* She also noted stiffness, tightness, and difficulty with standing and walking for long periods. *Id.* She also noticed tingling and numbness and night pain in her leg.

On exam of the right knee, Petitioner had trace effusion, pain with deep flexion in the anterior knee related to capsular tightness, 5-/5 flexion and extension strength, pain with maximal muscle testing with flexion, positive grind test, mild fullness to the popliteal region, and pain along the medial and lateral joint lines with palpitation and patellofemoral compression. (RX 2, Dep. Ex. 2 p. 3) There was mild patellofemoral crepitans and 2+ pitting edema in both lower extremities. *Id.* There was decreased sensation below the mid shin down the foot in a nonspecific pattern. *Id.* X-rays taken that day showed near complete medial joint space narrowing with relative neutral vagus alignment, and some tricompartmental osteoarthritic changes with lateral osteophytes and inferior superior patellofemoral osteophytes. *Id.*

Dr. Nogalski reviewed prior medical records and noted that Petitioner had a right knee arthroscopy on in July 2014, and an emergency department visit in December 2018 when she struck her knee against a drawer at work. (RX 2, Dep. Ex. 2 pp. 3-4) He also reviewed medical records subsequent to Petitioner's work accident. *Id.* His impression was osteoarthritis of the right knee and status post right knee strain on February 3, 2022, as well as bilateral lower extremity neuropathy and edema. (RX 2, Dep. Ex. 2 p. 6) He stated that her current condition of osteoarthritis was not causally related to her February 3, 2022, accident. (RX 2, Dep. Ex. 2 p. 7) He felt that she was not in need of further treatment for conditions that were related to her work accident and felt that she had reached MMI for same as of her October 6, 2022, evaluation with Dr. Bradley, and stated, "A 10/06/2022 evaluation by Dr. Bradley was for her hip. She had multiple complaints at that time, but did not note or state any right knee pain or problems." *Id.* He stated that she had osteoarthritis, and her symptoms were continuing from her pre-existing condition. *Id.*

Dr. Nogalski testified via deposition on October 28, 2024. (RX 2) On direct examination, his testimony was consistent with his report. He testified that he has retired from the practice of medicine and was now performing exams and records reviews, of which he performs one to two per week. (RX 2 pp. 15-16)

He believed that Petitioner sustained a strain of her knee, which he believed resolved in a matter of weeks. (RX 2 p. 17) He did not believe Petitioner sustained an aggravation of her pre-existing arthritic condition as a result of her fall. *Id.*

He did not have any records indicating that Petitioner had seen a physician for her knee from 2018 until the time of her accident. *Id.* at 17. Although he stated that the medication Petitioner was taking for other conditions overlapped to cover her knee, he admitted that he did not review any records which indicated Petitioner was prescribed medication which was specific to her knee. (RX 2 pp. 18-19)

He admitted that her 2018 episode of knee pain consisted of one emergency room visit and that there was no surgical recommendation at that time. (RX 2 p. 19) He admitted that following Petitioner's work accident, however, she was recommended for surgery with Dr. Wood. (RX 2 pp. 19-20)

DEPOSITION OF DR. MATTHEW BRADLEY

Dr. Bradley testified via deposition on September 25, 2024. (PX 17) Dr. Bradley is a board-certified orthopedic surgeon who performs 12 to 15 surgeries per week, three to five of which are joint replacement surgeries. (PX 17 pp. 4-5) On direct examination, his testimony was consistent with his medical records.

He testified that if an individual has arthritis in the knee and has a traumatic event, it can cause the arthritis to become active and symptomatic. (PX 17 pp. 16-17) He stated that in Petitioner's case, he scoped her knee, shaved her meniscus, and took away some of her shock

absorber, and that her postoperative increasing pain from degenerative disease is something he sees often and it is the result of both the injury and the treatment. *Id.* When asked why he did not perform a total knee arthroplasty to begin with, Dr. Bradley explained that if there is a reasonable chance of preserving a patient's own knee, he tries to do that. (PX 17 pp. 18-19) Therefore, he performed a simple surgery to address Petitioner's meniscus tear, hoping that same would provide her enough pain relief to return to baseline, however, it did not. *Id.*

With respect to causation, he stated:

I think the injury she sustained when she slipped and fell did two things. One is it tore her meniscus, and two is it exacerbated her underlying degenerative disease. I think all of our nonoperative and operative treatments were designed to treat those two diagnoses. I think we successfully treated the meniscus tear. She is not having the catching, clicking, and locking. Unfortunately, I don't think we have addressed the exacerbation, which I would now characterize as an aggravation of some chronic degenerative disease. And so I think everything was reasonable as it related to her injury, but I still think there is some more to go, including a knee replacement. (PX 17 pp. 20-21)

He testified that when he first saw Petitioner, she had narrowing of her joint space but she still had joint space. (PX 17 p. 21) When he saw her x-rays two years later, however, she had no joint space, was almost bone-on-bone, and had bone-on-bone changes in some particular areas. *Id.* When asked what he attributed to Petitioner's loss of cartilage, he explained:

So arthritis is a disease that you can't really cure unless you cut out a patient's joint. But arthritis can be pretty kind of quiet, almost like in hibernation, where it's present but it's not really painful, it's not really progressing, but some sort of a trauma or some sort of an event can aggravate it. I always tell my patients it's like having a pitbull sleeping in the corner of the room. If you leave the pitbull alone, no big deal. The pitbull is there, but it's not creating a problem. But if you go up and you kick the pitbull, now you have got a real problem. Now you got a pitbull that's awake and mad and angry. And that's kind of what arthritis is. And so just like the pitbull, our first thing to do is trying to calm the arthritis down. You try to give the pitbull a bone or a dog treat, and hopefully it will go back to bed. You know, you try to do the same thing with arthritis, but sometimes you can't get the pitbull to go back to sleep, and you end up having to replace the entire knee, and I think that's exactly what happened here, is that we treated the meniscus tear okay but we aggravated the arthritis, and I just couldn't get it to go back to sleep. (PX 17 pp. 22-23)

He testified that he reviewed Dr. Nogalski's report, and he agreed with Dr. Nogalski that Petitioner's symptoms were due to her arthritis. (PX 17 pp. 25-26) However, he did not believe that Petitioner would need a knee replacement regardless of her February 2022 injury. (PX 17 pp. 27-28) He testified that there are hundreds of thousands of people with arthritis like Petitioner's that do not need a knee replacement because they do not have pain and symptoms associated with same. *Id.* He stated:

So I can't predict the future, I can't tell you what's going to happen with Ms. Burris in the future, so I can't say for certain whether she would or would not need this in the future. I could say she didn't need it before her injury, and she certainly needs it now, and I think Dr. Nogalski and I both agree to that. And I think even Dr. -- the orthopedist that saw her before I saw her said that she may very well need it. So I think everybody is in agreement with the treatment. I just -- I disagree with the fact that she 100 percent would have needed this had she not been injured. I don't know that anybody can say that. (PX 17 pp. 27-28)

He testified that Petitioner's meniscus tear was subacute with some fraying and explained that by the time he operated on her, it was five months after the accident, and her findings were consistent with a meniscus tear that was five or six months old. *Id.* at 32, 33. He stated it was not a degenerative meniscus tear. *Id.* at 32, 33.

Dr. Bradley testified that he was proposing surgery to treat Petitioner's pain and symptoms. (PX 17 pp. 36-38) He was asked if Petitioner's fall was the causative factor giving rise to her symptoms, and he stated he believed that her symptoms were a combination of her fall causing the arthritis to become active and tear the meniscus, and also from the surgery, wherein 75% of her meniscus was removed, and that this put more weight and pressure on the inside of her knee. (PX 17 pp. 39-40). Therefore, he felt that both her injury and her subsequent treatment led to her current condition. *Id.*

Dr. Bradley felt that if Petitioner underwent a total knee replacement, her prognosis would be excellent and that she would be more functional. (PX 17 p. 23)

DEPOSITION OF DR. MATTHEW GORNET

Dr. Gornet testified via deposition on September 28, 2023. (PX 16) Dr. Gornet is an orthopedic surgeon with a subspecialty in spine surgery. (PX 16 p. 5) He sees 100 to 120 patients per week and performs five to 10 surgeries each week. (PX 16 p. 6)

Dr. Gornet testified that Petitioner admitted to a history of previous problems in her neck and low back, but they focused more on the exact issues with her neck at the time of her initial exam. (PX 16 pp. 11-12) He did not believe she had prior lumbar surgery, but he believed she had an evaluation. (PX 16 p. 12)

With respect to Petitioner's mechanism of injury, Dr. Gornet stated that the fall could cause disc injury in the cervical or lumbar spine and that a sudden mechanical load could disrupt a disc that had pre-existing degeneration. *Id.* at 12, 13. He stated in the case of a fusion, patients are more likely to injure the adjacent areas. *Id.* at 12, 13.

With respect to causation, he stated that Petitioner had neck and back issues prior to her injury; however, in their level of severity, he felt her symptoms were caused by her February 3,

2022 accident. (PX 16 pp. 14-15) He felt that at a minimum, she aggravated her underlying condition but also had the potential for disc injuries. *Id.*

Dr. Gornet agreed that the physicians with whom Petitioner was treating in 2021 were perhaps not the most qualified to recommend appropriate treatments which could have included lumbar spine surgery; however, his opinions regarding causation of Petitioner's lumbar and cervical spine remained unchanged. (PX 16 pp. 43-44)

Dr. Gornet was asked if Petitioner's cervical spine treatment in 2021 was consistent with what she told him about her pre-accident symptoms, and he stated:

Well, yes. In the sense she never once said she didn't have neck pain, and after the surgery she had. It would be unlikely that she would ever be pain-free. So that -- taking medications and her complaints of what she's describing were not inconsistent with my knowledge of treating like or similar patients or her description. The only thing I have is that she got substantially worse, and I think it was -- and I have to check back in the notes -- increasing right shoulder arm symptoms, so. (PX 16 p. 32)

Dr. Gornet clarified that his causation opinion was based on Petitioner's history as well as his knowledge of treating like or similar patients, the refractory, the treatment, and the fact that Petitioner never had a recommendation for surgery. (PX 16 pp. 24-25)

He was confident that Petitioner had symptoms in the past; however, the issue was whether or not her symptoms worsened. *Id.* at 33. He was not aware of any new recommendations for surgery to Petitioner's neck since her last cervical surgery. (PX 16 p. 22) He testified that he had the lumbar spine MRI that was taken prior to her fall and testified that in 2021, Petitioner did have disc pathology at L4-5 and L5-S1, but that she aggravated her condition. (PX 16 p. 19) He testified that although her records did not document complete resolution of her symptoms, there was nothing in the treatment records that documented a recommendation for surgical intervention. (PX 16 p. 41)

Dr. Gornet testified that he agreed with Dr. O'Boynick in that Petitioner had a pre-existing history of neck and low back complaints and stated that this was disclosed on her initial visit. (PX 16 pp. 20-21) He felt that the real issue where he and Dr. O'Boynick disagreed was whether the slip, fall and the striking of Petitioner's head could aggravate or injure her underlying condition, which was more tolerable prior to her accident. *Id.* Dr. Gornet opined that the fall could easily do that, as he has seen in multiple cases and situations. *Id.* He did not disagree that Petitioner had pre-existing issues, but believed that her fall aggravated her underlying condition. *Id.*

He testified that Petitioner had already failed conservative treatment, including therapy and injections. (PX 16 p. 22) He did not expect Petitioner to improve without the lumbar surgery, as she had obvious disc pathology as demonstrated by her MRI and CT, and he stated that this would worsen over time. *Id.*

DOCUMENTARY EVIDENCE

An injury report from February 3, 2022, indicated that Petitioner slipped on ice covering the sidewalk and injured the right side of her body to include her shoulder, hip, knee, leg, and hand areas. (PX 15) The incident report was prepared by the city clerk, Lorrie Hesselrode. *Id.*

PETITIONER'S TESTIMONY

Petitioner was a member of the United States Air Force and retired prior to her employment with Respondent. (Tr. p. 22)

Petitioner was forthcoming that she had a prior injury to her right knee four to five years prior to her current accident, and that she had surgery on her right knee in 2014. (Tr. pp. 14-15, 22-23) She testified that at the time of her 2022 injury, she was not under any doctor's care or treatment and was not taking medication with regard to her right knee, nor was she missing time from work as a result of her prior injury. (Tr. pp. 15-16)

Petitioner acknowledged that prior to her work accident, she received periodic treatment to her low back, including injections and MRIs, and that she had prior neck surgery, including a fusion. (Tr. pp. 26-27)

With respect to her low back, she is desirous of undergoing the surgery recommended by Dr. Gornet and testified that her symptoms stay at a 6 or 7 on a scale of 1 to 10. (Tr. pp. 18-19) She stated that she goes "to bed all the time" for her symptoms, but it does not relieve the pain. (Tr. p. 19) She is not taking prescription medication for her symptoms and has tried over-the-counter medications, but they do not work. (Tr. pp. 19-20)

CONCLUSIONS OF LAW

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

"[I]t is for the Commission to determine which medical opinion is to be accepted, and it may attach greater weight to the treating physician's opinion." *Piasa Motor Fuels v. Industrial Comm'n*, 368 Ill. App. 3d 1197, 1206 (2006).

An employee is entitled to benefits where a second injury occurs due to treatment for the first. See *Shell Oil Co. v. Indus. Comm'n*, 2 Ill. 2d 590, 119 N.E.2d 224 (1954); *International Harvester Co. v. Indus. Comm'n*, 46 Ill.2d 238, 263 N.E.2d 49 (1970); *Lincoln Park Coal & Brick v. Indus. Comm'n*, 317 Ill. 302, 148 N.E. 79 (1925); *Harper v. Indus. Comm'n*, 24 Ill.2d 103, 180 N.E.2d 480 (1962), *Brookes v. Indus. Comm'n*, 78 Ill.2d 150, 399 N.E.2d 603 (1979); *Tee Pak, Inc. v. Indus. Comm'n*, 141 Ill.App.3d 520, 490 N.E.2d 170 (1986). "Every natural consequence that flows from an injury that arose out of and in the course of the claimant's employment is compensable unless caused by an independent intervening accident that breaks the chain of

causation between a work-related injury and an ensuing disability or injury.” *Vogel*, 354 Ill. App. 3d 780, 786, 821 N.E.2d 807, 812 (2005). Where the second injury occurs due to treatment for the first, there is no break in the causal chain. *International Harvester*, supra.

Furthermore, the law holds that differences between a claimant’s testimony and other parts of the records are not fatal to a claim. See *Danny Farris v. Phoenix Corp. of Quad Cities*, 11 I.W.C.C. 0610 (2011), aff’d by *Farris v. Illinois Workers’ Comp. Comm’n*, 2014 IL App (4th) 130767WC, 22 N.E.3d 54; *Jennifer Stronz v. Alexian Brothers Medical Center*, 07 I.W.C.C. 0289 (2007); *Jamie Blommaet v. Ford Motor Co.*, 06 I.W.C.C. 0682 (2006). A claimant’s testimony should not be expected to exactly mirror medical proofs due to the fact that the burden of proof is the preponderance of the evidence and inconsistency and error is inherent in the history taking process. *Blommaet*, 06 I.W.C.C. 0682 (2006); *Danny Farris v. Phoenix Corp. of Quad Cities*, 11 I.W.C.C. 0610 (2011), aff’d by *Farris v. Illinois Workers’ Comp. Comm’n*, 2014 IL App (4th) 130767WC, 22 N.E.3d 54.

The law holds that 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*, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 672-673 (2003). [Emphasis added]. Where a preexisting condition is present, Petitioner need only show that the prior condition was aggravated or the need for treatment accelerated. *Sisbro, Inc. v. Indus. Comm’n*, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 672-673 (2003); *Schroeder v. Illinois Workers’ Comp. Comm’n*, 2017 IL App (4th) 160192WC, 79 N.E.3d 833. Allowing a claimant to recover under such circumstances is a corollary of the principle that employment need not be the sole or primary cause of a claimant’s condition. *Land & Lakes Co. v. Indus. Comm’n*, 359 Ill. App. 3d 582, 834 N.E.2d 583 (2005). Employers are to take their employees as they find them. *A.C. & S. v. Industrial Comm’n*, 304 Ill. App. 3d 875, 710 N.E.2d 837 (1999) citing *General Electric Co. v. Industrial Comm’n*, 89 Ill. 2d 432, 434, 433 N.E.2d 671, 672 (1982).

“Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury.” -*Fierke v. Industrial Commission*, 309 Ill. App. 3d 1037, 723 N.E.2d 846 (2000). The law is clear that if a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Rock Road Constr. v. Indus. Comm’n*, 227 N.E.2d 65, 67-68 (Ill. 1967), 37 Ill. 2d 123; see also *Illinois Valley Irrigation, Inc. v. Indus. Comm’n*, 66 Ill. 2d 234, 362 N.E.2d 339 (1977).

A compensable aggravation occurs when a claimant’s need for surgery is accelerated. *Judith Wheaton v. State of Illinois/Choate Mental Health Center*, 13 I.W.C.C. 0467; *Bowman v. Gateway Reg’l Med. Ctr.*, 14 I.W.C.C. 1022; *Clutterbuck v. UPS*, 15 I.W.C.C. 0046; *Howard v. St. Clair Hwy. Dept.*, 16 I.W.C.C. 0187, modified 16 MR 106.

In the instant case, Respondent does not dispute that Petitioner suffered an accident wherein she slipped and fell, but disputes causation as to her injuries. (Arb. Ex. 1)

With respect to Petitioner's cervical spine, the Arbitrator notes that the notice of injury completed by Ms. Hesselrode included Petitioner's shoulder. (PX 15) At the initial emergency room visit, Petitioner had complaints of a neck ache, a CT of her neck was performed, and her diagnoses included cervicgia. (PX 3) The records demonstrate that in addition to neck symptoms, Petitioner had consistent complaints of right shoulder/upper extremity symptoms, which radiated down her arm. (PX 5 p. 2; PX 6 p. 4; PX 7; PX 8 pp. 2 & 5) Dr. Bradley noted that although Petitioner felt as though her symptoms were coming from her shoulder, he felt they were emanating from her neck. (PX 8 p. 6) Despite Petitioner's history of prior neck symptoms and surgeries, both Dr. O'Boynick and Dr. Gornet agreed that her upper extremity complaints constituted radiculopathy which flowed from her injury, and Dr. O'Boynick felt additional treatment for same would be appropriate. (PX 11 p. 13; RX 1, Dep. Ex. 2; PX 16 p. 32) Although Petitioner's neck treatment is on hold at this time because Petitioner's other problems are more prominent, the Arbitrator finds current cervical spine symptoms to be causally related to Petitioner's work accident of February 3, 2022.

With respect to Petitioner's lumbar spine, the Arbitrator has examined the evidence and considered the opinions of Dr. O'Boynick and Dr. Gornet and finds the opinions of Dr. Gornet to be more logical and persuasive than those of Dr. O'Boynick.

The Arbitrator notes that although Dr. O'Boynick concluded that no lumbar spine complaints were documented until March 2022, the initial emergency room department visit as well as Petitioner's initial and subsequent visits with NP Greenley noted pain in Petitioner's hip. (RX 1, Dep. Ex. 2; PX 3; PX 4) After working up Petitioner's hip, Dr. Bradley concluded that her hip symptoms were, in actuality, emanating from her lumbar spine, and that Petitioner thought she injured her hip but did not relate this to a back problem. (PX 8 p. 17) When Petitioner began treatment with Dr. Gornet, her hip symptoms continued to be documented in the context of her lumbar spine condition. (PX 11) Therefore, although there is no explicit reference to Petitioner's lumbar spine until March 31, 2022, the evidence suggests that Petitioner's initial and continued complaints of hip symptoms were related to her lumbar spine. (PX 3; PX 5) Therefore, the record demonstrates that Petitioner had immediate symptoms relating to her lumbar spine at the time of her accident.

There is no dispute that Petitioner had significant chronic low back symptoms prior to her injury. As Dr. Gornet pointed out in his deposition, the real issue is whether Petitioner's accident could aggravate or accelerated her underlying condition. (PX 16 pp. 20-21) Dr. O'Boynick felt that the low back issues, for which Petitioner sought subsequent to her accident, were pre-existing and were the same as the issues she had before her work accident. (RX 1, Dep. Ex. 2) Dr. Gornet reviewed Petitioner's pre-accident lumbar spine MRI, agreed that Petitioner had preexisting pathology, was aware that Petitioner had symptoms of significance in her low back prior to her injury, and felt that her work injury aggravated same. (PX 16 pp. 14-15, 20-21) Dr. O'Boynick reviewed Petitioner's pre and post-accident MRI scans and admitted that Petitioner's annular tear at L5-S1 was more visible on her post-accident scan. (RX1, Dep. Ex. 3)

Although Respondent did not introduce Petitioner's prior treatment records into evidence, Dr. O'Boynick's report indicates that Petitioner had documented symptoms in October 2021, around four months prior to her work injury. (RX 1, Dep. Ex. 2) Although there appeared to be a recommendation for a pain pump at that time, there is no evidence that Petitioner received same. *Id.* Further, as Dr. Gornet noted, although the records did not document complete resolution of Petitioner's symptoms at that time, there was no recommendation for surgical intervention. (PX 16 p. 41) Following October 2021, no further treatment or symptoms were documented until after Petitioner's work accident. (RX 1, Dep. Ex. 2)

Therefore, after considering the totality of the evidence and testimony, the Arbitrator finds and concludes that Petitioner suffered an aggravation of her pre-existing condition, and as such, her current condition of ill-being with respect to her lumbar spine is causally related to her February 3, 2022 accident.

With respect to Petitioner's right knee, the Arbitrator has considered the evidence and testimony, and finds the opinions of Dr. Bradley to be more logical and persuasive than those of Dr. Nogalski. To this point, the Arbitrator notes Dr. Nogalski's opinion that Petitioner's current condition of osteoarthritis is not related to her injury. (RX 2, Dep. Ex. 2) The question at hand, however, is not whether Petitioner's osteoarthritis resulted from her injury; there is no question that she had a preexisting degenerative disease, and Dr. Bradley testified that she indeed had preexisting degeneration. (PX 8 p. 24-26) Rather, the question is whether Petitioner's current condition of ill-being relates to her accident, and the Arbitrator finds and concludes that there is sufficient evidence to support that causal connection exists.

Although Petitioner had right knee surgery in 2014 and a brief flare up in 2018 which resulted in one emergency department visit, there is no evidence that she received treatment for her right knee from 2018 until the time of her accident, and even Dr. Nogalski agreed that this was the case. (RX 2 p. 17; RX 2, Dep. Ex. 2) Following the accident, however, Petitioner had immediate symptoms of right knee pain, which was documented in the injury report from Respondent, in the emergency department records, and in her records thereafter. (PX 3; PX 8; PX 15)

Moreover, both Dr. Wood and Dr. Bradley felt that Petitioner's meniscus tear was acute and occurred at the time of the injury. (PX 6 p. 10; PX 17 pp. 32-33) Although Dr. Nogalski indicated that Petitioner only suffered a strain as a result of her work injury that should have taken a matter of weeks to resolve, he also stated that the date she was at MMI for her injury was October 6, 2022, which took place months after her injury and after her initial arthroscopy procedure with Dr. Bradley. (RX 2, Dep. Ex. 2; RX 2 p. 17)

Regarding the October 6, 2022, appointment, Dr. Nogalski stated in his report that "A 10/06/2022 evaluation by Dr. Bradley was for her hip. She had multiple complaints at that time but did not note or state any right knee pain or problems." (RX 2, Dep. Ex. 2) However, the

Arbitrator notes that this statement is inaccurate, as Dr. Bradley stated in his October 6, 2022, note, “We again reviewed the MRI scan of her knee which clearly showed some tears to her meniscus which continues to bother her[.]” (PX 8 p. 16) Although Dr. Bradley felt that these symptoms might be related to her spine and recommended evaluation with Dr. Gornet before pursuing further treatment on her knee, there is clear evidence that Petitioner reported continued symptoms in her knee to Dr. Bradley on that date. *Id.* The Arbitrator further notes that even while treating with Dr. Gornet, Petitioner reported knee symptoms to the point where she was referred back to Dr. Bradley, who noted on December 21, 2023, that Petitioner had increasing knee pain that had been present since surgery but was worsening, demonstrating that Petitioner never returned to her preinjury baseline. (PX 11 p. 14; PX 8 p. 18)

Furthermore, Dr. Bradley explained that Petitioner’s increasing postoperative pain was resultant of an aggravation of her arthritis when she fell and of removing a significant portion of her meniscus, and the Arbitrator finds this to be logical. (PX 17, pp. 16-17, 39-40) Dr. Bradley identified via diagnostic testing that Petitioner had a significant worsening of her degeneration since her injury at a rate greater than he would have expected if she had not undergone surgery. (PX 8 p. 26) This explanation is persuasive, and even more so considering the lack of documentation of treatment to Petitioner’s knee from 2018 until the time of her accident. Therefore, the Arbitrator finds and concludes that Petitioner’s right knee condition is causally related to her February 3, 2022, work injury.

In summary, pursuant to the above, the Arbitrator finds Petitioner’s conditions of ill-being in her cervical spine, lumbar spine and right knee are causally related to her February 3, 2022, work injury.

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?

Upon establishing causal connection and the reasonableness and the necessity of recommended medical treatment, employers are responsible for necessary prospective medical care required by their employees. *Plantation Mfg. Co. v. Indus. Comm’n*, 294 Ill.App.3d 705, 691 N.E.2d 13 (1997). This includes treatment required to diagnose, relieve, or cure the effects of claimant's injury. *F & B Mfg. Co. v. Indus. Comm’n*, 325 Ill. App. 3d 527, 758 N.E.2d 18 (2001).

The right to be compensated for medical costs associated with work-related injuries is at the very heart of the Workers' Compensation Act. *Hagene v. Derek Polling Const.*, 388 Ill. App. 3d 380, 383, 902 N.E.2d 1269, 1273 (2009).

With respect to Petitioner’s cervical spine, although treatment that condition is on hold due to Petitioner’s more severe low back symptoms, the Arbitrator notes that even Dr. O’Boynick

admitted that additional treatment to resolve Petitioner's symptoms would be reasonable as it relates to the injury, and even stated that if she failed nerve root blocks, that a posterior fusion at C3-4 could be considered. (RX 1, pp. 25-26)

With respect to Petitioner's low back, Petitioner has been treated conservatively with therapy and injections; however, due to her persistent symptoms, disc replacement surgery has been recommended by Dr. Gornet. (PX 7; PX 11; PX 13) Although Dr. O'Boynick did not agree as to causation with respect to Petitioner's lumbar spine condition, he agreed that lumbar disc replacement at L4-5 and L5-S1 could provide Petitioner with relief of her symptoms. (RX 1, p. 29) Petitioner testified at trial that she wants to undergo the recommended surgery due to the severity of her symptoms, and Dr. Gornet testified that without the surgery, Petitioner's condition would worsen. (Tr. pp. 18-20; PX 16 p. 22)

With respect to Petitioner's right knee, Dr. Bradley noted that Petitioner needs a right total knee replacement surgery due to her bone-on-bone changes associated with aggravation of her degenerative disease and removal of a substantial portion of her meniscus following her injury. (PX 17, pp. 39-40) Although Dr. Nogalski did not agree as to causation, he admitted that Petitioner had ongoing symptoms due to her condition. (RX 2, Dep. Ex. 2) Dr. Bradley testified that if Petitioner were to undergo the recommended surgery, her prognosis would be excellent and she would be more functional. (PX 17, p. 23)

Therefore, pursuant to the aforementioned findings with respect to causation, the Arbitrator finds that the treatment rendered to Petitioner's cervical spine, lumbar spine and right knee have been reasonable, necessary, and causally related to Petitioner's work injury of February 3, 2022, and that Respondent is liable for payment of the medical expenses as outlined in Petitioner's Exhibit 1.

Although Petitioner's neck treatment is on hold pending treatment to her lumbar spine, the Arbitrator finds that Petitioner is entitled to prospective medical treatment with respect to her cervical spine as recommended by Dr. Gornet.

The Arbitrator finds and concludes that Petitioner is entitled to prospective medical treatment with respect to her right knee, as recommended by Dr. Bradley, including, but not limited to, right total knee replacement surgery, and that Petitioner is entitled to prospective medical treatment to her lumbar spine as recommended by Dr. Gornet, including, but not limited to, lumbar disc replacement surgery at L4-5 and L5-S1.

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.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	23WC000889
Case Name	Jennifer Shaw v. State of Illinois - Illinois Department of Corrections - Dixon Correctional Center
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	25IWCC0515
Number of Pages of Decision	10
Decision Issued By	Amylee Simonovich, Commissioner

Petitioner Attorney	Alexis Ferracuti
Respondent Attorney	Valarie Owino

DATE FILED: 12/30/2025

/s/ Amylee Simonovich, Commissioner

Signature

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 Choose reason	☐ Second Injury Fund (§8(e)18)
☐ Modify down	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JENNIFER SHAW,
 Petitioner,

v.

No. 23WC000889

STATE OF ILLINOIS - ILLINOIS
 DEPARTMENT OF CORRECTIONS -
 DIXON CORRECTIONAL CENTER,
 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 issue of nature and extent of the permanent disability, corrects 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 corrects an error in the award of TTD, and strikes paragraph two of the Order section of the Decision, replacing it with the following:

“Respondent shall pay Petitioner temporary total disability benefits of \$1,090.98/week for 4/7 weeks, as Petitioner was totally disabled from 8/1/22 through 8/7/22, as provided in section 8(a) of the Act. Respondent shall receive a credit for any TTD it has already paid.”

The Commission corrects the third paragraph of the Conclusions of Law section of the Decision, striking the first sentence and replacing it with the following:

“Regarding the issue of TTD and consistent with the findings above, the Arbitrator further finds that Petitioner was temporarily totally disabled from August 1, 2022, through August 7, 2022.”

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 on July 3, 2025, is corrected as stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of \$1,090.98 per week for a period of 4/7 weeks, commencing August 1, 2022, through August 7, 2022, that being the period of temporary total incapacity for work under §8(b).

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.

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

December 30, 2025

O: 12/16/25

AHS/ps

051

/s/ *Amylee H. Simonovich*
Amylee H. Simonovich

/s/ *Stephen J. Mathis*
Stephen J. Mathis

/s/ *Kathryn A. Doerries*
Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
DECISION SIGNATURE PAGE

Case Number	23WC000889
Case Name	Jennifer Shaw v. State of Illinois - Illinois Department of Corrections, Dixon Correctional Center
Consolidated Cases	
Proceeding Type	Request for Hearing
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	7
Decision Issued By	Gerald Granada, Arbitrator

Petitioner Attorney	Alexis Ferracuti
Respondent Attorney	Valarie Owino

DATE FILED: 7/3/2025

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



JULY 3, 2025

/s/ Michele Kowalski

Michele Kowalski, Secretary
Illinois Workers' Compensation Commission

/s/ Gerald Granada, Arbitrator
Signature

INTEREST RATE WEEK OF JULY 1 2025 4.11%

STATE OF ILLINOIS)
)SS.
COUNTY OF **LA SALLE**)

☐	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

Jennifer Shaw
Employee/Petitioner

Case # **23** WC **000889**

v.

Consolidated cases: _____

Dixon Correctional Center
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 **Gerald Granada**, Arbitrator of the Commission, in the city of **Ottawa**, on **May 8, 2025**. 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 **7/28/22**, 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 **\$85,096.44**; the average weekly wage was **\$1,636.47**.

On the date of accident, Petitioner was **45** 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 **\$0** under Section 8(j) of the Act.

ORDER

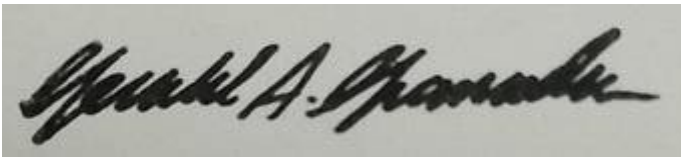
Respondent shall pay for all reasonable and related medical services, as set forth in Petitioner's exhibits at the lower of the Fee Schedule or any negotiated rate, as provided in Section 8(a) of the Act. Respondent shall receive a credit for any medical expenses it has already paid.

Respondent shall pay Petitioner temporary partial disability benefits of \$1,090.98/week for 6/7 week, commencing on 7/29/22 and from 8/11/22 through 8/15/22, as provided in Section 8(a) of the Act. Respondent shall receive a credit for any TTD it has already paid.

Respondent shall pay Petitioner permanent partial disability benefits of \$981.88/week for 10 weeks, because the injuries sustained caused the 2% 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.



JULY 3 2025

Signature of Arbitrator Gerald Granada

Jennifer Shaw v. Dixon Correctional Center, 23WC000889**Attachment to Arbitration Decision****Page 1 of 4****FINDINGS OF FACT**

This case involves Petitioner Jennifer Shaw, who was injured while working for the Respondent Dixon Correctional Center on July 28, 2022. Respondent disputes Petitioner's claim, with the issues being: 1) causation; 2) medical expenses; 3) TTD; and 4) nature and extent.

Petitioner worked for Dixon Correctional Center as a correctional counselor II. Rx 1. Her job duties include a regular interview routine for each assigned individual in custody to ensure their needs are being met, preparing professional reports, including transfer reports and supplemental program consideration reports, and processing requests for work release and housing needs upon release.

Petitioner testified that on July 28, 2022, she was working in building 68. At around 1:00 p.m. she spilled some water on her desk. Rx 2 at 1. She got up to get some paper towels to clean up the spill when she tripped over the cords that were uncovered on the floor. *Id.* She testified that she fell forward with significant force and landed on her knees, hurting the left side of her back and knee. On August 2, 2022, she reported the accident to Kevin Gehl and Lieutenant Renee Stevens. Rx 3.

Petitioner testified that she did not seek treatment on the date of the accident as she had planned a trip to Mississippi for her grandson's birthday. After work on July 28, 2022, she went home and left for Mississippi by car for the ten-hour drive. She sat in the front seat for about three hours and eventually moved to the back since she was in so much pain and needed to lay down. Petitioner testified that they were driving a Jeep Grand Cherokee and nothing else was in the backseat where she lay fully extended to relieve the pain radiating down her legs. She testified that her height is 5' 6". She further testified that on getting to Mississippi, she spent most of the visit and her grandson's party sitting with a heat pad to her back and could not lift her grandson. Petitioner did not seek any medical treatment in Mississippi since it was the weekend, and she was not sure whether her insurance would cover.

When Petitioner returned from her trip on August 1, 2022, she sought treatment for her pain. She saw her chiropractor who adjusted her back and administered hot and cold therapy. Petitioner testified that she disagrees with the Chiropractor notes from August 1, 2022, which state that her injury was a result of her laying in an awkward position and she is not sure where the chiropractor would get that history.

On August 02, 2022, Petitioner sought treatment at Katherine Shaw Bethea Hospital where she was seen by Dr. Hernandez hoping that she would prescribe pain medication. She testified that the record from that visit shows that she was visiting Memphis and twisted her back in the shower, which is inaccurate as she did not stop in Memphis overnight. Her daughter is a few minutes from Memphis, and she believes that may have caused the misunderstanding as Memphis is the easiest location to tell people.

Petitioner testified that she did not return to work until August 8, 2022. She had taken July 29, 2022, as vacation day and returned to work August 8, 2022.

Summary of Petitioner's Witness Thomas Shaw

Petitioner's husband Thomas Shaw testified that he has been married to Petitioner for the last 29 years. He also works at Dixon and the two have overlapping shifts. On the alleged date of the accident, Petitioner called him to let him know that she had fallen.

They have gone to Mississippi a few times every year. On the weekend, following the alleged accident, they drove to Mississippi to visit their grandson, he was not sure what the celebration was. He drove the Jeep

Jennifer Shaw v. Dixon Correctional Center, 23WC000889**Attachment to Arbitration Decision****Page 2 of 4**

Cherokee but does not recall what year the vehicle is. As they were driving, he noticed that Petitioner was in pain, and they stopped so she could move from the passenger side to the back seat. She laid down in the back. He also stated that there were probably some blankets in the backseat. He testified that as Petitioner lay in the back, she moved pretty frequently. He does not recall where Petitioner sat on the drive back. He was unsure whether she sat on the passenger side or whether she was laid in the back.

Summary of Medical Treatment**Pre-injury Treatment**

Records show that Petitioner had been receiving treatment for her back since, 2018. Starting in October 26, 2020, Petitioner had been treating at Pitkin Family Chiropractic. Px. 5. She presented to the facility indicating that she has been feeling constant moderate pain in the lower back. *Id.* During that time, she underwent the Oswestry test in which she stated that she gets extra pain while travelling but it does not compel her to seek alternative forms of travel. *Id.* The record notes that she has had ongoing lower back pain and left leg pain in the past and had undergone a microdiscectomy in 2018 that calmed it down, but it continued to flare up episodically. *Id.* Petitioner continued treating at Pitkin in 2020, 2021 and 2022. On February 14, 2022, she returned to Pitkin indicating that she was suffering from a constant recurrence of moderate pain in the lower back region and frequent left leg pain which was assessed as an acute flare up of her chronic condition. *Id.*

Post-Accident Treatment

On August 1, 2022, Petitioner returned to Pitkin stating that she had a severe recurrence of the constant left back pain. *Id.* She stated that she had been doing well until she went out of town. *Id.* She reported that she had been sleeping in the back seat of the car in an awkward position for the ten-hour drive and when she woke up the next day, she had pain. *Id.* She had endured the pain for the long ride home but stopped at Pitkin before going home in hopes of getting relief. *Id.* Petitioner was diagnosed with an acute flare up of her existing condition. *Id.* Petitioner returned on August 2 and August 5, 2022, and was recommended to consult with her orthopedic doctor to ensure that her prior back surgery was not causing her back pain. *Id.*

On August 2, 2022, Petitioner presented at KSB with a complaint that she had travelled to Memphis, Tennessee and while in the shower she turned and developed severe pain to her left lower back that rated at a 10 out of 10, with burning pain radiating down to her left buttock, left thigh and left ankle. *Id.* On August 10, 2022, Petitioner called Dr Juan Hernandez's office and asked that the office change the off work note issued on August 02, 2022, to show that she was being placed off work due to a fall so she could be paid for the week that she took off work. *Id.* On August 11, 2022, Dr Hernandez added an addendum stating that Petitioner fell at work on July 28, 2022, tripping over a cord, and then went out of town the next day. *Id.* Petitioner was released back to work at MMI on August 8, 2022. *Id.*

On August 8, 2022, Petitioner presented at L. Johnson Chiropractic with a complaint of lower back pain radiating into the left buttock. Px 4. She stated that she had fallen at work on July 28, 2022, and two days later had a ten-hour car ride to Mississippi. *Id.* She also reported pain with twisting in the shower and residual pain since. *Id.* Petitioner had chiropractic adjustments at L Johnsons three times a week for two weeks. *Id.*

On August 10, 2022, Petitioner sought treatment at Carlson Acupuncture and Chiro clinic. Px 2. The records note that after the fall she drove for ten hours, when she went to get out of the car, her back was in spasm, and she could not walk. *Id.* Petitioner noted that she had been receiving chiropractic care and was seeing her medical doctor for pain medication. *Id.* Petitioner received acupuncture for her lower back and left hip and additional sessions were recommended for two weeks, twice a week. *Id.* Her diagnosis was Lumbago with sciatica on the left side. *Id.*

Jennifer Shaw v. Dixon Correctional Center, 23WC000889**Attachment to Arbitration Decision****Page 3 of 4**

On August 23, 2022, the clinical assessment at KSB by Dr Hernandez was that her subjective history and objective findings indicated that Petitioner's pain was related to piriformis syndrome. Px 3. Petitioner did not seek additional treatment until August 29, 2022 as she was out of town for a trip. *Id.* Upon her return she returned to KSB following a chiropractic visit that irritated her left leg and which had caused her to jump off the table. *Id.* Petitioner stated that she had been on vacation to Disney World and did not ride many rides but did a lot of walking. *Id.*

Petitioner was released at MMI on October 26, 2022, following completion of treatment at L Johnson Chiropractic. Px 4. On January 12, 2023, Petitioner returned to KSB and stated she had no back pain, no neck pain, no joint pain, no muscle pain, and no decreased range of motion. Px 3.

Petitioner's Current Condition

At trial, Petitioner testified that she has difficulty lifting. She does not have to do any lifting at work and there is no difficulty in twisting. She was released back to full duty work and was not in any pain. She testified that she occasionally has flare ups and uses cold packs or Aleve to relieve her pain. She is currently not on any prescriptions. She is currently employed at Dixon as Correctional Officer III, earning more than she did at the time of the accident.

CONCLUSIONS OF LAW

1. Regarding the issue of causation, the Arbitrator finds that the Petitioner has met her burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's testimony and the medical evidence which show that following Petitioner's undisputed work accident on July 28, 2022, she began to experience spasms in her low back, which became more noticeable following a road trip she took the very next day. Petitioner's history provided to her supervisors and her medical providers were consistent in that she fell at work and afterwards began noticing pain in her back. Although Petitioner has had a history of back problems, the records show that she did not seek treatment from her last chiropractic visit in February, 2022, until after her work accident over 5 months later. Based on the medical evidence, it appears the Petitioner had aggravated her pre-existing back condition that resulted in spasms for which she was later diagnosed with lumbago and sciatica. Based on the facts above, the Arbitrator concludes that the Petitioner's current condition of ill-being in her back is causally related to her July 28, 2022 work accident.

2. Regarding the issue of medical expenses, the Arbitrator finds that the Petitioner's medical treatment related to her spine have been reasonable and necessary in addressing her work-related conditions. The records show that the Petitioner was compliant with her medical treatment and showed improvement to the point she was able to return to her normal work activities. Accordingly, the Arbitrator awards the Petitioner any unpaid medical expenses incurred as a result of her July 28, 2022 work accident as set forth in Petitioner's exhibits, subject to the Fee Schedule. Respondent shall receive a credit for any medical expenses it may have already paid.

3. Regarding the issue of TTD and consistent with the findings above, the Arbitrator further finds that Petitioner was temporarily totally disabled on July 29, 2022 and from August 11, 2022 through August 15, 2022. This finding is supported by Petitioner's un rebutted testimony and the medical evidence that show Petitioner was completely taken off work during this time period. Therefore, the Arbitrator awards Petitioner TTD benefits for these periods and Respondent shall be credited for any TTD it has paid.

Jennifer Shaw v. Dixon Correctional Center, 23WC000889**Attachment to Arbitration Decision****Page 4 of 4**

4. Regarding the issue of the nature and extent of the Petitioner's injuries, the Arbitrator applies the factors set forth in Section 8.1b of the Act and notes the following: (i) no impairment rating was submitted into evidence and the Arbitrator gives no weight and relevance to this factor; (ii) Petitioner was a Correctional Counselor II who was able to return to this job with no restrictions following the accident - a factor to which the Arbitrator gives significant weight and relevance; (iii) Petitioner was 45 years old at the time of injury - a factor to which the Arbitrator gives some weight and relevance; (iv) there was no direct evidence of future earnings being impacted due to this injury and the Arbitrator gives no weight and relevance to this factor; (v) there was evidence of disability which show that the Petitioner sustained injury to her back, for which she underwent conservative care in the form of chiropractic treatment from which Petitioner still has some occasional complaints - the Arbitrator gives great weight and relevance to this factor. Based on the factors above, the Arbitrator concludes the injuries sustained by Petitioner caused a 2% loss of use of the person as a whole.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	21WC017438
Case Name	Leonard Anderson v. Amsted Industries, Inc.
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	25IWCC0516
Number of Pages of Decision	24
Decision Issued By	Kathryn Doerries, Commissioner, Kathryn Doerries, Commissioner

Petitioner Attorney	Giambattista Patti
Respondent Attorney	Julie Pagano

DATE FILED: 12/31/2025

/s/Kathryn Doerries, Commissioner

Signature

DISSENT

/s/Kathryn Doerries, Commissioner

Signature

21 WC 17438

Page 1

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))
☐ Modify	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Leonard Anderson,

Petitioner,

vs.

NO: 21 WC 17438

Amsted Industries, 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 causal connection, medical expenses, prospective medical 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. 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 vs. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 1, 2024, 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.

21 WC 17438

Page 2

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.

December 31, 2025

o-11/4/25

KAD/rm

042

/s/ *Amylee H. Simonovich*

Amylee H. Simonovich

/s/ *Stephen J. Mathis*

Stephen J. Mathis

DISSENT

I partially dissent from the majority's decision affirming and adopting the Arbitrator's decision. I concur with the decision finding Petitioner's lumbar spine injury causally related; however, I disagree with the majority's decision finding the cervical spine condition was causally related. For the reasons set forth below, I would reverse the Arbitrator's award of medical expenses and prospective medical benefits related to the cervical spine.

On May 24, 2021, Petitioner was working when he fainted due to heat exposure. The parties stipulated on the record that the outdoor temperature that day was between 86 and 88 degrees. (T. 18) Petitioner testified the interior temperature was generally hotter than outside. (T. 20) Petitioner went to get a drink of water and go outside for fresh air. (T. 22) Petitioner sat down for a few minutes and then fainted as he stood. A radio call was placed to Respondent's onsite medical office reporting an employee had passed out. On arrival, the EMT found Petitioner laying on the ground and appearing in and out of consciousness with an abrasion to the forehead. (PX3 at 1) The EMT noted Petitioner complained of neck soreness and refused a C-collar. (PX3 at 1)

Petitioner received medical attention in the emergency department at Gateway Regional Medical Center where he reported feeling fine. (PX4 at 1) Petitioner denied chest pain, dizziness, blurred vision or headaches. Petitioner had no neck pain, though stiffness was noted. On examination, the attending physician found Petitioner's neck was normal and without tenderness. X-rays of the facial bones and cervical spine were negative for acute findings. (PX4 at 2) The doctor diagnosed heat related syncope and directed Petitioner to follow-up with his personal physician. The emergency department was unable to perform a CT scan of the head due

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Petitioner's size. Petitioner's height and weight were documented as 6'6" and 226.8 kilograms, or approximately 500 lbs. (PX4 at 2) Petitioner telephoned Respondent's medical office and reported he had been discharged and everything "checked out fine." (PX3 at 1) The medical office advised Petitioner he must obtain a full release from his personal medical provider and then be seen by the company doctor.

On May 27, 2021, Petitioner followed-up with his chiropractor, Dr. Brooks, at Multicare Specialists. (PX1 at 40) Petitioner complained of back pain commencing the date he passed out at work, especially when bending. He also complained of pain radiating down his legs bilaterally. Petitioner had no documented complaints of neck pain.

Petitioner then presented to Dr. Nukala at Anderson Medical Group on May 28, 2021, for the purpose of establishing care as a new patient. (RX12 at 4) Petitioner provided a consistent accident history and complained of back pain. Petitioner had no documented complaints of neck pain, though Dr. Nukala noted abnormal cervical range of motion secondary to Petitioner's body habitus.

It must be noted here that Petitioner previously filed a workers' compensation claim alleging repetitive trauma resulting in injuries to his shoulder and hand with trigger finger. (T. 26) Petitioner was still under treatment for those injuries when he passed out at work on May 24, 2021. (T. 27) That claim, case number 21 WC 10029, alleged an accident date of January 6, 2021. (AX2) The two cases were consolidated and both cases proceeded to trial under section 19(b). The Arbitrator's decision for the first claim is not before the Commission on review, though the medical records concerning the right upper extremity are part of the transcript. The shoulder complaints are relevant to the disputed cervical spine condition as will be discussed below.

The medical records indicate Petitioner began experiencing right shoulder pain in December of 2020. (PX11 at 1) The medical records further reflect ongoing treatment at Multicare Specialists from January 2021 through the date of Petitioner's second accident on May 24, 2021. Petitioner continued to complain of right shoulder pain as recently as April 15, April 20, April 22, May 2, May 10, and May 13, 2021. (PX1 at 1-38)

Following the fainting episode on May 24, 2021, Petitioner discontinued working and continued treating with Dr. Brooks at Multicare Specialists. This clinic maintained two sets of progress notes during his treatment visits, often generating two office visit notes for the same day of service, separately addressing Petitioner's right shoulder condition related to the first claim and Petitioner's low back injury related to the second claim. Petitioner treated with Dr. Brooks from June 1, 2021, through June 28, 2021. (PX1 at 45-114) During this period, Petitioner saw Dr. Brooks on twelve occasions with no documented neck complaints. *Id.* The records documented ongoing shoulder complaints over the course of numerous visits on June 3, June 7, June 8, June 10, June 14, June 15, June 17, June 21, June 22, June 24, and June 28, 2021. (RX1 at 45, 57, 59, 65, 77, 91, 95, 101, 108).

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Petitioner also returned to Dr. Nukala on June 11, 2021, for follow-up regarding lab results and to initiate medications. Petitioner did not report any neck problems during his visit with Dr. Nukala. (RX12 at 11) Petitioner returned to Dr. Nukala again on June 29, 2021, to discuss the results from ultrasound imaging of the abdomen. Dr. Nukala's review of systems noted back pain and knee pain with no mention of neck pain. (RX12 at 17)

On July 1, 2021, Petitioner presented to the company doctor for a return to work evaluation and received clearance to resume working effective July 5, 2021. (RX10 at 3) Petitioner returned to Multicare Specialists on July 1 and July 5, 2021 for right shoulder pain and low back pain with bilateral radiculitis. (PX1 at 116, 118)

On July 6, 2021, Dr. Priebe evaluated Petitioner at Multicare Specialists for his persistent shoulder pain and it was his impression that Petitioner had a right rotator cuff tear. (PX1 at 128) There were no documented complaints of neck pain at that time. *Id.* Dr. Priebe administered a Lidocaine/Marcaine injection into the right shoulder. *Id.*

Petitioner testified he returned to work a few weeks after the accident but could not recall the exact date. (T. 28) Petitioner's attorney asked if he returned on July 6, 2021, but Petitioner was unable to recall the date he returned to work other than he went back a few weeks after his fall. (T. 28) Petitioner further testified his first day back at work went well during the first couple of hours and then as time went on he began noticing neck pain. (T. 28-29) Petitioner testified he had never felt neck pain before his accident. (T. 29)

On July 8, 2021, Petitioner returned to Dr. Nukala and reported he returned to work and was feeling low back pain shooting into his shoulder blades. (RX12 at 23) Petitioner also complained of bilateral leg pain. Dr. Nukala diagnosed lumbar radiculopathy and ordered an MRI. There was no reported neck pain; however, given the pain between the shoulder blades, it was Dr. Nukala's impression that Petitioner had cervical radiculopathy and x-rays were ordered for the cervical spine.

On July 13, 2021, Dr. Brooks noted significant pain relief in the right shoulder following the injection given by Dr. Priebe. (PX1 at 145) Notably, there was no reported neck pain or intrascapular pain, which should have been more noticeable to Petitioner if he had a symptomatic cervical spine disorder at that time. That same day, Petitioner's therapist noted Petitioner's right shoulder was feeling pretty good with no significant pain. (PX1 at 145)

Petitioner continued treating with Multicare Specialists. On July 15, 2021, Dr. Brooks reviewed the results of a lumbar MRI which revealed disc herniation at L4-L5 and disc bulging at L5-S and multilevel degenerative changes. Dr. Brooks referred Petitioner to Dr. Gornet for orthopedic evaluation. (PX1 at 148-149) Dr. Brooks further noted right shoulder stiffness and the therapist noted the right shoulder was feeling sore after the previous therapy session. (PX1 at 150, 152)

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On July 20, 2021, Petitioner reported to his therapist he was having an increased pain traveling up the side of his neck to behind the ear when eating. (PX1 at 158)

On July 26, 2021, Petitioner complained of right sided neck pain radiating into the right shoulder. (PX1 at 167) Petitioner also reported he had been feeling neck pain since the fall but never reported it before because he thought it would go away. Dr. Brooks ordered an MRI of the cervical spine. (PX1 at 167)

On July 30, 2021, Petitioner presented to Dr. Gornet for complaints of neck and low back pain. Dr. Gornet noted the neck pain involved the base of the neck and right trapezius, along with right shoulder pain and pain between the shoulder blades and frequent headaches. (PX8 at 1) Petitioner denied upper extremity numbness or tingling and he exhibited 5/5 strength bilaterally. Dr. Gornet ordered an MRI of the cervical spine. Unfortunately, Petitioner was unable to have the MRI of the cervical spine due his size. (PX8 at 8) Dr. Gornet noted Petitioner's weight was 479 pounds and recommended weight loss.

Five months later, Petitioner was able to undergo the MRI of the cervical spine on January 3, 2022. (PX10) The radiologist found congenital central canal stenosis at each level from C3 through C7. The radiologist further noted left and right foraminal protrusions at C4-C5 resulting in ventral cord flattening and moderate to severe central canal stenosis and bilateral foraminal stenosis, left greater than right. *Id.*

On November 05, 2021, Dr. O'Boynick examined Petitioner at Respondent's request for evaluation of the lumbar and cervical spine. (RX6, deposition exhibit #2) Petitioner provided a consistent accident history and reported he did not have any neck pain until after he returned to work. (Dep exhibit #2 at 1) Dr. O'Boynick generated a 17-page report containing a detailed summary of the medical records. Dr. O'Boynick noted the first documented complaint for parascapular pain was identified during a visit with Dr. Nukala on July 8, 2021, and the first documented complaint for neck pain was identified on July 26, 2021, a nearly two-month gap between the accident and the first documented neck complaint. Dr. O'Boynick opined that the complaints related to the neck and right-sided trapezial region were more likely a shoulder problem than a cervical spine problem based on the positive pain relieving response to the shoulder injection performed by Dr. Priebe, and in any event, there could be no causal connection between the cervical complaints and the accident given the 6-8 week gap in time without neck pain. (Deposition exhibit #2 at 14)

Dr. Gornet saw Petitioner for follow-up on February 17, 2022, and indicated the MRI demonstrated annular tears at C3-C4, C4-C5, and C5-C6 with some spinal cord changes at C4-C5. (PX8 at 10) Dr. Gornet further noted Petitioner was very tight throughout his entire canal. Petitioner denied having any gait changes or motor changes. Dr. Gornet noted Petitioner did not have any increasing myelopathic symptoms and recommended observation. Dr. Gornet indicated more aggressive treatment could be attempted if Petitioner could reduce his weight to at least 350-375 pounds. *Id.*

Meanwhile, Petitioner continued treatment for his right shoulder and saw Dr. Paletta on February 22, 2022. (PX11 at 1) Dr. Paletta reviewed an MRI of the shoulder obtained earlier in July 2021, and it was his impression that Petitioner's shoulder had rotator cuff tendinopathy involving the supraspinatus and infraspinatus tendons with a partial-thickness tear of the infraspinatus. Dr. Paletta noted the shoulder pain had been ongoing for the past year and a half. Dr. Paletta noted Petitioner had received two prior injections, the second of which provided three to four months relief. Dr. Paletta obtained x-rays which showed some hypertrophic degenerative changes at the AC joint which he felt were age appropriate. Dr. Paletta recommended a series of diagnostic injections to determine whether the rotator cuff or the AC joint was the predominant source of the pain.

Petitioner underwent a diagnostic shoulder injection with Dr. Blake on March 16, 2022. (PX9 at 15-16) According to her procedure note, Dr. Blake administered the injection into the AC joint with Petitioner in a seated position, and "[a]fter approximately five-minute wait time, Petitioner had complete relief of his pain." (Emphasis added.) *Id.* Dr. Blake's procedure note further reported Petitioner was able to perform cross body adduction without pain after the injection and had no tenderness over the AC joint. (PX9 at 16) Immediately following the diagnostic injection, Dr. Blake spoke with Dr. Paletta's office and the decision was made to administer a second therapeutic steroid injection into the shoulder to help provide longer lasting benefit. (PX9 at 16) Petitioner was also in a "seated position" for that injection. (PX9 at 16-17)

Dr. Paletta then saw Petitioner that same day and noted the significant relief obtained from the shoulder injections. (PX11 at 8) Dr. Paletta determined the AC joint was the source of the shoulder pain and indicated they would wait to see if symptoms returned, with arthroscopic surgery to be considered if the pain relief turned out to be temporary. Petitioner had no documented neck complaints.

Petitioner returned to Dr. Paletta on April 27, 2022. At that time, Petitioner's AC joint pain was improved but Petitioner began experiencing a popping and snapping sensation, which Dr. Paletta noted was localized in the anterior aspect of the shoulder in the region of the bicipital groove, associated with repetitive upper extremity flexion and extension activity. (PX11 at 12) On examination, Petitioner's overall range of motion was excellent but tenderness to palpation was present over the bicipital groove. It was Dr. Paletta's impression that the shoulder pain was largely resolved, only to be replaced with medial instability of the long head of the biceps. Dr. Paletta recommended dynamic ultrasound imaging to further assess the stability of the biceps tendon. *Id.* Petitioner continued to have no documented neck complaints. On May 6, 2022, Dr. Paletta noted the ultrasound was negative for biceps subluxation or instability and recommended home exercises with surgery to be considered in the future if mechanical symptoms continued. (PX11 at 16)

On June 8, 2022, Petitioner returned to Dr. Paletta. Petitioner complained of recurrent and ongoing pain in the shoulder involving the anterior superior aspect of the shoulder in the region of the AC joint and also the anterior chest wall and over the bicipital groove. Petitioner also complained of discomfort when reaching cross body. Notably, Petitioner reported his pain had sort

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of worked its way back from the point of relief that he had received from the injection. (PX11 at 17) Dr. Paletta diagnosed recurrent right shoulder pain and a probable persistently symptomatic partial thickness tear of the infraspinatus based on the prior MRI. (PX11 at 18) Dr. Paletta noted “[i]t certainly appears the majority of his symptoms are related to the AC joint” and he recommended Petitioner consider arthroscopic surgery with distal clavicle excision and operative examination of the infraspinatus. In the alternative, Petitioner could consider repeating the MRI scan to further evaluate the infraspinatus. Dr. Paletta noted Petitioner would weigh his options. *Id.*

On August 4, 2022, Petitioner underwent hand surgery with Dr. Brown for an A1 pulley release of the right middle finger. The pre and post-operative diagnosis was chronic trigger finger that failed conservative treatment. (PX7) As mentioned, the trigger finger was related to Petitioner’s consolidated repetitive trauma claim.

On November 3, 2022, Dr. Frisella performed an IME at Respondent’s request for evaluation of the right shoulder. (RX4) Dr. Frisella noted Petitioner had worked with Respondent for 25 years and began noticing right shoulder pain in January 2021. Dr. Frisella noted Petitioner came under the care of Dr. Paletta and received physical therapy and an injection. Petitioner reported the physical therapy was not particularly helpful; however, the injection provided pain relief for 3 weeks and then wore off. Regarding Petitioner’s then-current complaints, Dr. Frisella’s IME report indicated the following:

He currently reports pain in the front and side of his right shoulder radiating down his arm, pain at night, *pain with reaching and lifting*. No neck pain, no tingling and numbness. (Emphasis added.) (RX4 at 1)

Dr. Frisella obtained Petitioner’s work history and reviewed medical records. Dr. Frisella diagnosed a right partial-thickness tear of the rotator cuff and AC joint arthritis. (RX4 at 2) Dr. Frisella opined the right shoulder rotator cuff pathology was causally related to Petitioner’s “work exposure” and recommended surgery. *Id.* As reflected in the Arbitrator’s decisions, Respondent approved the surgery recommended by Dr. Paletta. Petitioner was advised to reduce his weight before undergoing the shoulder surgery.

Dr. Gornet then saw Petitioner on November 17, 2022. (PX8 at 13) Dr. Gornet noted Petitioner had lost ten pounds since his last visit and confirmed there had been no increase in myelopathic symptoms. Dr. Gornet recommended continued weight loss and advised Petitioner he should reduce his current BMI of 52 down to a BMI of 40-45 prior to cervical spine surgery, which would place Petitioner’s weight in the area of 375 pounds. *Id.*

On June 06, 2023, Dr. O’Boynick re-examined Petitioner at Respondent’s request. (RX6, deposition exhibit #3) Dr. O’Boynick reviewed the imaging from the MRI of the cervical spine completed on January 3, 2022. He noted cord signal change posterior to C4-C5 consistent with myelomalacia. Dr. O’Boynick also noted multilevel spinal stenosis, most severe at C4-C5 and C5-C6 secondary to congenital stenosis and disc bulging. Dr. O’Boynick reviewed updated

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medical records from Dr. Paletta and noted the positive response with significant relief of symptoms following the diagnostic and therapeutic injections into the AC joint on March 16, 2022. He also reviewed the IME report by Dr. Frisella and records from Dr. Gornet. Based on the updated medical information, Dr. O'Boynick diagnosed continued cervicgia with cervical spinal and foraminal stenosis, and myelomalacia without radicular or myelopathic symptoms. (Deposition exhibit #3 at 6) The doctor further noted the cervical MRI demonstrated congenital spinal stenosis and commented that the cord signal change at C4-C5 was likely secondary to pressure on the cord. Dr. O'Boynick also noted that cervical myelopathy can slowly result into a subtle onset of neurological dysfunction but Petitioner did not exhibit any of those symptoms. Dr. O'Boynick continued to opine that the cervical spine condition was unrelated to the fall at work in May 2021 and reiterated the same two reasons given in his first IME report, namely, the pain relieving response to the shoulder injection and the 6-8 week gap in complaints related to the neck.

Dr. Gornet next saw Petitioner nine months later on August 17, 2023. (PX8 at 15) Dr. Gornet noted Petitioner reduced his weight to 437 pounds which was not enough for cervical spine surgery. Dr. Gornet noted Petitioner had recently been approved for shoulder surgery with Dr. Paletta and indicated he cautioned Petitioner that he probably should address his cervical spine condition first before proceeding with shoulder surgery. *Id.*

At trial, Petitioner testified that Dr. Gornet was not recommending surgery for his lumbar spine. (T. 29-30) Petitioner testified he received injections and nerve blocks for the low back condition which provided relief. (T. 30) Regarding his cervical spine, Petitioner testified he underwent an MRI at a different location due to his size and that Dr. Gornet recommended a three-level disc replacement. (T. 31) Petitioner testified he wants to move forward with the recommended cervical spine surgery. *Id.* Petitioner agreed that Dr. Gornet recommended he have his cervical spine surgery before he has shoulder surgery with Dr. Paletta. (T. 34-35) Petitioner testified he is continuing with his weight loss efforts and understands Dr. Gornet wants him below a certain weight in order to have the surgery. (T. 36-37)

Regarding the onset of his neck pain, Petitioner testified he began noticing neck pain after working for a few hours during his first day back at work. (T. 28) Petitioner further testified he never had any neck pain before the accident and that his neck pain began after the accident. (T. 29) On cross-examination, Petitioner confirmed his neck pain began after he returned to work:

Q. And had you been having those problems since the date of injury until you saw Dr. Gornet?

A. The injury, I don't remember. I don't remember having the problems until I actually started -- until I went back to work, until I started working and moving and doing the routine at work, that's when I remember having problems. (Emphasis added.) (T. 45-46)

On further cross-examination, Petitioner agreed he began treating with Dr. Paletta for his shoulder in February of 2022. (T. 47) Petitioner agreed he received an injection in his right shoulder which provided relief of his symptoms. (T. 47-48) Petitioner agreed he last saw Dr. Paletta in June 2022 and testified he was supposed to return to Dr. Paletta when he reduced his weight; however, that has been postponed due to his neck issue. Petitioner testified that Dr. Paletta's stated goal was for Petitioner to reduce his weight to 380 and Petitioner currently weighs 391. (T. 48)

Respondent disputes liability for the cervical spine condition and relies on the medical opinions of its section 12 IME physician, Dr. O'Boynick, who testified via deposition in March 2024. (RX6) Dr. O'Boynick testified Petitioner reported he did not have neck pain until after he returned to work. Dr. O'Boynick testified Petitioner received treatment during this intervening period of time, which included the initial emergency room treatment, followed by treatment with Dr. Brooks, therapy with Cory Voss, and primary care visits with Dr. Nukala. Regarding the cervical x-rays taken at the emergency room, Dr. O'Boynick testified it is common practice to take cervical x-rays any time a patient comes in with head trauma. (RX6 at 16) Dr. O'Boynick noted there were no documented neck complaints. Dr. O'Boynick testified Petitioner had an MRI of the lumbar spine and the treatment provided to Petitioner prior to his first IME had been primarily conservative care addressing the lumbar spine including lumbar spine injections with Dr. Blake. Dr. O'Boynick further testified that at least one injection had been performed for the shoulder which provided improvement. (RX6 at 7)

On the question of causation, Dr. O'Boynick continued to opine that Petitioner's cervical spine condition was not causally related to the work accident. (RX6 at 12) Dr. O'Boynick testified he had two reasons for reaching that opinion. The first reason was Petitioner's response to the shoulder injection:

So he had right-sided cervical complaints that he relayed to me as well as some shoulder complaints, and he received an injection in the right shoulder and that alleviated a large portion of his symptoms. So there's some overlap between the neck and the shoulder in terms of where the pain goes, and if a shoulder injection makes it all go away, then the majority of the pain is likely coming from the shoulder, and so based upon that response to the injection, I thought that a large portion of his complaints relating to the right side of his neck, trap and shoulder were related to an intraarticular pathology. (RX6 at 12)

Dr. O'Boynick testified that Petitioner reported to him that the shoulder injection helped quite a bit. (RX6 at 14-15) Dr. O'Boynick further commented that it's not the duration of the relief; it's the quality of the relief that matters for diagnostic purposes. (RX6 at 15) Dr. O'Boynick testified that the positive response to the shoulder injection indicated that some component of his pain was coming from the right shoulder. *Id.*

The second reason was the delayed timing of Petitioner's neck pain. (RX6 at 12) Dr. O'Boynick testified there was a gap in time reflected in the treatment records showing there was

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no neck pain for 6 to 8 weeks reported to any of the treating healthcare providers. (RX6 at 13) Dr. O'Boynick further testified that the timing of Petitioner's neck pain was inconsistent for a trauma induced neck injury. (RX6 at 18)

Dr. O'Boynick also testified that Petitioner underwent an MRI of the cervical spine after the first IME which revealed congenital spinal stenosis and myelomalacia, though Petitioner did not exhibit any abnormal neurological findings. (RX6 at 24-25) Dr. O'Boynick testified that his causation opinion did not change following his second IME. Regarding the myelomalacia, Dr. O'Boynick testified that the condition results from prolonged pressure on the spinal cord for a long time. (RX6 at 26) Dr. O'Boynick further testified that if Petitioner's myelomalacia had been caused by the fall at work, there would have been profound neurological change, and while those changes can take time to develop, no such changes have taken place. From a causation standpoint, Dr. O'Boynick testified, "so that would be another wrinkle there 'cause if you fall hard enough to develop a spinal cord injury, you're going to be different when you stand up and he was not [from a neurological perspective]." Dr. O'Boynick agreed with Dr. Gornet's recommended treatment plan based on the MRI findings; however, Dr. O'Boynick noted that surgical intervention for the cervical spine would not be causally related to the work accident. (RX6 at 27)

On cross-examination, Dr. O'Boynick agreed that the lumbar spine condition was causally related to the work accident. (RX6 at 32) Dr. O'Boynick agreed that the cervical spine condition warrants treatment but it remained his opinion that the work accident did not cause or aggravate the pathology present in Petitioner's cervical spine. (RX6 at 33) Dr. O'Boynick agreed as a general principle that falling down and striking the head can be a consistent mechanism of injury for aggravation of a cervical spine condition; however, in this case the timeline was the problem. (RX6 at 33)

On continued cross-examination, Dr. O'Boynick agreed that shoulder pain can emanate from the cervical spine. Dr. O'Boynick further agreed that problems at the C4-C5 level can cause shoulder pain; however, Dr. O'Boynick explained that "problems coming from C4-5 don't respond to shoulder injections and that's the big wrinkle here." (RX6 at 37-38) Finally, Dr. O'Boynick testified that while patients can have both a cervical injury and a shoulder injury, in this particular case "it's a low likelihood based upon the presentation of symptoms in terms of when the neck pain was reported." *Id.*

Dr. Gornet provided two explanations attempting to refute Dr. O'Boynick's opinions. Dr. Gornet discounted the time gap for the reason that Petitioner injured his spinal cord at the C4-C5 level which also produces shoulder pain. Dr. Gornet further noted that Petitioner complained of shoulder pain early on after the accident. (PX13 at 18) Dr. Gornet thus believed that the shoulder pain originated from the cervical spine condition and the time gap was essentially non-existent. Additionally, Dr. Gornet testified that the positive response to the shoulder injection did not eliminate the cervical spine as a pain generator. Dr. Gornet noted Petitioner had spinal cord changes at the C4-C5 level which also produces shoulder pain, and it was his opinion that the

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injection did not truly eliminate the cervical spine as a contributing source of pain on the theory that the injected pain relieving medication “spread” into the neck and produced overall pain relief.

I find Dr. Gornet’s explanations unpersuasive. As to the opinion that the gap in time without neck pain was essentially non-existent by reason of the right shoulder pain, Dr. Gornet was seemingly unaware of the ongoing pre-existing right shoulder pain that continued uninterrupted through the date of Petitioner’s fainting episode on May 24, 2021. Dr. Gornet’s reliance on the presence of shoulder pain as a manifestation of a cervical injury is not credible given that Petitioner had documented shoulder pain both before and after the fall-down accident without change. Therefore, because Dr. Gornet’s causation opinion for the cervical spine condition is based on an inaccurate understanding of when the shoulder pain started, I would accord his opinion no weight.

As to Dr. Gornet’s second opinion that the shoulder injection had “spread” to cover the neck, I find that explanation equally unpersuasive. Dr. Gornet failed to explain how the solution injected into the AC joint could spread *upward* through the trapezius and into the neck and reach the C4-C5 disc level. Dr. Gornet also failed to explain how an injection into the AC joint could directly alleviate neck pain if the neck pain originates from the spine. Where a medical witness provides an opinion without further explanation or elaboration, the opinion may be considered incomplete and accorded less weight. See *Collazo vs. Eklind Tool Co.*, 2018 Ill. Wrk. Comp. LEXIS 1362, 18 IWCC 560 (where the Commission affirmed the arbitrator’s findings that the treating physician “simply determined that the Petitioner’s employment caused her CTS because the Petitioner reported performing computer work for six years” and “[h]is causation opinion failed to explain why Petitioner’s symptoms were work related.”); and *Cole vs. State of Illinois, Illinois Veteran’s Home*, 2011 Ill. Wrk. Comp. LEXIS 900, 11 IWCC 816 (where the Commission affirmed the arbitrator’s finding that the treating surgeon’s recommended three level cervical fusion was not reasonable and necessary “because he *failed to explain* his rationale for the proposed treatment.”) (Emphasis added.)

In his Conclusions of Law analysis, the Arbitrator focused on the neck soreness documented by EMT personnel immediately after the accident, and found that sufficient to establish causation based on a chain of events analysis. There is a valid question as to whether that soreness truly supports a chain of causation; however, as the emergency room records indicated there was no cervical tenderness and the cervical exam was normal. This is consistent with Petitioner’s refusal of a C-collar from the EMT. Moreover, the Arbitrator did not directly address the absence of any neck complaints in the treatment notes from May 27, 2021 through July 8, 2021, the date on which Petitioner complained of pain between the shoulder blades, or the July 20, 2021 therapy visit where Petitioner complained of neck pain. Based on the 6-8 week passage of time without neck complaints, despite numerous opportunities to report neck pain at his visits on May 27, 2021, May 28, 2021, June 3, 2021, June 7, 2021, June 8, 2021, June 10, 2021, June 11, 2021, June 14, 2021, June 15, 2021, June 17, 2021, June 21, 2021, June 22, 2021, June 24, 2021, June 28, 2021, July 1, 2021, July 5, 2021, and July 6, 2021, the isolated neck soreness documented

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by EMT personnel was in my view an insufficient basis for inferring causation based on a chain of events analysis.

In *William Clayton vs. State of Illinois, Vienna Correctional Center*, 23 IWCC 0090, the Commission found the claimant failed to prove causation based on the timing of the symptoms. In *Clayton*, the claimant was a correctional officer who stepped into a hole while stepping off a sidewalk and “jarred everything.” The accident date was July 19, 2019. The claimant received treatment for the lumbar spine and was diagnosed with low back pain and right sided sciatica. On a referral from his primary care physician, the claimant saw Dr. Gornet, the same physician involved in the case at bar, for treatment of his lumbar spine on August 1, 2019, and then received therapy. Petitioner underwent lumbar spine injections on September 24, 2019. The claimant returned to Dr. Gornet on October 28, 2019 and reported the onset of neck pain. Relying on the records, the Commission noted the “the cervical complaints did not begin for at least eight weeks after his work accident.” (Emphasis added.) Dr. Gornet opined the delayed onset was not inconsistent with causation; however, the Commission rejected the opinion. The Commission ultimately determined:

Based on the above and the evidence in the record, we find that Petitioner’s cervical symptoms did not develop in a reasonable amount of time, under the present circumstances, to prove that they are causally related to his work accident. On this issue, we find Dr. Chabot’s opinion more persuasive than that of Dr. Gornet.

I would apply the same reasoning here and conclude that the 6-8 week delayed onset of neck pain was inconsistent with a trauma induced cervical spine injury. The diagnosed myelomalacia, as noted by Dr. O’Boynick, is a condition that develops over a long period of time secondary to pressure on the cord, and in this case Petitioner’s condition stems from a congenitally narrowed spinal canal. Had the myelomalacia resulted from trauma, there would have been neurological signs which have not occurred. I would also find the positive response to the shoulder injection given by Dr. Blake, which resulted in complete pain relief for a significant period of time, as evidence pointing to the shoulder as the primary source of Petitioner’s right-sided shoulder, trapezial, and right sided neck pain.

Therefore, considering the record as a whole, and for the reasons explained above, I partially dissent from the majority’s decision. I would find Petitioner failed to prove a causal connection between the accident and his cervical spine condition and would therefore vacate the award of medical expenses and prospective medical benefits for the cervical spine condition.

/s/ Kathryn A. Doerries

Kathryn A. Doerries

December 31, 2025

ILLINOIS WORKERS' COMPENSATION COMMISSION
DECISION SIGNATURE PAGE

Case Number	21WC017438
Case Name	Leonard Anderson v. Amsted Industries, Inc.
Consolidated Cases	21WC010029;
Proceeding Type	19(b) Petition Remand Arbitration
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	11
Decision Issued By	Bradley Gillespie, Arbitrator

Petitioner Attorney	Giambattista Patti
Respondent Attorney	Julie Pagano

DATE FILED: 7/1/2024

/s/ Bradley Gillespie, Arbitrator
Signature

THE INTEREST RATE FOR THE WEEK OF JUNE 25, 2024 5.14%

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)

Leonard Anderson

Employee/Petitioner

v.

Amsted Industries, Inc.

Employer/Respondent

Case # **21** WC **017438**

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 **Bradley Gillespie**, Arbitrator of the Commission, in the city of **Collinsville**, on **5/15/24**. 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, **5/24/21**, 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 **\$31,319.76**; the average weekly wage was **\$894.85**.

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 **\$0.00** for TTD, **\$N/A** for TPD, **\$N/A** for maintenance, and **\$2,634.96** for other benefits, for a total credit of **\$2,634.96**.

Respondent is entitled to a credit of **\$any/all paid** under Section 8(j) of the Act.

ORDER

Respondent shall pay for the reasonable and necessary medical treatment as set forth in Petitioner's Exhibit 12 pursuant to Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay for the medical treatment recommended by Dr. Gornet along with any follow up care attendant thereto.

Respondent shall pay temporary total disability benefits for the period between May 25, 2021, through June 29, 2021, and July 30, 2021, through October 28, 2021, representing 18-1/7 weeks. Respondent is entitled to a credit of \$2,634.96 for nonoccupational indemnity disability benefits.

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.

Bradley D. Gillespie

Signature of Arbitrator

July 1, 2024

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LEONARD ANDERSON,	)	
	)	
Employee/Petitioner,	)	
	)	
v.	)	Case No.: 21WC010029
	)	21WC017438
AMSTED INDUSTRIES, INC.,	)	
	)	
Employer/Respondent.	)	

19(b) DECISION OF ABRITRATOR

On April 19, 2021, Leonard Anderson [hereinafter "Petitioner"] filed a claim alleging repetitive trauma injuries to his right shoulder, right arm, right middle finger, and body as a whole while working for Amsted Industries, Inc. [hereinafter "Respondent"] with a reported date of accident on January 6, 2021. (Arb. Ex. 2) This claim was assigned Case Number 21WC010029. *Id.* On June 15, 2021, Petitioner filed an Application for Adjustment of Claim alleging injuries to the body as a whole as a result of a fall due to heat exhaustion while working for Respondent on May 24, 2021. (Arb. Ex. 4) This claim was assigned Case Number 21WC017438 and was eventually consolidated with 21WC010029. There were no disputed issues before the Commission for Case Number 21WC010029, and the proposed shoulder surgery recommended by Dr. Paletta has been approved. (Arb. Ex. 1)

The issues in dispute for Case Number 21WC017438 are as follows:

- Accident;
- Temporary Total Disability;
- Medical Expenses; and
- Prospective Medical Treatment.
- All other issues have been stipulated.

(See Arb. Ex. 3) This claim was tried to on a 19(b) in Collinsville on May 15, 2024.

FINDINGS OF FACT

At the time of the hearing, Petitioner was 51 years old, single with no dependent children. (Tr. p. 15) He has worked for Respondent for 26 years and has held numerous positions. *Id.* Petitioner currently works as a fork truck operator. *Id.* He had worked in various capacities for Respondent including the paint unit, knockout, blast operator, Drake operator and various other positions. (Tr. p. 16)

On May 24, 2021, Petitioner worked in the paint unit for Respondent. (Tr. p. 16) Petitioner testified that they had been off work for three weeks due to the pain unit being moved

from one building into another. *Id.* Petitioner testified the paint unit was being moved from one building to another, but it was not fully ready for operation, so he was instructed to sweep and take out trash. (Tr. pp. 16-17) He asked his superintendent, Justin Eckstein, about the fans which had not been installed in the new building, noting they were vital to keep air circulating and the workplace cooler. (Tr. p. 17) He stated that there had been fans in the old paint unit. *Id.* Petitioner testified that it is hot in the paint unit and the fans help to circulate the air and keep it cooler. *Id.* Petitioner testified that his shift was 6:00 a.m. until 4:30 p.m. *Id.* He estimated that the temperature in the plant was approximately 96 to 98 degrees on the date in question. (Tr. p. 18) The parties agreed and stipulated that the temperature on May 24, 2021 was between 86 and 88 degrees outdoors. *Id.*

Petitioner said that the door to building was approximately 30 by 100 foot tall but was about 50 to 55 feet away. (Tr. p. 19) He stated that there three doors, all of which were 50 feet away. (Tr. p. 20) Petitioner could not say whether the other doors were open. *Id.* He testified that the temperature was hotter inside the building. *Id.* Petitioner estimated that the temperature was 96 to 98 degrees by 11:00 a.m. *Id.* By 11:00 o'clock, Petitioner had taken a 15 minute break from 9:00 to 9:15 and was already sweating. (Tr. p. 21) He testified that he began feeling ill, so he went to get a drink and sat down a few minutes. (Tr. p. 22) At that point, he started feeling worse, went to stand up to go outside for some fresh air and that is all he remembered. *Id.* Petitioner's next recollection was that there were several people gathered around him. (Tr. p. 23) He was taken to Gateway Regional Hospital via ambulance. *Id.* Records from Amsted EMT report that they were called to C&F center bay for an employee who had passed out. (PX 3) EMT's report that Petitioner was in and out of consciousness and they called for an ambulance. *Id.* Physical exam findings included a contusion and abrasion to the left forehead and that Petitioner complained of neck soreness. *Id.*

The emergency room physician noted a history of working in a hot environment, sweating profusely, feeling really bad, starting to walk outside to cool off and passing out hitting his head on the ground. (PX 4) Petitioner's neck was noted to be stiff, he had abrasions to his face and was positive for a loss of consciousness. *Id.* He was diagnosed with heat syncope. *Id.* After being evaluated, Petitioner was released. (Tr. p. 23)

Petitioner followed up with Dr. Nukala and reported a consistent history of being overheated. (PX 5) Dr. Nukala excused Petitioner off work and prescribed blood pressure medication. (Tr. p. 27) At the time of trial, Petitioner testified that he no longer requires that blood pressure medication after losing over one hundred (100) pounds. (Tr. p. 28) Petitioner began losing weight so he can move forward with the surgery recommended by Dr. Gornet. *infra*

Petitioner identified photographs taken by his then girlfriend on May 29, 2021, of the abrasion on his forehead. (Tr. pp. 24-25) Petitioner testified that the abrasion was from when he fell from heat exhaustion and confirmed it was not present before his work accident. (Tr. p. 24)

Petitioner testified that prior to the May 24, 2021, incident, he had filed a repetitive trauma case alleging repetitive trauma to his shoulder and hand, specifically his right middle

finger. (Tr. 26-27) He acknowledged receiving treatment for this accident at MultiCare Specialist. (Tr. p. 27)

Petitioner returned to work on July 6, 2021, and after a few hours he noticed increasing pain in his neck, shoulders, and low back. (Tr. pp. 28-29) Petitioner has no history of neck issues and does not recall any neck pain prior to his May 24, 2021, fall. (Tr. p. 29) Petitioner readily admitted a history of low back pain and notes his low back pain became worse following his work accident. *Id.*

Petitioner reported his cervical complaints to Dr. Brooks on July 26, 2021. (PX 1) During this time, Petitioner continued to treat at MultiCare Specialists for his repetitive trauma claim. Petitioner was referred to Dr. Matthew Gornet. *Id.*

Petitioner first saw Dr. Gornet on July 30, 2021, and provided a consistent history of accident. (PX 8) He reported neck pain to the base of the right trapezius and right shoulder, as well as frequent headaches. *Id.* He also described low back pain central to both sides, both buttocks, both hips and paresthesia down both legs. *Id.* Dr. Gornet noted Petitioner had a history of low back pain, but no cervical issues. *Id.*

Dr. Gornet performed a physical examination and reviewed MRI films of his lumbar spine. (PX 8) Dr. Gornet opined Petitioner's MRI were consistent with an acute injury to the lumbar spine in the face of preexisting degeneration that was consistent with the mechanism provided by Petitioner. *Id.* Dr. Gornet excused Petitioner from work, prescribed physical therapy and chiropractic care, anti-inflammatories, muscle relaxants and an MRI of his cervical spine. *Id.* He opined Petitioner's symptoms were related to his May 24, 2021, work accident. (PX 8)

Petitioner followed up with Dr. Gornet on October 28, 2021. (PX 8) Petitioner had undergone medial branch blocks in his lumbar spine which provided some relief, but he was unable to get an MRI due to his size. *Id.* Dr. Gornet noted Petitioner weighed 479 pounds, down 18 pounds from his initial visit. *Id.*

Petitioner underwent a cervical MRI, and the findings were reviewed by Dr. Gornet on February 17, 2022. (PX 8) The films revealed a narrowed canal, central disc protrusions at C3-4, C4-5, and C5-6 but "more importantly...spinal cord changes at the 4-5 level right adjacent to his disc pathology, and that...could cause the symptoms he described, particularly shoulder pain." (PX 13 p. 11) Dr. Gornet testified that the MRI findings were consistent with the mechanism of injury described by Petitioner. (PX 13)

Due to Petitioner's congenitally narrowed spinal canal, he was not a candidate for injections at the cervical level. (PX 8; PX 13) Dr. Gornet recommended weight loss so he could treat Petitioner's neck. During a November 17, 2022, follow up visit, Dr. Gornet noted that Petitioner continued to lose weight and weighed in at 453 pounds. Dr. Gornet testified that if Petitioner reached 375 pounds, he would move forward with treatment to the neck, but, until then, Dr. Gornet placed light duty restrictions of no lifting more than 20 pounds, and no overhead work. (PX 13) Petitioner no longer works in the paint shop and now works as a fork truck operator which allows him to work within his restrictions. (Tr. p. 15)

Dr. Gornet recommends a three-level cervical disc replacement at C3-4, C4-5, and C5-6. Consideration could be given to treating C6-7, but additional imaging would be necessary. (PX 13) Dr. Gornet explained that due to Petitioner's congenitally narrowed spinal canal, he needs to have the cervical procedure before the accepted shoulder procedure recommended by Dr. Paletta. *Id.* Dr. Gornet explained that some of Petitioner's shoulder pain is coming from the pathology at C4-5 which is known to cause shoulder pain which will likely prevent him from adequately rehabbing his shoulder post-operatively thus adversely affecting the outcome of Petitioner's shoulder surgery. (PX 13 pg. 14) Dr. Gornet also notes that Petitioner's congenitally narrowed spinal canal also presents a significant risk during surgery because movement during a shoulder surgery could result in quadriplegia.

Petitioner was examined by Dr. Christopher O'Boynick at the behest of Respondent on November 5, 2021. (RX 6) Dr. O'Boynick believes Petitioner's symptoms are not related to his work accident because of the pain relief he felt from his shoulder injections. *Id.* He felt the gap between the inciting incident and treatment of Petitioner's neck symptoms, prevented him from drawing a causal connection between Petitioner's fall and his cervical condition. *Id.* He also believed if Petitioner's symptoms were related to his work accident, they would have presented sooner than 6-8 weeks. *Id.*

Dr. O'Boynick acknowledged Petitioner cervical pathology warrants medical treatment and recognizes that Petitioner provided a consistent history of accident. (RX 6) He acknowledged there is an interplay between shoulder and neck complaints and recalled his own patients that have gone through initial treatment for a shoulder problem that turned out to be a cervical issue. (RX 6 pg. 34) He acknowledged that Petitioner underwent cervical x-rays at the emergency room immediately following the work accident, and Dr. Nukala also examined Petitioner's cervical spine noting abnormal range of motion.

Dr. O'Boynick and Dr. Gornet agree that Petitioner's pathology at C-4-5 could cause shoulder pain and his cervical spine should be treated before his shoulder. The doctors both agree that Petitioner has demonstrated an active role in his own care with his weight loss.

Dr. Russell Cantrell, a Physical Medicine and Rehabilitation doctor, performed a records review on August 30, 2021, and opined that the cause of Petitioner's syncopal episode is unknown concluding the records do not support a heat-related cause. (RX 5) He cites Petitioner's body temperature in the emergency room, and normal blood urea nitrogen, and normal respiratory rate. *Id.*

At trial, Petitioner recalled two prior instances of heat exhaustion and noted he felt the same on May 24, 2021, as his previous two occurrences.

Petitioner testified that he wants to move forward with surgery recommended by Dr. Gornet. (Tr. p. 31) He testified that "my neck's locking up when I turn it to the left." (Tr. p. 32) He described daily pain that progresses to the point where he cannot hold his head up by midday. (Tr. pp. 32-33) At work, he lays his head on his shoulder while he drives a fork truck. (Tr. p. 36) Driving the fork truck also causes pain as he is "jostled around like...a pogo stick." *Id.* Since his work accident, Petitioner takes 800 milligrams of ibuprofen a day. (Tr. p.50) Petitioner testified

that his neck hurt during his testimony, and he answered questions with his head tilted due to the pain. (Tr. p. 55) He did not tilt his head in that way before his work accident. (Tr. pp. 55-56)

In preparation for surgery, he has lost over one hundred (100) pounds. He was given a shot to aid with his weight loss and he has stopped drinking soda, eating bread, and reduced the portion size of his meals. (Tr. p. 36)

CONCLUSIONS OF LAW

In Support of the Arbitrator's Decision regarding (C) and (F), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent; and is Petitioner's current condition of ill-being causally related to the injury?

The Arbitrator incorporates by reference the Findings of Fact set forth in the foregoing paragraphs. In order for a work injury to be compensable, it must arise out of and in the course of employment. "The 'arising out of' component is primarily concerned with causal connection. To satisfy this requirement it must be shown that the injury had 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*, 129 Ill. 2d at 58, 133 Ill.Dec. 454, 541 N.E.2d 665

The first step in risk analysis is to determine whether the claimant's injuries arose out of an employment-related risk—a risk distinctly associated with the claimant's employment. *Mytnik v. Industrial Comm'n*, 2016 IL App (1st) 152116WC, ¶ 39, 409 Ill.Dec. 491, 67 N.E.3d 946; *Steak 'n Shake*, 2016 IL App (3d) 150500WC, ¶ 38, 409 Ill.Dec. 359, 67 N.E.3d 571. As noted above, a risk is distinctly associated with an employee's employment if, at the time of the occurrence, the employee was performing (1) acts he or she was instructed to perform by the employer, (2) acts that he or she had a common-law or statutory duty to perform, or (3) acts that the employee might reasonably be expected to perform incident to his or her assigned duties. *Caterpillar Tractor*, 129 Ill. 2d at 58, 133 Ill.Dec. 454, 541 N.E.2d 665; see also *The Venture—Newberg-Perini, Stone & Webster v. Illinois Workers' Compensation Comm'n*, 2013 IL 115728, ¶ 18, 376 Ill.Dec. 823, 1 N.E.3d 535; *Sisbro*, 207 Ill. 2d at 204, 278 Ill.Dec. 70, 797 N.E.2d 665. *McAllister v. Ill. Workers' Comp. Comm'n*, 2020 IL 124848, 181 N.E.3d 656, 450 Ill.Dec. 304 (Ill. 2020)

There is no question as to whether Petitioner suffered an accident on May 24, 2021, as evidenced by the photographs admitted at trial showing the abrasion on Petitioner's suffered when he fell. His fall was witnessed by co-workers, and he was taken to the hospital by ambulance. The only question is why Petitioner fell.

Here, Petitioner was exposed to a risk incidental to his employment. He testified that building where he worked on May 24, 2021, did not have fans and it was unseasonably hot on that day. He arrived at work at 6 a.m. and by 11 a.m. had only one 15-minute break and was sweating profusely. Petitioner testified that he is familiar with heat exhaustion as he has succumbed to it on two other occasions. Petitioner began his day like any other and worked a normal day. The risk incidental to his employment was the lack of air flow due to the absence of

fans on a hot day. Petitioner sat down when he began to feel ill and began to walk outside when he lost consciousness striking his head on the floor.

Petitioner was engaged in an act his employer might reasonably expect him to perform incident to his duties, namely, walking outside to get fresh air on a hot day. This establishes his accident arose out of his employment by Respondent.

An employee is considered to be in the course of employment when he or she engages in certain acts of personal comfort. The personal comfort doctrine provides that the employee, while engaged in work, may do those things that are necessary and reasonable to his or her health and comfort and remain in the course of employment. This applies even if the act is personal in nature and done for only the benefit of the employee. *Illinois Consol. Tel. Co. v. Industrial Comm'n*, 314 Ill.App.3d, 347, 247 Ill.Dec.333, 732 N.E.2d 49 (5th Dist. 2000) The course of employment is not broken by these personal acts. *Eagle Discount Supermarket v. Industrial Commission*, 82 Ill.2d 331, 421 N.E.2d 492 (1980).

Petitioner did not leave the course of his employment because under the Personal Comfort doctrine because an employee does not leave the course of his employment when engaged in reasonable acts for the benefit of his health and comfort. The act of getting fresh air represents a reasonable act by Petitioner and therefore his accident occurred in the course of employment. The Arbitrator finds and concludes that Petitioner sustained an accident that arose out of and in the course of his employment by Respondent.

Respondent urges this Commission to deny benefits based on allegations that Petitioner was not exposed to a risk greater than that to which the public is exposed. The Supreme Court definitively addressed this issue in *McAllister*.

Respondent also argues Petitioner's fall was not heat related and due to a personal risk. In support, they cite a handwritten note claimed to be authored by Dr. Dierkers inserted in Petitioner's file on June 10, 2021, sixteen (16) days after Petitioner's accident. The note claims the emergency room diagnosis of heat syncope was incorrect. This opinion was reached without examining Petitioner and without Petitioner's relevant medical history of prior heat related syncope. This opinion is contradicted by Dr. Nukala who also diagnosed heat syncope. The emergency room physician and Petitioner's primary care physician both examined Petitioner and Dr. Dierkers' note does little to contradict their diagnosis.

Respondent also relies on the opinion of Dr. Cantrell, who stated he could not definitively conclude Petitioner suffered a heat related syncopal episode. The Arbitrator finds these opinions to lack necessary information which is required to give them a reliability such as Petitioner's temperature when he was first encountered by EMS.

Petitioner testified that on May 24, 2021, he felt the same way he felt before the first two heat related incidents. Petitioner asked about the absence of fans at the beginning of his shift because he knew the building was warmer than the temperature outside and lacked airflow which was only made worse by the absence of fans.

The law holds that an 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. Industrial Comm'n*, 207 Ill.2d 193, 205, 797 N.E.2d 665, 672-673. [Emphasis

added]. “Petitioner need only show that some act or phase of employment was a causative factor of the resulting injury.” *Fierke v. Industrial Comm’n*, 93 Ill.2d 59, 442 N.E.2d 908 (1982).

Circumstantial evidence, especially when entirely in favor of the Petitioner, is sufficient to prove a causal nexus between an accident and the resulting injury, such as a chain of events showing a claimant’s ability to perform manual duties before accident but decreased ability to still perform immediately after accident. *Pulliam Masonry v. Indus. Comm’n*, 77 Ill. 2d 469, 397 N.E.2d 834 (1979); *Gano Electric Contracting v. Indus. Comm’n*, 260 Ill.App.3d 92, 96-97, 631 N.E.2d 724 (1994); *International Harvester v. Indus. Comm’n*, 93 Ill.2d 59, 442 N.E.2d 908 (1982).

In this case, Petitioner testified credibly regarding his neck and shoulder symptoms. The medical records show Petitioner immediately reported neck soreness to the EMT from Amsted on the date of accident. Dr. O’Boynick acknowledged Petitioner’s cervical pathology may cause shoulder pain. Furthermore, the record establishes Petitioner had no cervical complaints prior to his May 24, 2021, work accident. Finally, Respondent’s argument that Petitioner suffered an idiopathic fall is not supported by the medical evidence. It is further rebutted by Petitioner’s unrebutted testimony as to the cause of his fall.

Therefore, the Arbitrator finds and concludes that Petitioner suffered an accident that arose out of and in the course of his employment by Respondent and his current condition of ill-being is causally related to the May 24, 2021, work accident.

In Support of the Arbitrator’s Decision regarding (J) and (K), 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; Is Petitioner entitled to prospective medical care?

The Arbitrator incorporates by reference the Findings of Fact and Conclusions of Law set forth in the foregoing paragraphs. The right to be compensated for medical costs associated with work-related injuries is at the very heart of the Workers’ Compensation Act. *Hagene v. Derek Polling Center*, 388 Ill. App. 3d 390, 902 N.E. 2d 1269 (5th Dist. 2009). The purpose of the Act is to place on industry the burdens of caring for the casualties of industry instead of placing this burden on the public or on the individuals whose misfortunes arise out of the industry. *Shell Oil v. Industrial Commission*, 2 Ill. 2d 590, 119 N.E. 2d 224 (1954).

There is no evidence of unreasonable or unnecessary medical treatment found in the record. Upon establishing causal connection and the reasonableness and necessity of recommended medical treatment, employers are responsible for necessary prospective medical care by their employees. *Plantation Mfg. Co. v. Indus. Comm’n*, 294 Ill.App.3d 705, 691 N.E.2d. 13 (1997) This includes treatment to diagnose, relieve, or cure the effects of claimant’s injury. *F&B Mfg. Co. v. Indus. Comm’n*, 325 Ill.App. 3d 527, 758 N.E.2d 19 (2001)

Therefore, Respondent shall pay amounts pursuant to Sections 8(a) and 8.2 of the Act, for reasonable and necessary medical services referenced herein. Respondent is entitled to a credit for amounts it has previously paid to the providers referenced herein.

Dr. Gornet opined that Petitioner's mechanism of injury is consistent with his clinical presentation and that his injuries are causally related to his May 24, 2021, work accident. The Arbitrator finds that Dr. Gornet's opinions are more persuasive than those put forth by Dr. O'Boynick. Dr. Gornet is recommending a three level cervical disc replacement and Petitioner wishes to proceed. Petitioner has fully participated in his treatment and has lost the weight necessary to proceed. Dr. O'Boynick agrees Petitioner's cervical pathology warrants treatment. Having established accident and causation, the Arbitrator orders Respondent to authorize the three-level cervical disc replacement and the necessary follow up care as recommended by Dr. Gornet.

In Support of the Arbitrator's Decision regarding (L), What temporary benefits are in dispute?

Petitioner was excused from work for two different periods of time. The first period immediately followed his May 24, 2021, work accident from May 25, 2021 through June 29, 2021, and the second period between July 30, 2021, through October 28, 2021.

Petitioner bears the burden to prove each and every element of his claim, including the right to temporary total disability benefits. *Rambert v. Industrial Comm'n*, 133 Ill.App.3d 895, 903, 87 Ill.Dec. 836, 477 N.E.2d 1364 (1985). He is entitled to these benefits until his condition stabilizes. *Mechanical Devices v. Industrial Commission*, 800 N.E.2d 819, 826, 344 Ill.App.3d 752, 279 Ill.Dec. 531 (Ill.App., 2003)

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 146, 337 Ill.Dec. 707, 923 N.E.2d 266. *Holocker v. Ill. Workers' Comp. Comm'n*, 2017 IL App (3d) 160363WC, 82 N.E.3d 658WC (Ill. App. 2017) Therefore, to prove temporary total disability, an employee must demonstrate not only that he did not work, but also that he was unable to work. He is not required to demonstrate total incapacity or helplessness before a total disability award may be awarded. *Interlake, Inc. v. Industrial Comm'n*, 86 Ill.2d 168, 176, 56 Ill.Dec. 23, 427 N.E.2d 103 (1981).

Here, Petitioner was excused from work by Dr. Nukala between 5/25/21 through 6/29/21 and no evidence was presented to rebut this recommendation. Dr. O'Boynick acknowledged that Petitioner was not at maximum medical improvement at the time of his Section 12 examination. There was no evidence presented that Dr. Gornet's restrictions were unreasonable and no evidence to suggest Respondent could accommodate Petitioner's restrictions. Therefore, temporary total disability benefits shall be paid to Petitioner for the periods listed *supra*.

Having established accident and causation, the Arbitrator finds Petitioner is entitled to TTD benefits for the period between May 25, 2021, through June 29, 2021, and July 30, 2021, through October 28, 2021, representing 18-1/7 weeks. Respondent is entitled to a credit of \$2,634.96 for nonoccupational indemnity disability benefits.